North Staffordshire Combined Healthcare NHS Trust

# MEETING OF THE TRUST BOARD

## TO BE HELD IN PUBLIC
## ON Wednesday 26th September 2018, 10:00AM,
**BOARDROOM, LAWTON HOUSE, TRUST HEADQUARTERS,**
**BELLRINGER ROAD, TRENTHAM LAKES SOUTH,**
**STOKE ON TRENT, ST4 8HH**

| | AGENDA | |
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| 1. | **APOLOGIES FOR ABSENCE**<br>*To NOTE any apologies for absence* | Note |
| 2. | **DECLARATIONS OF INTERESTS RELATING TO AGENDA ITEMS** | Note |
| 3. | **MINUTES OF THE OPEN AGENDA – 26th July 2018**<br>*To APPROVE the minutes of the meeting held on 26th July 2018* | Approve<br>Enclosure 2 |
| 4. | **ACTION MONITORING SCHEDULE & MATTERS ARISING FROM THE MINUTES**<br>*To CONSIDER any matters arising from the minutes* | Note<br>Enclosure 3 |
| 5. | **CHIEF EXECUTIVE'S REPORT**<br>*To RECEIVE a report from the Chief Executive* | Note<br>Enclosure 4 |
| 6. | **CHAIR'S REPORT**<br>*To RECEIVE a verbal report from the Chair* | Note |
| 7. | **STAFF RETIREMENTS**<br>*To EXPRESS our gratitude and recognize staff who are retiring*<br>*To be introduced by the Chief Executive and presented by the Chair* | Verbal |
| 8. | **REACH RECOGNITION INDIVIDUAL AWARD ON EXCELLENCE**<br>*To PRESENT the REACH Recognition Individual Award to Anna Frary, Deputy Ward Manager AMH Inpatient Services*<br>To be introduced by the Chief Executive and presented by the Chair | Verbal |

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| 9 | **PATIENT STORY – SHAMUS HARVEY HILCREST**<br>*To RECEIVE a Patient Story from Shamus Harvey – Hillcrest to be introduced by Maria Nelligan, Executive Director of Nursing & Quality* | Verbal / Video |
| | **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**<br>*To RECEIVE an update from, Wendy Dutton Chair of the Service User and Carer Council* | Assurance Enclosure 5 |
| | **ENCOURAGE, INSPIRE AND IMPLEMENT RESEARCH AND INNOVATION AT ALL LEVELS** | |
| 12 | **RESEARCH AND DEVELOPMENT ANNUAL REPORT 2017/18**<br>*To RECEIVE the Research and Development Annual Report from Dr Darren Carr, Clinical Director NOAP* | Assurance Enclosure 6 |
| | **TO PROVIDE THE HIGHEST QUALITY SERVICES** | |
| 13 | **NURSE STAFFING MONTHLY REPORTS - JUNE AND JULY 2018**<br>*To RECEIVE the Nurse Staffing Monthly Report from Maria Nelligan, Executive Director of Nursing & Quality* | Assurance Enclosure 7 |
| 14 | **SAFEGUARDING CHILDREN & ADULTS ANNUAL REPORT 2017/18**<br>*To RECEIVE the Safeguarding Children and Adults Annual Report from Maria Nelligan, Executive Director of Nursing & Quality* | Assurance Enclosure 8 |
| 15 | **INFECTION PREVENTION AND CONTROL ANNUAL REPORT**<br>*To RECEIVE the Infection, Prevention and Control Annual Report from Maria Nelligan, Executive Director of Nursing & Quality* | Assurance Enclosure 9 |
| 16 | **HEALTH AND SAFETY ANNUAL REPORT**<br>*To RECEIVE the Health and Safety Report from Maria Nelligan, Executive Director of Nursing & Quality* | Assurance Enclosure 10 |
| 17 | **COMPLAINTS AND PALS ANNUAL REPORT**<br>*To RECEIVE the Complaints and PALS Report from Maria Nelligan, Executive Director of Nursing & Quality* | Assurance Enclosure 11 |
| 18 | **AHP DRAFT STRATEGY**<br>*To RECEIVE the AHP Draft Strategy from Maria Nelligan, Executive Director of Nursing & Quality* | Assurance Enclosure 12 |

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| 19 | **MEDICAL REVALIDATION ANNUAL ORGANISATIONAL (AOA) COMPARATOR REPORT**<br>*To RECEIVE the Medical Revalidation Annual Organisational Comparator Report from Dr Darren Carr, Clinical Director, NOAP* | Assurance Enclosure 13 |
| 20 | **SMOKE FREE PROGRESS REPORT**<br>*To RECEIVE the Smoke Free Progress Report from Dr Darren Carr, Clinical Director, NOAP* | Assurance Enclosure 14 |
| 21 | **PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 4**<br>*To RECEIVE the Month 4 Performance Report from Suzanne Robinson, Director of Finance, Performance and Digital* | Approval Enclosure 15 |
| | **CREATE A LEARNING CULTURE TO CONTINUALLY IMPROVE** | |
| 22 | **BEING OPEN QUARTERLY REPORT**<br>*To RECEIVE the Being Open Quarterly report from Caroline Donovan, Chief Executive* | Assurance Enclosure 16 |
| | **MAXIMISE AND USE OUR RESOURCES INTELLIGENTLY AND EFFICIENTLY** | |
| 23 | **FINANCE REPORT – MONTH 4 (2018/19)**<br>*To RECEIVE for discussion the Month 4 Financial position from Suzanne Robinson, Director of Finance, Performance and Digital* | Approval Enclosure 17 |
| 24 | **ASSURANCE REPORT FROM THE FINANCE, PERFORMANCE & DIGITAL COMMITTEE**<br>*To RECEIVE the Finance, Performance & Digital Committee Assurance report from the meetings held 3rd August 2018 and 6th September 2018 from Tony Gadsby, Chair/Non-Executive Director* | Assurance Enclosure 18 |
| 25 | **DECLARATION OF INTERESTS – August 2018**<br>*To RECEIVE for information and assurance the Trust Board Register of Interests to August 2018 from Laurie Wrench, Associate Director of Governance* | Assurance Enclosure 19 |
| | **ATTRACT AND INSPIRE THE BEST PEOPLE TO WORK HERE** | |
| 26 | **ASSURANCE REPORT FROM THE PEOPLE & CULTURE DEVELOPMENT COMMITTEE**<br>*To RECEIVE the People and Culture Development Committee Assurance report from the meeting held 10th September 2018 from Lorien Barber, Non-Executive Director* | Assurance Enclosure 20 |

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| 27 | **ASSURANCE REPORT FROM THE AUDIT COMMITTEE**<br>*To RECEIVE the Audit Committee Assurance report from the meeting held 6th September 2018 from Gan Mahadea, Non-Executive Director* | Assurance Enclosure 21 |
| 28 | **ASSURANCE REPORT FROM THE QUALITY COMMITTEE**<br>*To RECEIVE the Quality Committee Assurance report from the meeting held 9th August 2018 from Patrick Sullivan, Non-Executive Director* | Assurance Enclosure 22 |
| 29 | **2018 TRUST WORKFORCE RACE EQUALITY STANDARD WRES REPORT AND ACTION PLAN**<br>*To RECEIVE the 2018 Trust Workforce Race Equality Standard WRES Report and Action Plan from Caroline Donovan, Chief Executive* | Assurance Enclosure 23 |
| | **CONTINUALLY IMPROVE OUR PARTNERSHIP WORKING** | |
| 30 | **LOCALITY WORKING / RESTRUCTURE**<br>*To RECEIVE an update regarding Locality Working / Restructure from Jonathan O'Brien, Director of Operations* | Assurance Enclosure 24 |
| | **ANY OTHER BUSINESS** | |
| | *The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday 25th October 2018 at 10:00am.* | |
| | **MOTION TO EXCLUDE THE PUBLIC**<br>*To APPROVE the resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admissions to Meetings) Act 1960)* | |
| | **THE REMAINDER OF THE MEETING WILL BE IN PRIVATE** | |
| | **DECLARATIONS OF INTEREST** | Note |
| | **DECLARATIONS OF ANY OTHER BUSINESS** | Note |
| | **SERIOUS INCIDENTS** | Assurance |
| | **PERFORMANCE** | Approve |
| | **ESTATES** | Assurance |
| | **WORKFORCE AND AGENCY** | |
| | **ANY OTHER BUSINESS** | |

# TRUST BOARD

## Minutes of the open section of the North Staffordshire Combined Healthcare NHS Trust Board meeting held on Thursday 26th July 2018 At 10:00am in the Boardroom, Trust Headquarters, Lawton House Bellringer Road, Trentham, Stoke on Trent, ST4 8HH

**Present:**

**Chairman:**

David Rogers
Chairman

**Directors:**

Caroline Donovan
Chief Executive

Dr Buki Adeyemo
Medical Director

Suzanne Robinson
Director of Finance, Performance and Digital

Patrick Sullivan
Non-Executive Director

Alex Brett
Executive Director of Workforce, Organisational Development and Communications

Gan Mahadea
Non-Executive Director

Tony Gadsby
Non-Executive Director

Jonathan O'Brien
Director of Operations

Sue Tams
Service User Care Council Representative

Lorien Barber
Non-Executive Director

**In attendance:**

Laurie Wrench
Associate Director of Governance

Lisa Wilkinson
Corporate Governance Manager (minutes)

Jenny Harvey
Unison Representative

Members of the public:
None

Retirees
Helen MacMahon – Head of Directorate CYP

Julie Anne Murray
Deputy Director of Nursing and Quality

REACH Team Recognition Award
The Paediatric Team CYP
Ruth Fishwick
Carol Martin
Jane Parker

The meeting commenced at 10:03am.

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| **153/2018** | **Apologies for Absence**<br><br>Maria Nelligan Executive Director of Nursing and Quality, Dr Keith Tattum GP Associate and Wendy Dutton, Chair of Service User Carer Council, Joe McCrea, Associate Director of Communications | **Action** |

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| **154/2018** | **Declaration of Interest relating to agenda items**<br><br>There were no declarations. | |
| **155/2018** | **Minutes of the Open Agenda – 21st June 2018**<br><br>The minutes of the open session of the meeting held on 21st June 2018 were approved. | |
| **156/2018** | **Matters arising**<br><br>The Board reviewed the action monitoring schedule and agreed the following:-<br><br>***116/2018 – Learning from Deaths Quarterly Report -*** *Update due at September Trust Board.*<br><br>***125/2018 – Cybersecurity Suzanne Robinson to confirm if Trust are insured against a Cybersecurity attack –*** *Quotes have been sourced the range is between 12k and 34k. This will be discussed further during Finance and Performance Committee. Remove.*<br><br>***139/2018 – Towards Outstanding Innovative Practice*** *– Appointment has been made to the Digital and Media post a priority of which will be to look at positive communications for the Trust.*<br><br>***140/2018 – Safer Staffing Monthly Report April 2018*** *- Update due at October Trust Board.*<br><br>***141/2018 (1) – Serious Incident Report (1)*** *- Update due at September Trust Board.*<br><br>***141/2018 (3) – Serious Incident Annual Report (3)*** *– Agenda item for Quality Committee 9th August 2018*<br><br>***145/2018 – Month 1 Finance Report*** *– Actioned*<br><br>***148/2018 – Assurance Report from the Quality Committee*** *– Actioned*<br><br>***150/2018 – Locality Working / Restructure*** *– Agenda item today* | |
| **157/2018** | **Chief Executive's Report**<br><br>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.<br><br>**LOCALITY TRANSFORMATION PASSES SIGNIFICANT MILESTONES**<br>The programme to introduce locality working has passed significant | |

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| | milestones.<br><br>**Phase 1** formally completed on schedule on Friday 6th July. Following formal consultation interviews for the new Clinical Directors (CD) and Associate Directors (AD) have taken place.<br><br>These are:<br><br>• **Stoke Directorate** - Jane Munton-Davies (AD) and Dennis Okolo (CD)<br>• **North Staffordshire Directorate** - Samantha Mortimer (AD) and Darren Carr (CD)<br>• **Specialist Services Directorate** - Ben Boyd (AD) and Darren Perry (CD)<br>• **Acute & Urgent Care Directorate** - we currently have a remaining vacancy for the post of Associate Director and Carol Sylvester has been appointed as Interim Clinical Director.<br><br>**Phase 2** commenced on the 4th June 2018 through formal consultation and closed on the 4th July 2018. This phase relates primarily to the senior Professional Leadership Structure within the Trust concerning Heads of Nursing, Allied Health Professionals, Psychology, Social Work and Medical Associate Directors. This phase was led by the Trust's Medical Director, Dr Buki Adeyemo and Director of Nursing and Quality, Maria Nelligan.<br><br>The next part of the process will involve considering any feedback received to date as part of the consultation, ensuring we have responded where required and confirming the structure moving forwards leading to the appointment of any vacancies.<br><br>**Phase 3 – Configuration of Associate Clinical Directors & Clinical Leads, and all Service Managers, AHP and Psychology Leads and Quality Improvement Lead Nurse - began on 16th July.**<br><br>Phase 3 of the locality restructure focuses on the Management structures within each of the newly established Directorates. These include the roles of Service Managers, Quality Improvement Lead Nurses, Clinical, Psychology, AHP Leads and Social Care Leads. The newly appointed CD's and AD's are leading this phase, including ownership of the launch and the resulting consultation under a Management of Change process. This will be co-produced by teams themselves.<br><br>The Trust has reminded all staff that, if they have any questions about our plans, how they affect them and the opportunities it offers, they can get in touch either with the project lead, Nicky Griffiths, the HR Team or alternatively they can use our dedicated web page including an FAQs page and a web form they can use to ask us anything they like and get an answer. They can, if they prefer, even ask a question or give us a comment anonymously.<br><br>There will also be a number of Engagement Sessions with affected teams over the coming months. | |

**LATEST AWARDS SUCCESS**

Two projects from Combined were finalists in the mental health category at the recent HSJ Patient Safety Awards.

The first was medication reduction in a Learning Disability inpatient service**.** Antipsychotics and antidepressants are often prescribed for people with a learning disability without appropriate clinical indications and a substantial number who are prescribed drugs for the purpose of behavioural management can safely have their medication reduced or withdrawn. Prescribing often starts at a specialist level and is then passed onto primary care resulting in GPs overseeing the management and prescribing long term, often unnecessary, medications. The aim of this project was to improve the quality of life of people with a learning disability admitted to our Assessment & Treatment unit by reducing the potential harm of inappropriate psychotropic drug use.

The second was for our High Volume User Pilot. A small number of patients make frequent attendances to emergency departments and account for a disproportionate amount of the total Accident and Emergency (A&E) workload. The team is made up of registered mental health staff working in collaboration with the British Red Cross, both having expertise in reach work to support complex health and social care needs. The team works in collaboration with the UHNM, the ambulance service and local Clinical Commissioning Groups, all of which have signed up to a data sharing agreement to support a system wide approach to the reduction in attendances at A and E .

**APPEARANCE IN FRONT OF STAFFORDSHIRE OVERVIEW AND SCRUTINY**

Caroline Donovan recently attended the Staffordshire Overview and Scrutiny Committee with STP colleague Dr Abid Khan, Medical Director at Midlands Partnership Foundation Trust and Jonathan O'Brien, Director of Operations. The Trust was there to discuss with councillors the Together We're Better STP Mental Health Programme.

It was a positive session with discussions focussing on joint working across the whole of Staffordshire and Stoke-on-Trent is bearing fruit and delivering real results for local patients and their families.

Real progress was reported, including:

- New IAPT services for people with Long Term Conditions across Staffordshire
- Improved support for frail elderly via outreach services – supporting winter pressures
- Integration of mental health into place based locality teams – MPFT and NSCH redesigning their organisations to align with this.
- Alliance Boards established to support integration
- 24/7 Crisis and Home Treatment Services for adults – now recurrently commissioned across Staffordshire

- 24/7 Mental Health Liaison Teams supporting patients in all the emergency portals at Stoke hospital. Seven day support is offered at Burton hospital.
- Development of plans for Mental Health Crisis Care Centre including increased capacity for Place of Safety at Harplands Hospital
- STP is currently ranked 4th out of 44 STPs for Out of Area Placements as at November 2017
- New Psychiatric Intensive Care Unit (6 beds) to open in Autumn 2018
- Development of Pan-Staffordshire suicide prevention campaign.
- Latest data shows fall in three-year rolling total of suicides across Stoke and Staffordshire
- GPs and wider primary care staff to have suicide prevention training in 2018/19

**PAN STAFFORDSHIRE AND STOKE-ON-TRENT NEDS, POLITICAL LEADERS, CHAIRS AND CEOs MEETING**

Caroline recently attended a meeting of all the NEDs, Political Leaders, Chairs and CEOs from across Staffordshire and Stoke-on-Trent. It was useful to be able to come together as a whole group to talk through the challenges we face system-wide and share insights and lessons with each other.

Caroline alongside Neil Carr, Chief Executive, Midlands Partnership NHS Foundation Trust and Dr Shammy Noor, Chair of the South East Staffordshire and Seisdon Peninsula CCG presented the work we are doing together to support integrated locality working and integrated teams.

It was really positive that progress is being made with great examples given, including from Shammy, the Lichfield Care Home Project, which has achieved:

- Much lower demand on GPs
- Higher continuity of care for patients
- Lower ambulance conveyance
- Lower admission rates
- Less form filling
- More confidence in the care homes
- Direct access to a range of services (i.e. not back through the GP)
- Patients know who will be coming to visit them

**STP DIGITAL CONFERENCE**

Caroline opened the first ever ‘Together We're Better’ Digital Conference.

A packed audience of over 100 digital leaders from across the patch were able to hear from a range of external speakers from Leeds to the Wirral and

from Hampshire to Bristol. All of them were happy to share their experiences and lessons-learned to inform the Staffordshire and Stoke-on-Trent Digital Strategy.

The opening session was livestreamed and the event also featured an introductory video welcome from the STP Chair, Sir Neil McKay, who unfortunately was unable to attend due to a prior commitment, but who wanted to stress his own personal commitment and support for our digital vision.

**RECORD BREAKING REACH AWARDS**

Caroline Donovan, our Chairman, David Rogers and the Board were absolutely delighted and felt very privileged to present the Trusts Annual REACH (Recognising Excellence and Achievement in Combined Healthcare) Awards. This year's event was the biggest we've ever held, with more nominations and awards than ever before.

300 nominations were received - a record number. The winners and those highly commended in each category were:

- **Leading with Compassion Award** - (Joint Winners, Carol Sylvester and Carolyn Wilkes - Highly commended, Rachel Birks, Darren Perry, Andrew Adams, Zoe Grant)
- **Proud to CARE Award** - (Winner, Sharon Tunicliffe)
- **Volunteer/Service User Representative** (Winner, Simon Voiels - Highly commended, Phil Leese, Narissa Meredith, Jean Cunningham)
- **Developing People** - (Winner, Melanie McNair - Highly commended, New Beginnings, Dr Mike Jorsh, Phil Wardle, Dr Laura Stevenson)
- **Innovation** (Winner, Ward 3 - Highly commended, Assessment and Treatment Team, CAMHS ADHD Team, Parent and Baby Unit, BeAble App - NOAP)
- **Valuemaker** (Winner, Dr Ravi Belgawar - Highly commended, Christine Horler, Nicky Wood, Joshua Deakin, Julianne Kettle)
- **Partnership** (Winner, Care Home Liaison Team - Highly commended, Criminal Justice Mental Health Team, Staff Side, NOAP Outreach Team, Health Facilitation and Acute Liaison Team)
- **Unsung Hero** (Winner, Samantha Dawson - Highly commended, Wahida Mohamed, Georgia May Ellis, Rania Mosedale, Lesley Birkin)
- **Service User & Carer Council** (Winner, Julie Baker - Highly commended, Phil Leese, Linda Lock)
- **Rising Star** (Winner, Dr Rebecca Chubb - Highly commended, Lisa Lummis, Cherelle Laryea, Gavin Hicks, Sarah Tombs)
- **Team of the Year** (Winners, Service User and Carer Council - Highly commended, Recovery and Resettlement Team, Ward 4,

Ward 1, Older Person's City CMHT)

- **Chairman's Award** (Winner, Dr Rebecca Chubb)

A very special part of the evening was announcing the first recipients of the Justin Griffiths scholarship. In creating the scholarship, the Trust really wanted to encourage research, personal development and education in Justin's memory throughout the services that he played a crucial part in setting up and supporting throughout his career, and in providing this scholarship fund we felt that this would be the best way to celebrate his life and work.

Following last year's REACH awards the Trust opened up the scholarship for applications and trustees met to review the applications we were very happy to agree the following six applications:

- **Books for all the Community Mental Health Teams** to support service user needs - **Lynne Burton**
- A book fund to support his higher education - **Simon Bratt**
- To attend a workshop regarding a specialist area of need within the MHA - **Jane Clewes**
- To attend an Approved Mental Health Professional conference - **Laura Rushton**
- A team training event for the Stoke AMHP team - **Denise Heatley**
- To attend the National Mental Health Law conference at Nottingham University - **Nick Slater**

It was really lovely having Nicky, Justin's wife and her 2 delightful daughters Nya and Eva with us.

The Trust also gave a special presentation to Jenny Harvey for her achievements and recognition by Stonewall as Diversity and Inclusion Role Model of the Year in the North West.

**CELEBRATING THE NHS 70TH BIRTHDAY**

The Trust held its REACH Awards to coincide with the NHS 70th Birthday and, as part of the evening, the Trust showed a special film celebrating the creation of the NHS, the values of its founder Nye Bevan and its amazing achievements over its first 70 years.

Throughout the day, events exhibitions and tea parties were being held by staff and volunteers across our sites.

Healthcare Support Workers at the Darwin Centre enjoyed the birthday celebrations with a Tea Party and some amazing creations. Well done to all the young people and staff who made this happen.

At the Harplands, there was a special NHS70 Birthday cake and friends from BBC Radio Stoke turned up to film and interview staff and get a glimpse into the history of NHS mental health care.

**MEDICAL LEADERSHIP EVENT**

Caroline Donovan attended the medical leadership workshop, at Port Vale Football Club, chaired by the Trusts Medical Director, Dr Buki Adeyemo and have a discussion about the future and the key role our medical workforce play in delivering high quality care. There are a number of future developments that the medics were keen to be involved including working more closely with GPs through our new locality working.

In this regard, it was really useful that the Trusts Director of Operations, Jonathan O'Brien was able to deliver a presentation on the Trusts vision for transformation through locality working and John Tacchi, Programme Director for Integration, on the strategic landscape in North Staffordshire.

## NATIONAL UPDATE

**HEALTH ANNOUNCEMENT ON NHS FUNDING**

It was very welcome to hear the outcome of discussions between 10 Downing Street, HM Treasury and NHS England on a future 5-10 year funding settlement for the NHS. The details were set out in a speech by the Prime Minister last week, in which she said

- NHS funding will grow on average by 3.4 per cent in real terms each year from 2019/20 to 2023/24.
- By 2023/24 the NHS England budget will increase by £20.5 billion in real terms compared with today. That means it will be £394 million a week higher in real terms.
- We also know we need to improve social care and continue to support prevention and public health, both for the benefits they bring in themselves and to relieve pressure on NHS care.
- So we will come forward with proposals to put social care on a more sustainable footing. And we will set out budgets for both social care and public health as part of the forthcoming Spending Review.

The Prime Minister also stressed her personal commitment to mental health.

“We will not have succeeded in building the NHS of the future unless we recognise the importance of looking after our mental health, just as much as our physical health, and we put the resources in to mental healthcare to make that a reality. So these are my five priorities: Putting the patient at the heart of how we organise care; a workforce empowered to deliver the NHS of the future; harnessing the power of innovation; a focus on prevention, not just cure; and true parity of care between mental and physical health.”

**HEALTHCARE SAFETY INVESTIGATION BRANCH (HSIB) PUBLISHES NATIONAL INVESTIGATION REPORT, ‘CAMHS TO AMHS’**

The Healthcare Safety Investigation Branch (HSIB) has published its

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| | second national investigation report – *CAMHS to AMHS.*<br><br>The investigation reviewed the transition of care from child and adolescent to adult mental health services. It identified possible issues with the transition process. It finds that young people using child and adolescent mental health services would benefit from a flexible, managed transition which has been carefully planned with the young person. It recommends that NHS England addresses some of the issues uncovered within the upcoming ten-year plan for the NHS. One of the key benefits of our new locality structure will enable improvements in young people transitioning into our adult services.<br><br>Jenny Harvey talked about proposals for Section 75 transfer. Staffordshire County Council are looking to transfer staff for a year into the Local Authority. Following a meeting with staff and members Unison will be formally objecting to the transfer. Jenny advised she would like to understand the view of the STP as we are supposed to be working collaboratively. Caroline Donovan agreed there can be no benefit from this decision. David Rogers was also in agreement that this is against everything the STP hope to achieve and their direction of travel. If decisions are made that are in the best interests of patients and staff there are actions we need to take to address this.<br><br>Patrick Sullivan felt it imposes a structure on community teams that takes the service backwards. We are in danger that this could destabilise services. We need to be clear as an organisation that this is a decision we do not support.<br><br>Jonathan O'Brien advised a meeting took place yesterday with staff affected by the TUPE. Staff are very clear and aware that this is not a decision the Trust wanted to take. Staff will be supported wherever possible. There was concern and lack of understanding as to why this is happening. Staff need to meet themselves with the County Council as they have questions the Trust cannot answer. Fortnightly sessions will take place going forward with staff.<br><br>**Received** | |
| **158/2018** | **Chair's Report**<br><br>David Rogers, Chairman provided an update.<br><br>We have a new Secretary of State Matt Hancock. In a recent speech the Secretary claimed he would focus on diversity, bullying, talent management, and more clinicians in management roles.<br><br>Simon Stevens, Chief Executive of NHS England is now working towards a plan built around a number of priorities which are likely to be cancer services - better screening and diagnosis, mental health and children's services, cardiovascular services, health inequalities, learning disabilities and short life expectancy. These are the themes outlined but the concern is | |

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| | that proprieties can be used by Commissioners to inform decisions on funding and anything requested outside of the themes not funded. New funding and a strategic plan will not be available until next year.<br><br>Regulators, NHSI and NHSE are being unified but this is taking time. The new regional directors will be announced in the Autumn, therefore it is likely that the winter period will bring pressures and challenges.<br><br>David informed the Board that Ken Jarrold, North Staffordshire Combined Healthcare's previous Chairman has published a book, 'In Other People's Shoes', which David recommended.<br><br>***Noted*** | |
| **159/2018** | **Staff Retirements**<br><br>**Helen MacMahon, Head of Directorate CYP**<br><br>Helen joined the Trust in January 2017 as Head of Directorate for the CYP Directorate. It is fair to say that at this time the service were looking for stability and clear leadership to take the service forward; Helen has been inspirational and shows a compassionate and focused style of leadership. This is demonstrated through Helen's natural ability to engage and involve people in all aspects of service delivery and staff personal development, with the overall outcome to provide accessible person-centred services for our children, young people and families. Through Helen's leadership the Directorate has achieved significant improvement recognised through the CQC in their last inspection with a rating of 'Good' across all domains for the service.<br><br>Staff have often said how approachable and caring Helen is. She has a 100% open door policy and is always ready to listen and support wherever she can, she will be hugely missed by her colleagues, the Trust and the Youth Council, with whom she has forged very positive relationships.<br><br>'Helen is just the sort of person that we need, she is so easy to talk to and listens to our concerns and ideas'. (Quote from the Youth Council)<br><br>On another note Helen's warmth and sense of humour often lifts people's mood, they leave the room with a smile on their face and a clear plan looking ahead. Helen will be missed by all and we wish her all the very best in her retirement.<br><br>***Noted*** | |
| **160/2018** | **REACH Team Recognition Award July 2018**<br><br>**The Paediatric Team – CYP**<br><br>The Paediatric Service is a Team of Clinical Psychologists providing Psychology support as part of 8 specialist Multi-Disciplinary Teams across 3 | |

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| | Acute Trusts. This has developed following examples of the work being recognised and the service has subsequently grown, including Burton Hospital wanting a “piece of Psychology” after consultation with the Cystic Fibrosis Psychologist covering Burton at the time. This resulted in an increase to the SLA in recognition of the demand and need for the specialist Psychology service.<br><br>The team are proud of their supportive nature – compassion runs deep within the team for each other, as well as the young people and families that they support. The team are passionate about their work, and the opportunities to develop psychological mindedness within the MDTs they support. The therapeutic approaches include CBT, behavioural therapy, narrative therapy, systemic work, Acceptance and Commitment Therapy (ACT), mindfulness and relaxation.<br><br>The General Paediatric element of the service receives a high number of referrals for young people with ‘’ Chronic Pain ‘’. In order to meet this demand the team have recently piloted an evidence based 6 session group over 8 weeks supporting young people with chronic pain (Arthritis, Chronic Regional Pain Syndrome, Spherocytosis) and the offer includes 3 sessions for parents to attend. The young people praised the group – they no longer felt isolated as they have made friends with others who understand and could empathise with their position and provide ongoing support for each other. Parents are supporting the young people to continue to meet and this benefits them also.<br><br>The Trust’s young people often have life-long or chronic health conditions. As a result they may not fit the CAMHS model of 8 sessions, but it is important to recognise when longer term care is useful. The young people often have a life-long condition and face their own challenges relating to this. As a result the team can be supporting the young people for years rather than sessions, and should they be discharged, often bounce back at the next point of difficulty for them.<br><br>A lack of resource for General Paediatrics work continues to make through-put a challenge. Despite this, staff have consistently performed to meet trust and commissioning targets and this has an impacted on the through-put of clients. The team recognise that a shift towards a multi-modal approach in the General Paediatrics work is necessary to help improve access to the service. The supportive nature of each member of the Paediatric Psychology Service has allowed the team to function through challenges related to demand / capacity issues. The team continue to share examples of good practice with each other and provide training for 3rd year Clinical Psychology trainees at Staffordshire University.<br><br>The Paediatric Psychology team demonstrates all the Trust values of compassion, approachable, responsible and caring consistently. The Team are innovative with their small highly specialist resource in responding to challenges and they consistently go the extra mile with children and young people at the heart of everything they do. | |

Jane Parker, Carol Martin and Ruth Fishwick provided a presentation.

The team currently work with 8 Paediatric physical health MDTs across 3 physical health trusts. Services covered by the team are:

- Oncology
- PICU
- Cystic Fibrosis
- Diabetes
- Respiratory Medicine
- Children's Palliative Care and Complex Care
- General Paediatrics

The presentation illustrated the difference CAMHS and Paediatrics.

Carol provided a case example regarding a 14 year old male with a genetic condition who suffered from aggression and had suicidal intent. Carol talked about interventions and outcomes for him as a result of accessing the team.

Ruth talked about challenges and successes for the team over the last 12 months:

Challenges for the team:

- Limited resource v high demand
- Stalled Rheumatology SLA
- Demands of RTT 18wk
- Additional demands (case note audit, Lorenzo, training, requests for info) have impact on staff capacity
- Innovative service model means that 'traditional' activity doesn't fit
- Office moves

Successes for the team

- REACH nomination 2017
- Reduced wait for initial to <4wks
- Reduced wait for 2nd to 18wks
- Group intervention reduced impact on waiting list
- Developing a multimodal pathway
- Life-saving work
- Reducing impact on acute services
- Adapting to changes and demands

Andrew Hughes advised he is also a Trustee of the Teenage Cancer Trust this is in line with what the charity is trying to achieve at the moment and has joined with other charities around long term conditions it would be beneficial to use what you do to demonstrate real actual practice in what can be done to support it.

Patrick Sullivan asked the team to elaborate on the staffing challenge. Ruth advised the only way the team is increased is through service level agreements. A lot of money has been given to CAMHS but not passed to this team. Carol highlighted due to the nature of the work you can have

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| | young children with you for a long time therefore we are looking at a different model. It is a challenge to see 12 clients for half a day and be careful not to use lots of SLA time. Jane advised that previously the team had a full time consultant which is no longer available.<br><br>Ruth confirmed the team are providing support to children with a diagnosed physical health condition who are demonstrating distress.<br><br>Caroline Donovan highlighted that the Trust is in fact providing an additional service without commissioning. Caroline felt that the passion and enthusiasm from the team is fantastic and highlighted that the Trust is providing this service for children but not for adults.<br><br>Jane highlighted there have been changes to the law two years ago (SEND) if children have a statement that can last until they are 25 those children can request continuing healthcare.<br><br>Joan Walley highlighted that points have been picked up re: SLAs and funding and enquired as to the Trusts process of following up on this and seeing it through? Caroline advised we will discuss in the Executive meeting which follows each Trust Board.<br><br>David Rogers thanked the team for their presentation.<br><br>***Noted*** | |
| **161/2018** | **QUESTIONS FROM MEMBERS OF THE PUBLIC**<br><br>There were no questions / comments from the public. | |
| **162/2018** | **SERVICE USER AND CARER COUNCIL**<br><br>Sue Tams, Service User Carer Council provided an update in Wendy Dutton's (Chair) absence.<br><br>**REACH**<br>Sue thanked everyone on behalf of the Service User Carer Council for being nominated for and winning the Team Award at the recent REACH Award event.<br><br>**Person Centred Care**<br>Sue reported that a workshop took place on 27th June 2018. The group were able to take a fresh look at person centred care and in particular suggestions for the one page profile. (Service User and Carer Strategy on a page).<br><br>No meeting is planned for August. The September Business Meeting will include nominations for Vice Chair and the October workshop will review how the Service User Carer Council can best support service user's/carer's in the new structure. | |

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| | Lisa Sharrock presented the innovative Beable app, at the May meeting. Currently in simplistic prototype form, the potential breadth of application was discussed and encouraged. Sue stated she had been able to trial it for 2 weeks with some interesting outcomes.<br><br>**Citizens Jury**<br>The Citizens Jury is to enter an 'Action Plan' phase. The Service User Carer Council had been assured that this would involve service providers, 3rd sector workers as well as service users and carers.<br><br>**Life Works**<br>Life Works which supports Carers and Service users living with ASD has seen an increased volume and level of distress. The Trust is commissioned to assess 8 people per month and we are regularly exceeding this, and do not have the contract to offer treatment. CYP have also cited similar issues. It was highlighted that SSSFT were in a similar position. This was being raised regularly at performance meetings. Following a frank conversation it was agreed that Val Stronach from CYP would clarify the current position, Hilda Johnson would take back to Healthwatch for review prior to offering Life Works support in writing to local councillors/MPs<br><br>**Advocacy**<br>Recent changes have been made within advocacy services (now Voicability / Voice Staffordshire, based at Stafford) have a 5 year contract. While Sue Carson, the Service User Carer Council Advocacy member said there were exciting prospects, some gaps had been identified. One of these gaps was highlighted in reference to Life Works where carer support / assessment inefficiency could be flagged with the support of Voicability however no current contract for carers was present.<br><br>Concerns were again raised by Carer's regarding the renewed 18 month contract to the current provider despite concern at the lack of clarity of function / expenditure. This will again be taken back to Healthwatch.<br><br>***Received*** | |
| **163/2018** | **TOWARDS OUTSTANDING INNOVATIVE PRACTICE**<br><br>Dr Buki Adeyemo, Executive Medical Director provided a verbal update<br>The report details two examples of innovative practice both shortlisted for National awards.<br><br>**Valuemakers**<br>Combined Valuemakers is an engagement tool designed to increase awareness of finance and the importance of generating efficiencies in every day practices to support Cost Improvement. Cost Improvement culturally, had negative connotations and focussed on traditional, top down budget slicing rather than embracing sustainable transformational change.<br><br>The Trust needed a mechanism to engage the whole organisation, addressing cultural issues around Cost Improvement and that fostered a | |

culture where staff at all levels could be comfortable challenging “the way we do things around here.”

Combined Valuemakers was launched in early 2017 and is an interactive website where staff or service users can submit ideas to improve quality, efficiency or make financial savings. Once submitted, the finance team manages responses, contact submitters and awarding badges to those which lead to increased value! Stories are posted on the website to encourage others to submit ideas.

As part of the Value Makers theme, the Finance Performance and Digital Team also hosted a number of workshops with Directorates which presented finance, activity, performance and workforce information to encourage new ways of thinking. The workshops included junior staff which really empowered them to speak up and share ideas. Following on from the success of the workshops we have rebranded our Cost Improvement for 2018/19, applying a matrix approach in building our plans and have arranged separate valuemaker workshops for each of the plan themes.

The Combined Valuemaker award was launched in 2017 and awarded in both the 2017 and 2018 Reach Awards to recognise someone with an outstanding contribution to improving value in the Trust.

In the last 12 months we have received 33 suggestions into the portal. Of the 13 taken forward for further investigation 6 have been successfully implemented, 6 are still under investigation or being actively implemented and 1 has been closed

Of the successfully implemented schemes so far, the majority are around process efficiencies and improving processes which have not resulted in material cash releasing savings for the trust. The Trust identified that walking frames were not being collected hence the cost price was not being recovered by the Staffordshire Council resulting in wider STP savings.

For the schemes that are being actively implemented or under final investigation the potential cash releasing savings are approximately £180k upon successful implementation.

This scheme has been shortlisted for a number of awards.

**Meir Partnership Care Hub**

With a strong strategic ‘push’ at both a national and local policy level to join together integrated services around GP patient populations; the Meir Partnership Care Hub was developed. Operational since October 2016, Meir Hub has brought together and co-located health, social care and community practitioners to respond to individuals within individuals within five GP Practices. Meir Hub is a core team of adult social care and mental health practitioners, working with other agencies such as; the voluntary sector, fire and police.

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| | The Meir Hub has demonstrated that being able to respond quickly and without further referrals between services significantly improves both response and outcomes for individuals.<br><br>The approach has been increasingly effective for individuals involved and more efficient in terms of outcomes and time.<br><br>No additional costs have been incurred by the partners and efficiencies have been gained from the shared location and time involved with individual cases.<br><br>The Hub has received positive feedback from people using the service, those professionally directly involved in the service and those in the wider circle, both reporting positively on the new approach.<br><br>The project reports back to into the North Staffordshire Multidisciplinary Community Provider (MCP) development structure and MCP Locality Group. Partners, including the police community and council housing department are exploring how they collate and work with the Hub model. Combined and the council are further exploring how they can expand the model into a wider geographical footprint, with support from locality GP groups to cover all practices.<br><br>The scheme recently won a national award for positive practice in mental health.<br><br>Dr Adeyemo linked this to the decision making around Section 75 – this further demonstrates working together.<br><br>Joan Walley highlighted it is really important we look at geography and evidence base of where the need is and needed linking to the inequalities agenda also.<br><br>***Received*** | |
| **164/2018** | **SAFER STAFFING MONTHLY REPORT – MAY 2018**<br><br>Julie Anne Murray, Deputy Director of Nursing & Quality presented the report on behalf of Maria Nelligan, Director of Nursing and Quality and highlighted the following:<br><br>The paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during May 2018 in line with the National Quality Board requirements. The performance relating to fill rate (actual numbers of staff deployed vs numbers planned) during 2018 was 77% for registered staff and 103% or care staff on day shifts and 85% and 108% respectively on night shifts. Overall a 93% fill rate was achieved. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover and Ward manager supporting clinical duties. The data reflects that Ward Managers are staffing their wards to meet increasing patient needs as necessary. | |

The following key actions have been taken to strengthen RN staffing:

- Twenty six third year Keele nursing students have accepted a conditional offer to commence with Trust in Oct 2018
- Shift patterns have been altered in response to staff feedback
- Recruitment opportunities for RNs continue to be advertised (including bank)
- The Trust has joined the NHSI MH recruitment and retention programme
- Recruitment campaign continues for PICU
- Senior Advanced Nurse Practitioner commenced on Ward 4 in May 2018

Additionally we are progressing following actions which were presented to the Board last month :

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

The Trust has joined the NHSI Retention Support Programme. A project team visit has been completed and learning shared, this has been incorporated into the safer staffing Trust action plan.

Patrick Sullivan commented that looking at the number of vacancies, there have been almost 50 on some occasions, there has to be real questions asked about how we are managing / delivering patient services and the maintenance of safety when the Trust has such a level of vacancies. Julie Anne highlighted that backfill is supplied by bank.

Dr Adeyemo advised the report looks at only nursing vacancies and wards are not only staffed by nurses. In terms of safety we will backfill where required but staffing levels are supported by an MDT team. Occupancy is also reducing.

Caroline Donovan advised overall staffing needs to be included in the report going forward. The strategic issue is that it is really important to focus on recruitment and we are committed to this including those who have left the Trust. Julie Anne advised there is a piece of work being undertaken to look at this in conjunction with Human Resources. Caroline felt that Ward Managers play an important part in the ownership of this.

Alex Brett advised information received from exit interviews will be fed back to service areas.

Jonathan O'Brien talked about PICU and highlighted the need start conversation around PICU and including those vacancies in the report figures. Patrick felt these needed to be a priority as agreed by the Exec team.

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| | Jenny Harvey highlighted in terms of the Trust and retaining staff one of the main reasons is flexibility. We have seen the introduction of long shift but we have to consider that they might not meet all staff needs. We need to make considerable strides to change this. We need to ask bank staff / agency staff what it will take for them to come and work for us.<br><br>David Rogers highlighted the need to differentiate between our Trust and others, selling our Trust to the market.<br><br>The Trust Board is asked to:-<br><br>• Receive the report<br>• Note the challenges with recruitment and mitigations/action in place<br>• Note the challenge in filling shifts<br>• Be assured that safe staffing levels are maintained<br><br>***Noted / Received*** | |
| **165/2018** | **PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 2**<br><br>Suzanne Robinson, Executive Director of Finance, Performance and Digital, presented the report highlighting key points.<br><br>Suzanne highlighted this is a very positive start at Month 2.<br><br>CPA compliance remains positive in month 2:<br>• 97.9% of all service users in CPA received a follow up within 7 days of discharge (against a target of 95%)<br>• 96.5% of all service users on CPA for at least 12 months (NHSI measure) received their review within 12 months (against a 95% target)<br><br>Our IAPT services continue to perform well:<br>• 100% of service users referred to IAPT services treated within six weeks of referral (against a 75% target) and 71.7% of people accessing IAPT services moved in to recovery (against a 50% target)<br><br>Access and waiting time target performance for EIPS is positive:<br>• 75% of patients referred through early intervention in psychosis have been seen within 2 weeks of referral to treatment (target 53%)<br><br>For inpatient services:<br>• Emergency readmissions continue to reduce<br>• No patients have been sent out of area during May<br><br>In Month 2 there are 3 target related metrics rated as Red and 2 target related metrics rated as Amber; all other indicators are within expected tolerances. | |

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| | **Exceptions:**<br><br>Waiting times - 86.8% at M2 from 90.5% at M1. There has been a reduction in performance Trust-wide associated with the increased numbers of breaches in AMH Community, CYP and LD. All directorates have identified issues, are reviewing demand and capacity plans and are ensuring that recording reflects actual performance levels. Recovery Plans will be monitored through Performance Review meetings. At the time of writing this report CYP have met the improvement trajectory of 88% in June and are on track to meet their trajectory to achieve 92% by end of August. CYP are at 100% for referral to assessment within 18 weeks. In terms of referral to assessment 100% of children have been seen.<br><br>Mental Health Liaison - Response to A&E referrals within 1 hour - 93.0% at M2 from 94.8% at M1<br><br>Delayed Transfers of Care (DToCS) - Mental health delayed transfers of care (NHSI) - 9.1% at M2 from 5.5% at M1. The Trust is liaising with the City of Stoke-on-Trent and Staffordshire County Council to expedite the assessment and placement of individuals in need of social care packages or care home placements. There is a particular issue at the moment with the protracted process for sign-off in Staffordshire County Council, which is adding to delays. In M2 119 out of 210 delayed days were due to or included social care elements.<br><br>Admissions: Number of patients 16/17 year old admitted to Adult Psychiatric wards. 1.0 in M2 from 1.0 in M1 A female patient was admitted to Ward 3 on 31/05/18 and discharged to Priory Hospital on 01/06/18.<br><br>Bed Occupancy excluding Adult Inpatient wards (including home leave). 94.9% at M2 from 90.6% at M1. Bed occupancy for all wards (excluding Adult IP wards) has increased further above target at 94.9%. The increase in Neuro bed occupancy is being audited and will be reported through board sub-committee.<br><br>Caroline Donovan asked if we should be negotiating with Commissioners a lower target in relation to the RAI activity growth as we are not asking for more funding. Increasingly now NHSE dashboards are missing. Caroline asked if going forward the Trust can report by CCG within the exception report.<br><br>Patrick Sullivan referred to young people aged16 and 17 year olds being admitted to adult wards as a real concern. What is a 'one off 'can be become practice and stated the need to understand the clinical reasons for this.<br><br>Jonathan O'Brien advised there have been four cases and Maria Nelligan and Julie Anne Murray have looked at this in detail. There are two of the four cases whereby an adult ward was the most appropriate place admission. In one of the cases the young person who transitioned was 6 days off 18 years of age. In the case of the 16 year old this was a concern | **SR** |

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| | and policy was not followed.<br><br>Caroline highlighted the Trust are an outlier in a positive way in terms of Tier 4 CAMHS provision. If a child is on leave and there is a bed that is where the child should be placed.<br><br>The Trust Board is asked to:<br>Receive the Trust reported performance, management action and committee oversight on the Month 2 position<br><br>***Received / Approved*** | |
| **166/2018** | **ORGANISATIONAL DEVELOPMENT AND PEOPLE STRATEGY**<br><br>Alex Brett, Director of Organisational Development, Workforce and Communications presented the report highlighting key points.<br><br>As a Trust we recognise this contribution that our staff make every day and the important difference that all their roles make to our service users and carers. We are also clear that we need to continuously improve the employment experience that our employees have. This Organisational Development (OD) and People Strategic plan sets out a vision to make our organisation an outstanding place to work; this document sets out the Trust Board's commitment to do this.<br><br>We have 8 domains which outline the key areas of focus for us it is pleasing that Simon Stevens, Chief Executive of NHS England, view and some of the things he is saying are already within our plan.<br><br>Caroline Donovan asked if can we include under 'retention' the increase in flexible working and monitoring and understanding the reasons for people leaving the Trust cab ne included.<br><br>***Approved / Received*** | **AB** |
| **167/2018** | **MONTH 2 FINANCE REPORT**<br><br>Suzanne Robinson, Executive Director of Finance, Performance and Digital, presented the report highlighting key points.<br><br>During Month 2, the Trust had an in month trading position of £45k surplus against a plan of £1k deficit; giving a favourable variance of £46k. Sustainability and Transformation funding has been assumed at £35k for month 2, bringing the overall Trust control to a £80k surplus against plan of £34k; giving a favourable variance of £46k.<br><br>The Trust has not produced a detailed forecast at month 2, but expects to deliver in line with plan to give a trading surplus of £0.720m. Sustainability and Transformation funding is expected to be £0.703m in line with plan giving an overall Control Surplus of £1.423m. | |

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| | CIP - The Trust target for the year is £2,795k, as reported to NHSI. This takes into account the requirement to deliver a £1,423k control surplus for 2018/19. The Trust wide CIP achievement is 27% at M2 compared to plan. The forecast position at M2 for 2018/19 is £1,380k (49%), which represents an in year shortfall against the annual target of £1,415k.<br>Cash Flow - The Trust cash position at 31st May 2018 is £455k higher than planned. The Trust anticipates being in line with plan by March 2019.<br><br>Capital - The Trust's permitted capital expenditure agreed within the 2017/18 plan is £2,058k.<br><br>David Rogers referred to the RAG ratings for CIP and enquired as to why they were green for corporate services when this area is behind plan. Suzanne advised this is the forecast to show what schemes are identified.<br><br>The Trust Board are asked to:<br>Note:<br>• The reported YTD surplus of £140k against a planned surplus of £68k. This is a favourable variance to plan of £72k.<br>• The M2 CIP achievement:<br>• YTD achievement of £92k (27%); an adverse variance of £246k;<br>• 2018/19 forecast CIP delivery of £1,300k (47%) based on schemes identified; an adverse variance of £1,495k to plan;<br>• The recurrent value of schemes transacted at £313k, 11% of target.<br>• The cash position of the Trust as at 31st May 2018 with a balance of £7,510k; £455k better than plan<br>• Month 2 capital receipts for 2018/19 at (£611k) compared to a net planned capital expenditure of (£613k);<br>• Use of resource rating of 1 against a plan of 1.<br><br>Approve:<br>• The month 2 position reported to NHSI.<br><br>***Noted / Approved*** | |
| **168/2018** | **ASSURANCE REPORT FROM THE FINANCE, PERFORMANCE & DIGITAL COMMITTEE**<br><br>Tony Gadsby Non-Executive Director and Chair of the Finance, Performance and Digital Committee presented the report for assurance from the meeting that took place on 5th July 2018.<br><br>NHS Pay Award – An update on the NHS Pay award which has been agreed for 2018/19 and will be back paid in the August payroll. The announcement is that the pay award will be fully funded however the mechanism for payment to providers is yet to be announced so the true impact to the trust is yet to be determined.<br><br>STP Capital Prioritisation Process – Ms Robinson outlined the STP Capital | |

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| | Prioritisation process, for which the Trust has submitted a £2.6m bid, centred on enhancing Crisis and Alcohol services. The intention is to access national capital funding. There are 3 stages of the process and the Trust has already passed stage 1 and likely to pass stage 2. Should the bid pass the third stage it will be entered into the national bidding process on 16th July.<br><br>Cost Improvement Programme (CIP) - The Committee received an update for Cost Improvement for M2 and were concerned that the total identified was significantly short of the target. CIP achievement in M2 was £92k, giving an adverse variance of £246k. A high level forecast at M2 shows CIP delivery of £1,380k, giving an adverse variance to plan of £1,415k.<br><br>The Committee were assured that there was sufficient focus being placed on Cost Improvement but are unable to give assurance around the ability to deliver the target for 2018/19 given the level of unidentified schemes.<br><br>The Committee received an update on the Trust performance against Local and National KPIs. There was concern around performance against waiting times 18 week (Referral to Treatment) target, particularly in CYP which reduced to 65.2% in M2 from 82.4% in M1. The Committee were however assured that there were appropriate action plans in place to address the deviation.<br><br>Jenny Harvey commented with regards to the NHS Pay, Unison are aware that none of our employers have money to meet the costs. Trying to understand what the cost impact is straight away is difficult. It would be interesting to know when the uplifts have actioned if the Trust will be refunded. Suzanne advised the Trust is trying to analyse what the cost will be against the allocation given and this will be reported back to the Board when available.<br><br>David Rogers enquired as to whether the Trust is funding vacancies and is this a cost pressure? Suzanne advised the Trust is looking at what it means as a budget perspective and look at the reality and the future there are lots of scenarios that can occur. The 1% inflation is part of an efficiency in tariff we get an in build inefficiency. David asked Jenny if agency staff receive a rise in pay? Jenny advised agency staff are paid more by the hour and this is the decision of the employer.<br><br>Alex Brett confirmed with regards to other elements of the pay deal it will be predicated on people meeting their objectives and people not automatically going through to their increments. We are looking at all the implications of the pay deal but will mean a significant change in the way we undertake our Personal Development Reviews.<br><br>Suzanne Robinson advised there are other organisations raising concerns about significant shortfalls in funding.<br><br>In terms of CAMHS for assurance Jonathan O'Brien confirmed he is fully citied on waiting list issues in CAMHS. There are a number of systems in | |

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| | place to ensure this improves in terms of consistency. Actual performance for CAMHS at this moment in time is 95%.<br><br>Jonathan provided assurance that significant work is being undertaken around CIPs Mike Newton, Deputy Director of Finance and Jonathan have a meeting planned to go through in more detail.<br><br>The Board is asked to receive the contents of this report and take assurance from the review and challenge evidenced in the Committee.<br><br>***Received*** | |
| **169/2018** | **ASSURANCE REPORT FROM THE PEOPLE AND CULTURE DEVELOPMENT COMMITTEE**<br><br>Lorien Barber Non-Executive Director presented the report for assurance from the meeting that took place on 9th July 2018.<br><br>**Locality Working**<br>The Committee was informed that the Locality Working Phase 1 Management of Change involving both Heads of Directorate and Clinical Directors was now complete and whilst appointments had now been confirmed these had not yet been communicated.<br><br>Phase 2 consisting of the Professional Leads had also ended, and there was no risk of redundancy.<br><br>Phase 3 consisting of middle management, Matrons, Governance Leads, Associate Directors, etc. will commence imminently. It was noted that this phase will be the largest and most complex phase to date and will include roles some of which have dual responsibilities. There may be some redeployment of band 8a posts. It was however noted that there are a variety of opportunities for review within the dynamic structure. It was noted that an update paper would be submitted to the Senior Leadership Team meeting on July 10th by Jonathan Brien, Operations Director with the higher level of detail.<br><br>**Board Assurance Framework**<br>It was noted that the Trust has commissioned the 360 tool via Boo Consulting, which will commence with the Board, and be further disseminated via the leadership offer. The Medical Leadership programme has commenced around service improvement and Mr Sullivan will be supporting the final day of the programme to assist in judging the service improvements.<br><br>**Workforce & OD Risks**<br>A number of risks are monitored and reviewed through the Committee. The current risks have been identified and mitigation plans are in place<br><br>**Workforce Metrics**<br>The Committee was updated by exception. | |

Sickness absence is at 3.73% which is an improved position, however stress/anxiety/depression continues to be the major reason for absence, and it was noted that gastro problems had also increased as an absence reason. PDR compliance is 81%, and statutory/mandatory training 88%. Vacancies remain a challenge, and there were more leavers (11) than new starters (6) in May which is an exception.

**Workforce Plan**
The Committee received the plan that outlined the updated current workforce plan submissions. In January 2018 the plan showed a net increase of 16.62wte however a recalculation in March shows a net workforce change of -1.55wte for 2018-19. Work is also underway to map across to the new locality structures and the plans will be reviewed on a 6-monthly basis. It was noted the new Associate Directors will take ownership of the plans moving forward. The plan will be reviewed again at the January 2019 Committee meeting and the business planning work will commence in October 2018.

**Organisational Development & People Strategic Plan**
The Committee received draft 6 of the high level strategy which had received various reiterations since 2016. The strategic plan had now been expanded and built-on, and will be submitted to the Senior Leadership Team meeting on July 10th for comment ahead of submission to Board for ratification in September 2018.

**Annual Organisational Audit & Revalidation**
The Committee received the reports for assurance purposes.

**Quarterly Guardian of Safe Working Report**
The Committee received the report which was amended to note the report was compiled at Q4 and not Q1. The Guardian of Safe Working (Dr Stephanie Cress) was established following the new junior doctor contract, and for those on rotations to be made aware of the need to use the exception reporting system. The rotas are compliant in terms of satisfying the working hours laid down by the Terms and Conditions of Service for NHS Doctors and there have been no breaches or safety concerns raised.

It was noted that the tier 2 visa sponsorship has now been relaxed by the Government, which may allow the Trust to explore other opportunities for the recruitment of medics.

**Student Placement Feedback Report**
The Committee received the report for information. The report detailed the feedback from the various professional programmes that the Trust supports including: Nursing, Occupational Therapy, Physiotherapy, Clinical Psychology and Medicine. Areas for improvement will be addressed via the action plan.

**Policies**
The following policy was extended until the September Committee meeting

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| | to allow for changes arising from the SEAL meeting:<br><br>• Learning & Development Policy<br>• Job Evaluation Policy<br><br>The Board were asked to ratify.<br><br>***Received*** | |
| **170/2018** | **LOCALITY WORKING /RESTRUCTURE**<br><br>Jonathan O'Brien Director of Operations presented the report.<br><br>The paper provides an overview of progress to date and a briefing on the launch of Phase 3 of the Trust's localities working restructure on Monday 16th July 2018. The paper seeks to brief the Trust Board on progress to date and the current position.<br><br>Phase 3 is now underway. Associate Director posts will be appointed to as soon as possible.<br><br>Phase 3 launched into formal consultation with staff on Monday 16th July 2018. This Phase is being led by the new Clinical Directors and Associate Directors under the guidance and oversight of the Executive Director of Operations. Consultation will close on the 14th August 2018.<br><br>Two 'Dear Caroline' submissions have been received by the Chief Executive Officer since the last monthly report to board and relate specifically to the impact that the locality restructure will have on Substance Misuse service delivery and individuals roles within current Substance Misuse Services. These have been responded to by the Chief Executive Officer. Jonathan spend time with the Clinical Director and Head of Service yesterday to talk through their concerns they feel there are no changes. Suzanne and Jonathan met with the Substance Misuse Team to talk through their concerns we have asked them to consider different options and provide feedback.<br><br>***Received*** | |
| **171/2018** | **CQC LEARNING FROM LOCAL SYSTEMS**<br><br>Laurie Wrench, Associate Director of Governance presented the report.<br><br>The CQC has completed a programme of targeted local system reviews in 20 local authority areas to assess how well services are working together to care for a support people aged 65 and over. The resulting report, 'Beyond Barriers' summarises the CQCs findings from the review.<br><br>All 20 key themes identified are actions we have in place.<br><br>Report recommendations: | |

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| | • Encouraging and enabling commissioners to bring about effective joined up planning and commissioning<br>• A new approach to performance management<br>• A move to joint workforce panning<br>• Better regulation and oversight of local systems<br><br>David Rogers confirmed there Is an acknowledgment from the CQC and the Department of Health that Stoke-on-Trent is getting it right.<br><br>**Received** | |
| **172/2018** | **AOB**<br><br>**Quality Committee Summary**<br>The below noted policies have been considered by the Quality Committee at its meeting in June 2018.<br><br>Work is on-going to develop these policies further and the Quality Committee has agreed a recommendation for extension of the policy review dates until 31 October 2018.<br><br>Recommendation is for the policies to be ratified by the Trust Board.<br><br>1.25 Food Waste Policy<br>4.27 Protected Mealtimes<br>1.19 Chaperoning Policy<br>4.32 Privacy and Dignity<br>4.41 Responding to Patient Opinion<br>5.06 Waste Policy<br>5.09 Environment Policy<br>5.25 New and Expectant Mothers Risk Assessment<br>R07 CS Gas Policy<br>R10 Teaching Physical Intervention to Carers<br>1.04 Complimentary Therapies<br>1.70 Managing allegations of abuse<br>4.20 Volunteer Policy<br>4.22 Children Visiting MH & LD Hospitals<br>5.20 Health & Safety Audit Procedures<br>1.55 Advanced Statements<br>4.40 Being Open – duty of candour<br>5.19 Violence & aggression with Police Protocol<br>5.37 Pinpoint<br>5.38 Lockdown<br>4.33 Clinical Photography<br><br>**Ratified** | |
| **173/2018** | **Date and time of next meeting** | |

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|---|---|---|
| | The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Wednesday 26th September 2018 at 10:00am, in the Boardroom, Lawton House, Trust HQ. | |
| **174/2018** | *** Motion to Exclude the Public**<br><br>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 12.46pm

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 | 24-May-18 | 116/2018 | Learning From Deaths Quarterly Report - In all of the cases reviewed the care provided by our clinical teams was felt to be adequate to excellent. Caroline Donovan highlighted the need to identify where learning / improvements are being made and add to future reports. | Dr Buki Adeyemo | 26-Sep-18 | Report going to Quality Committee 27th September 2018 and will come to Trust Board 25th October 2018 |
| 2 | 21-Jun-18 | 140/2018 | Safer Staffing Monthly Report - April 2018 - Maria to bring an update on recruitment initiatives back to Trust Board | Maria Nelligan | 25-Oct-18 | |
| 3 | 21-Jun-18 | 141/2018 (1) | Serious Incident Annual Report (1)- Deep Dive Workshop outcomes on falls to go to Quality Commiitee and to Board. Detail around inclusion of family and carers and how this is undertaken to come back to Trust Board in next report. | Dr Buki Adeyemo | 26-Sep-18 | Deep Dive will be included in the Falls Annual Report which will be going to Quality Committee 27th September 2018. |
| 4 | 21-Jun-18 | 141/2018 (3) | Serious Incident Annual Report (3) - Report to go to Quality Committee regarding falls. | Maria Nelligan | 27-Sep-18 | Falls Annual Report to Quality Committee 27th September 2018 |
| 5 | 26-Jul-18 | 164/2018 | Safer Staffing Monthly Report May 2018 - Caroline asked for overall staffing needs to be included in the report going forward. | Maria Nelligan | 26-Sep-18 | Agenda item |
| 6 | 26-Jul-18 | 165/2018 | PQMF Month 2 - Exception report going forwarded to be reported on by CCG | Suzanne Robinson | 26-Sep-18 | Agenda item |
| 7 | 26-Jul-18 | 166/2018 | Organisational Development and People Strategy - Caroline asked if we can include under retention of staff the increase in flexible working and then monitor and understand the reasons for people leaving the Trust. | Alex Brett | 26-Sep-18 | Recruitment and retention workstream updated to include specific flexible working developments. Monitoring of reasons for leaving the Trust are reporting at PCD on a six monthly basis. |

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# REPORT TO OPEN TRUST BOARD

Enclosure No:4

| | | | |
|---|---|---|---|
| Date of Meeting: | 26th September 2018 | | |
| Title of Report: | CEO Board Report | | |
| Presented by: | Caroline Donovan, Chief Executive | | |
| Author: | Caroline Donovan, Chief Executive | | |
| Executive Lead Name: | Caroline Donovan, Chief Executive | **Approved by Exec** | ☐ |

| Executive Summary: | | **Purpose of report** | |
|---|---|---|---|
| This report updates the Board on activities undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest. | | **Approval** | ☐ |
| | | **Information** | ☒ |
| | | **Discussion** | ☒ |
| | | **Assurance** | ☐ |
| Seen at: | SLT Execs<br>Date: | Document Version No. | 1 |
| Committee Approval / Review | • Quality Committee<br>• Finance & Performance Committee<br>• Audit Committee<br>• People & Culture Development Committee<br>• Charitable Funds Committee<br>• Business Development Committee<br>• Digital by Choice Board | | |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement.<br>2. To provide the highest quality services<br>3. Create a learning culture to continually improve.<br>4. Encourage, inspire and implement research & innovation at all levels.<br>5. Maximise and use our resources intelligently and efficiently.<br>6. Attract and inspire the best people to work here.<br>7. Continually improve our partnership working. | | |
| Risk / legal implications:<br>Risk Register Ref | N/A | | |

| | |
|---|---|
| Resource Implications:<br><br>Funding Source: | N/A |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups) | The report describes our Second Staffordshire Symphony of Hidden Voices inclusion conference which was chaired by Jenny Harvey our staff side chair. The day was spent listening to real life stories and insights from a number of speakers from different backgrounds |
| STP Alignment / Implications | The report provides an update on key STP developments, both locally and nationally |
| Recommendations: | 1. To receive for information purposes |

North Staffordshire Combined Healthcare NHS Trust

# Chief Executive's Report to the Trust Board
# 26th September 2018

## PURPOSE OF THE REPORT

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

## LOCAL UPDATE

### 1. CQC RETURNING TO TRUST – OUR JOURNEY CONTINUES

As we said at the time, the results of our 2017 CQC inspection confirmed that the Trust's journey of improvement – previously described by the CQC itself as the fastest improving mental health trust in the country - had continued without let-up. We also said we are not complacent and we want our journey of improvement to continue.

Since then, we have done just that, particularly with our move towards locality working and our continuing leadership of key workstreams in the Together We're Better STP.

We all know the amount of effort that goes into supporting a CQC inspection, particularly in the middle of major change and transformation can seem a challenge. So I know it will come as mixed news that we have received a request from CQC for our Routine Provider Information Request – something we have to complete annually as part of the new well-led inspection regime. This also served as an announcement that we will receive an inspection within 6 months.

We submitted our provider information request (PIR) with over 200 returns by the deadline of 21st September. The requests were split between qualitative (narrative information requests) and quantitative (numerical data requests). Key operational and corporate leads worked on the data requests to ensure the return is an accurate reflection of our services and Trust performance.

We also have completed our own self-assessment of our 11 core services which demonstrate continual improvement. This was discussed collectively at the Senior Leadership Team meeting and will be presented to the Board.

The CQC inspections we have had to date have helped us to continually improve and we need to approach this next one with a mindset of showing the inspection team continued progress demonstrating the dedication and commitment shown by our staff.

### 2. LOCALITIES UPDATE

Our progress towards locality working continues. At the start of September, we published for our staff a response to the Stage 3 consultation. A really important principle of our process has been to make sure we are co-producing the new structure in partnership with staff. That is one of the main reasons that we have designed the process in 4 phases so we can co-produce, listen and respond.

There were five main themes that came out from the consultation:

- Directorate Makeup / Placement of Services
- Substance Misuse

- Psychology Structure
- Quality Improvement Lead Nurse / Matron
- Acute / Urgent Care

In the response document, we provided a considered response on each of these. As part of our commitment to openness, we made the Report available on the web after the staff have been given the opportunity to read it first. This is being presented by the Director of Operations later on the Agenda.

As you will be aware, the Trust has also created a dedicated website - http://localities.wpengine.com - to support the consultation process. This generated the majority of feedback. Every question and answer handled by the website is also published on the publicly available website.

As we said in the conclusion to our Response document, we thank all our staff affected by this consultation for their continued professionalism, engagement and for their valuable contributions to the finalised structure. We recognise that this process can be stressful and we have valued throughout the process their input into embedding a structure which further enhances the ability of our teams to deliver the fantastic, patient led services of which they - and we - are rightly so proud.

## 3. HEALTH AND WELL-BEING BOARD HEARS OF PROGRESS ON CQC LOCAL SYSTEM IMPROVEMENT PLAN

In August, I attended the latest meeting of the Stoke-on-Trent Health and Wellbeing Board. One of the key roles of the Board is to oversee the system CQC Improvement plan, which to date I have led. It was really positive to be able to present the plan in a very positive light and hand over the leadership to Paul Edmondson-Jones, the City Council's Director of Social care, Integration and Wellbeing. A call followed with the Department of Health lead Director who passed on compliments from the Secretary of State for Health on the progress we have made as a system - it has been a great example of system working - a massive thank-you to all who have contributed. We have just been informed that the CQC are returning in November to do a review of progress on the Stoke system. In addition, a CQC system review starts on 17th October across Staffordshire County Council and its partners.

## 4. ACTION ON INCLUSION

I was delighted to be able to open our Second Staffordshire Symphony of Hidden Voices. The inclusion conference which was chaired by Jenny Harvey our staff side chair was absolutely fabulous. I spent the whole day listening to incredible real life stories and insights:

- life as a British-born nurse, health expert, tutor, lecturer and medical professor of Irish and Nigerian descent by Professor Dame Elizabeth Anionwu;
- growing up as a young black man in the West Midlands in the aftermath of Enoch Powell's Rivers of Blood speech, by Roger McKenzie, Assistant General Secretary Unison
- how it was to live as a gay man before decriminalisation of homosexuality in 1967 and to have recovered from AIDS, by Maurice Greenham, Older People's LGBT Group;
- fascinating stories of living with a learning disability from service users in the Combined Healthcare Talk and Change Group
- insight into the work of Trans Staffordshire from Kirsty Lewis;
- discussion of the complexity of how different identities intersect with LGBT inclusion from Emma Jennings, Stonewall
- stories of how deafness can introduce particular challenges in living with and

providing support for people with mental health issues, from Julia Grint, Community Psychiatric Nurse

One particular highlight were two contributions from local poet Gabriella Gay. The second of her poems was an incredibly powerful piece about coping with racism in the workplace - which itself was based on the true life experience of a nurse working at Combined. It was truly humbling and painful to hear of her experiences. It is essential we learn and improve from them. We also were proud to give the Unison Award for Equality and Inclusion to Stevan Thompson.

Hearing about challenges and gaining insights means nothing if we don't act on what we hear. We will be working through all we have heard and coming forward with a very detailed plan of action, building on the work we have already undertaken on diversity and inclusion. On 20th September, I was pleased to chair the first meeting of our Inclusion Council where streams were identified for us to make improvements. These are:

1. Developing our HR Processes for inclusion - including recruitment and selection; disciplinary and grievance; workforce equality info processes; bank and agency staff (building in inclusion from start to finish of the process)
2. Supporting the development of our BAME staff : Developing equal and inclusive access to career, leadership and education development opportunities
3. Reporting, learning and improving following incidents and incidences of racist abuse and aggression (both preventing incidents as far as possible, and responding better and supporting people better when incidents do happen)
4. Culture of Inclusion: Developing clear standards of expected and unacceptable behaviour (policies, training, leadership styles, service user involvement ). Addressing how we treat each other day-to-day; inclusive treatment of colleagues; addressing micro-assaults and inequalities). Also considering religion and culture, food, etc.
5. Communication for inclusion – delivering clear communication inclusion, including: feedback from staff (including trainees); BAME network; engaging with our agency staff; events; posters; staff; BAME champions; app to gather staff experiences on exit – and starting with #WearRedDay #19Oct #ShowRacismTheRedCard

We have identified BAME Leaders to sponsor each of the programmes to ensure co-production.

## 5. SYSTEM DIAGNOSTIC

Over the last few weeks the STP have been leading on a 'System Diagnostic'; this looks at all the data and statistics that we have from across Staffordshire & Stoke-on-Trent and builds a story outlining where are key challenges and opportunities lie for improved quality and financial savings but from a system perspective rather than individual organisations. This work has been supported by the NHS Delivery Unit which is headed up by Tessa Walton the Director of RightCare so we are really privileged to have this level of support from her team but it's also important that we work together to get real value from what its telling us. The initial themes emerging highlight mental health where there is under investment across the system but high spend across acute, ambulance, primary care, mental health etc; which suggests that people aren't always able to access the support they need in the right setting and with clear pathways. This analysis supports the work that I have leading on through the STP Mental Health programme and I will be working with system partners to further develop our plans.

## 6. MENTAL HEALTH REGIONAL CONFERENCE

I was delighted to chair a fantastic regional mental health conference at the start of

September. The conference focused on sharing good practice with nearly all of our trusts across the region showcasing different services and innovations. Combined shared the work we have done on compassionate leadership. The event was opened by the Feel Good Choir - a community choir who were fantastic and talked to us about the importance of connection and wellbeing. We were also really pleased that Clare Murdoch, National Mental Health Director for NHS England, came to talk to us about progress of the mental health national strategy and thoughts for future priorities.

## 7. HEALTH KEELE UNIVERSITY PARTNERSHIP GOES FROM STRENGTH TO STRENGTH

In August myself, Dr Buki Adeyemo and Andrew Hughes went to visit Professor Trevor McMillan - Vice Chancellor and Helen Duffy - Partnership and Engagement manager from Keele University.

We had a really positive and exciting meeting and discussed the excellent progress the Trust has made from both an educational and research perspective. Really well done to everyone who has been involved.

Particular thanks to Dr Chris Link and Dr Darren Carr who have made such good progress. We will hopefully soon have more of our clinicians taking up senior lecturer roles in both education and research with Keele University and more plans afoot all which will help us improve patient care and attract and retain talented staff. Andrew is presenting an update later on the Agenda.

## 8. FIRST CONFERENCE FOR NON-REGISTERED CARE WORKERS

Maria Nelligan led a great conference this month to celebrate and support the work of our care workers. This staff group is amongst the biggest in the Trust, with the most proportion of time in direct patient-facing roles.

The event also featured keynote presentations from a great friend of the Trust, Tommy Whitelaw – Leading Change Adding Value Champion at NHS England and from Shaun Maher, Principal Educator Quality Improvement Team at NHS Scotland.
The morning session of the event gave opportunities from our care workers to share insights into the fantastic work they do at Combined, including presentations from:

- Ben Walmsley and Matt Wright – HCSWs, Darwin
- Lisa Boon – STR Worker, Access and Home Treatment
- Jackie Weightman – Assistant Practitioner, Ward 7
- Workers from our Learning Disabilities Team
- Amanda Dibble – HCSW, Intoxication Observation Unit
- David Hilton – Activity Worker, Ward 7

The afternoon session was devoted to a Listening Into Action event, facilitated by our OD Team, listening to feedback and ideas from our staff on how they feel about their work, the opportunities it offers as well as they challenges they face, what more the Trust can be doing to support them and how we can maximise the routes for personal and career development. Well done to everyone involved in putting on a great event.

## 9. CONTINUING TO SUPPORT POSITIVE PRACTICE

We are strong supporters of the Positive Practice in Mental Health Collaborative. This is a user-led multi-agency collaborative of 75 organisations, including NHS Trusts, CCGs, Police Forces, third sector providers, front line charities and service user groups. It exists to identify and disseminate positive practice in mental health services by working together across organisations and sectors to facilitate shared learning and to raise the profile of mental health with politicians and policy makers.

We're proud to play a very active role in the collaborative and to have been featured regularly in their Positive Practice Awards. This year's entries from Combined were the highest ever and we're really looking forward to the Awards ceremony in Liverpool next month. We're delighted to have been shortlisted for two of these awards - within the Mental Health Safety Improvement Category and the Mental Health Workforce Wellbeing Category.

We're even more proud to have been asked to lead the national Children's Positive Practice Awards next year. Myself, Carol Sylvester and Joe McCrea, had an enjoyable session this week with Angie and Tony Russell, Directors of Positive Practice, brainstorming ideas about how we can make the Awards a really fun and memorable event. We will be providing the Board with an update on progress.

## 10. BBC RADIO STOKE FOCUS ON MENTAL HEALTH

We have developed a strong and productive relationship with our local radio station, BBC Radio Stoke - and in particular with the breakfast programme "Liz Ellis and John Acres at Breakfast". This has included working with the programme's presenters and producers on developing and/or contributing to story ideas that raise the profile of mental health in an informed way, promote a recovery-based approach, and raise awareness of the services and support available either directly from ourselves, from our partners or more widely across our patch.

In August, the breakfast programme devoted a slot every day to stories on mental health - many of which featured input from ourselves or our partners. The stories were approached from the perspective of the service user or their families and provided a fascinating insight - not pulling punches, but also being positive and fair in the way they explained and included the input and perspective of services as well.

The week's topics were:

- Monday - the personal journey of recovery of a service user
- Tuesday - Coping with OCD
- Wednesday - Brighter Futures
- Thursday - Step On
- Friday - Coping with Eating Disorders and out of area placements

We continue to develop our relationship with the BBC as well as other local media outlets.

## 11. WORKING TOGETHER TO MEET THE CHALLENGE OF MONKEY DUST

Monkey Dust is a particular feature of substance misuse in Stoke-on-Trent and has been something on which we have been actively involved, both in providing support services via the Community Drug and Alcohol Service and in developing partnerships across the local NHS, local government, voluntary sector and emergency services including the police.

As with any relatively new substance, there is always the danger for the press to over dramatise the situation or exaggerate its prevalence. In times like this, it's really important that all of the agencies involved work together to ensure we communicate calmly and responsibly the reality of the situation and what is being done to address it.

I was really pleased to see that approach being adopted over recent weeks, in particular some really good work by Dr Derrett Watts, our Clinical Director for Substance Misuse and colleagues from the Community Drug and Alcohol Service. This welcome has been shared by Paul Edmondson-Jones, Director of Social Care, Health Integration and Well-being at Stoke City Council, who shared a message of thanks and appreciation for the collaborative approach being taken with the communications teams and services across our area.

We have collectively been emphasising:

- We have been aware of monkey dust in Stoke on Trent for some time
- Even though it's a small number of substance misuse users (we estimate about 5% of all substance misuse in Stoke-on-Trent and less in Newcastle) it's a challenge we recognise and certainly don't underestimate its significance and the importance of developing partnerships to deal with it and support users
- We have been leading the development over the past 12 months of a partnership approach to tackling the issue and supporting users in coming off the substance and recovery, together with colleagues in local government, public health, voluntary sector and emergency services including police.

## 12. DOUBLE CONTRACT SUCCESS FOR SUBSTANCE MISUSE

I am pleased to announce the Trust has been successful in securing the Stoke-on-Trent Drug and Alcohol Service (CDAS) contract in partnership with Addaction and BAC O'Connor through a procurement process.

The bid was submitted on the 10 July 2018 to Stoke-on-Trent City Council and was awarded on 23 August 2018 with commencement of service delivery on 1 January 2019. The contract period is 5 years plus option to extend the contract for a further two years and has a value of £3.9m per year.

CDAS offers support to adults, young people, carers, partners and families who live in Stoke-on-Trent to make a positive and sustainable change to their lives and the community they live in. It is a free service commissioned by Stoke-on-Trent City Council.

Also - working in a partnership of three organisations, the team have won a new contract for the delivery of health services at Stoke Heath Prison. The five-year contract – which was commissioned by NHS England – begins in April 2019 and includes a potential two-year extension that would take it to 2026.

It sees North Staffordshire Combined Healthcare NHS Trust teaming up with Shropcom and The Forward Trust to form what is being called the Stoke Heath Integrated Care partnership (SHIC). The partnership brings together three exceptionally experienced, passionate and proven healthcare providers with extensive experiencing safely and seamlessly transitioning services.

Combined will deliver secondary mental health and clinical substance misuse services. All three organisations already deliver health services at the prison, near Market Drayton, but the new contract involves the introduction of a new model of care that will be shaped over the next six months in the run-up to the launch on 1 April.

As a Trust we have been proud of our successful delivery of Substance Misuse services and we are excited to extend our service offer to include Mental Health services within the prison. We know how important it is to respond positively to Mental Health conditions whatever the environment and setting.

## 13. COLLABORATION WITH MICHAEL WEST ON NATIONAL WEBINAR

It was both a pleasure and a privilege to be asked to go to London with our Associate Director of Organisational Development, Jane Rook, to present a national webinar with Professor Michael West of The Kings Fund London.

This was part of a series of webinars to support the national Developing People, Improving Care Strategy. There are 5 conditions that underpin this, condition 2 is the need for compassionate, inclusive and effective leaders at all levels.

It was an opportunity for us to share insights on our Trust improvement journey and how our staff have been front and centre of that. Jane also shared the work we are doing to

strengthen our approach to inclusions. We now have over 756 of our staff who have been recognised for their acts of compassion.

It was a real pleasure to be able to share our work, with all the people nationally who dialled into the webinar.Some of you may remember meeting Michael at a previous Leadership Academy session which went down extremely well. I used the opportunity to invite him to work with us as part of the STP leadership development programme that I am SRO for.

## 14. COMBINED PLAYS ITS PART IN THE WORLD'S BIGGEST COFFEE MORNING

Lawton House are holding a 'World's Biggest Coffee Morning' on 28th September, fund raising in support of Macmillan Cancer Support. It's a great thing to be involved with, particularly because as part of this event our own Sue Slater, Education and Development Manager, is 'Braving the Shave' so at 1pm she will be be having all of her hair removed!

You can support Sue by clicking onto the link to go to her funding page: https://bravetheshave.macmillan.org.uk/shavers/sue-slater

We will be having cake and coffee for donations for the charity. We will also be filming and photographing Sue's shave so if you can't make it you will certainly be able to see it afterwards.

## 15. COMBINED SHORTLISTED FOR HSJ PATIENT DIGITAL PARTICIPATION AWARD

Combined has been shortlisted for the HSJ Patient Digital Participation award for our Autographer project. The new category has been introduced to recognise how the use of digital technology can radically improve patient interaction with their own care. The wearable camera 'Autographer' was used as a memory support intervention for patients with dementia, which helped to build self-care and management capabilities.

## 16. WINTER PLANNING

As normal, over the summer months our operational teams have been working with partners across the health economy to plan for the forthcoming winter period. This has involved partners working together to ensure that additional capacity and resources are available over the winter months and specifically December 2018 to March 2019. Our local acute trust, University Hospitals of North Midlands, have received a capital allocation of almost £9m to build two additional wards and these are currently on plan to open in December 2018.

Combined Healthcare has been supporting by planning to provide additional capacity within our older peoples' community teams, mental health liaison services and crisis services. Specifically, we have been asked once against to contribute by increasing capacity on Ward 4 in Harplands Hospital from 15 to 19 beds over this period. We are currently awaiting confirmation that funding will be made available for this uplift in capacity and will communicate further on this, once we have confirmation.

## 17. WELCOME TO LINDA HOLLAND

Alex Brett will be taking up a new role with MPFT on the 1st October. We are delighted that Linda Holland will be starting as Interim Director of Workforce and Organisational Development from mid November 2018, starting to work in the Trust on ad hoc days from September onwards. Linda is a very experienced Director and we are lucky to attract her from her current Director role at Mid Cheshire Hospitals NHS FT. We are really looking forward to welcoming Linda to Combined Healthcare. In the meantime the HR function will

be led by Jonathan O'Brian, Communications by Buki Adeyemo and Organisational Development by myself.

## NATIONAL UPDATE

### 18. NEW FLU VACCINATION TO REDUCE BURDEN ON NHS THIS WINTER

Delegates at the Public Health England (PHE) conference heard that a more effective flu vaccine for those aged 65 and over this winter has the potential to prevent deaths and significantly reduce the burden on the NHS.

The vaccine, available for the first time this year in the UK for those aged 65 and over, could reduce GP consultations by 30,000, hospitalisations by over 2,000 and prevent over 700 hospital deaths from flu in England, alleviating some of the health burden that seasonal flu places on the population, workplaces and the NHS.

The newly available 'adjuvanted' vaccine is expected to significantly boost effectiveness by improving the body's immune response to the vaccine. This is important because typically, older adults' bodies do not respond as well to the flu vaccine due to their naturally weaker immune systems. Older adults are also more likely to suffer complications from flu.

Rob Sillito from Combined Healthcare was interviewed this month by Stuart George on BBC Radio Stoke. The main focus on the interview was to promote health care and social care staff to get their free flu jab. But also to promote the general public to seek out more information about the flu jab.

Rob discussed who is eligible for a free Jab, these being people over 65, children, people with some chronic medical conditions e.g. diabetes, chronic heart disease, COPD and also healthcare and social care staff. He also discussed how people can get their flu jab by speaking to infection control or Team Prevent. He then went on to discuss the importance of staff getting the flu jab - for protecting ourselves, other staff, family and most importantly protecting the patients we are caring for. Finally, he dispelled people's false beliefs that the flu jab can give you the flu or a cold and explained that the flu jab has a killed virus in and this makes the body produce antibodies and when we are exposed to the flu virus in the flu season, our body is ready to fight the virus.

Combined Healthcare will be kicking off our flu campaign on the 5th October with a 24 hour Jabathon, with a member of staff roaming and giving as many staff as possible the flu vaccine throughout the day and night.

### 19. MENTAL HEALTH THERAPISTS IN GP PRACTICES COULD BE THE NORM

New guidance has been drawn up to encourage doctors to place mental health therapists in practice surgeries – bringing more mental and physical health services under one roof. These new therapists will be integrated into primary care teams and focus on common mental health disorders such as anxiety and depression, particularly where this occurs in patients with a long term physical health condition such as diabetes, respiratory or heart problems.

Evidence suggests nine out of 10 adults with mental health problems are supported in primary care and broadening the range of services for patients, means local health services are better equipped to deal with patients' physical and mental health needs.

Claire Murdoch, NHS England's national director for mental health said**:** "Joining up talking therapy services in primary care settings is another big step forward for our patients and a

key plank in putting mental health at the centre of the long-term plan for the NHS. We are on track to deliver 3,000 therapists in primary care, with over 800 in surgeries at the end of last year and this handy guidance should convince those practices that are yet to take the plunge of the benefits."

In line with the National Directive the Healthy Minds service operates a Stoke Locality Hub and Spoke Model where IAPT Long Term Condition therapists are located in the therapy suite at the northern part of the city and a the second hub operates in a shared location with third sector in south stoke.

The spokes of the service where therapy is delivered are:

- GP Practice's
  More specifically some GP Practices have offered room space for IAPT Long Term Condition (LTC) therapists to be co-located with the nursing practice teams so that there is a holistic approach to client care for people where the therapist is part of the overall GP Primary Care Team.
- Primary Care Centre's
  The Healthy Minds IAPT- LTC therapists have been co-located in Primary Care Centre's and Health Centre's with the Specialist COPD and Diabetes Physical Health Teams.
- Community Venues

The Interface within Primary Care has been implemented including:

- Outreach visits by the IAPT Clinical Lead to GP Practice Teams and GP Locality Meetings.
- Co-location with the Specialist Physical Health Teams (COPD, Diabetes, GP Teams) across the locality enables therapists to attend physical healthcare clinical team meetings, provide opportunities for clinical consultation.
- Specialist Case Recognition Training has been delivered for the COPD and Diabetes teams and physical health training has been reciprocated for the IAPT-LTC/Core team.
- Shadow working arrangements have been developed with the Community COPD and Diabetes Teams to understand the roles between practitioners.
- IAPT-LTC therapists deliver 'wellbeing educational programs' as part of the COPD Pulmonary Rehab and Diabetes treatment programs within practices.
- Cardiac Educational Programs have been developed and rolled out for the Cardiac Rehab Team by IAPT-LTC therapists.
- To improve access to the service specialist physical health leaflets have been marketed and distributed across the locality.

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# REPORT TO: TRUST BOARD

Enclosure No:5

| | | | |
|---|---|---|---|
| Date of Meeting: | 26 September 2018 | | |
| Title of Report: | Service User & Carer Council Report | | |
| Presented by: | Wendy Dutton, Chair, Service User & Carer Council | | |
| Author: | Wendy Dutton, Chair, Service User & Carer Council | | |
| Executive Lead Name: | Maria Nelligan, Executive Director of Nursing & Quality | Approved by Exec | ☒ |

| Executive Summary: | | Purpose of report | |
|---|---|---|---|
| This report has been prepared to provide an update to Trust Board of the Service User & Carer Council since the last meeting | | Approval | ☐ |
| | | Information | ☒ |
| | | Discussion | ☐ |
| | | Assurance | ☒ |
| Seen at: | SLT ☐ Execs ☐<br>Date: | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☐<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☒<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Digital by Choice Board ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement.☐<br>2. To provide the highest quality services ☐<br>3. Create a learning culture to continually improve.☐<br>4. Encourage, inspire and implement research & innovation at all levels.☐<br>5. Maximise and use our resources intelligently and efficiently.☐<br>6. Attract and inspire the best people to work here.☐<br>7. Continually improve our partnership working. ☐ | | |
| Risk / legal implications:<br>Risk Register Reference | None identified | | |
| Resource Implications:<br><br>Funding Source: | None identified | | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | The Service User & Carer Council supported the principle of increasing representation across the Protected characteristics when reviewing the Diversity and Inclusion Strategy.<br><br>They also committed to supporting inclusive services and workforce in their review of the Strategy | | |
| STP Alignment / Implications: | As part of ongoing service user/carer engagement, service user and carer views are encouraged within the STP workstreams | | |
| Recommendations: | The Trust Board receives the update for information and assurance | | |
| Version | Name/Group | Date issued | |
| | | | |
| | | | |

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**SERVICE USER AND CARER COUNCIL UPDATE**
**FOR TRUST BOARD ON 26th September 2018.**

## 1 Workshop on 27th June 2018

- For the second time we used Academic 2 & 3 between 5-7pm. Again only a small number were able to attend for a variety of reasons.
- We were able to take a fresh look at person centred care and in particular suggestions for the one- page profile. Notes from this have been sent out to Service User & Carer Council members for comment, and copies will be available at the next Service User & Carer Council Business meeting. This work was also taken forward to the 1st Non- registered staff conference on the 14th September, 2018 this is currently being collated, looking for common themes and ideas to take forward.
- Citizens Jury is to enter an 'Action Plan' phase. This will we are assured involve service providers, 3rd sector workers as well as service users and carers. Maria Nelligan, Executive Director of Nursing & Quality is involved in this stage.

## 2 Service User & Carer Council Business meeting to be held 26th September 2018

- A visit has been arranged for Service User & Carer Council members to have a conducted tour of the Psychiatric Intensive Care Unit.
- The agenda is diverse reviewing work to date and Directorate updates.
- There will be an update on the Patient Aide application and changes to non-emergency transport by Ben Boyd alongside a discussion on the BeAble application. I was lucky enough to trial for 2 weeks, currently in simplistic prototype form, the potential breadth of application was discussed and encouraged, the trial had some interesting outcomes.
- A robust review of all open actions with a view to refreshing targets and agenda in line with the new Directorate structure.
- Nominations for Vice Chair and October workshop (by which time hopefully the new Directorate structure will be in place) a review as to how we can best support service user's/carer's

## 3 Continued Service User & Carer Council Membership Involvement

- Trust Board meetings
- Interviews
- PLACE Assessment
- Un announced visits
- SUEEG Meetings
- Business Meetings
- People and Development
- Inductions
- Access Meetings
- Adult In-patient meetings
- Ward and Admin Volunteers and more!

**Wendy Dutton**
**Chair, Service User & Carer Council**
**18th September 2018**

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# REPORT TO OPEN TRUST BOARD

Enclosure No:6

| | | | |
|---|---|---|---|
| Date of Meeting: | 26TH September 2018 | | |
| Title of Report: | Research and Development Team: Annual Report | | |
| Presented by: | Dr Darren Carr, Clinical Director, NOAP | | |
| Author: | R&D Team contributors include; Dr Chris Link, Kerri Mason, Sandra Storey | | |
| Executive Lead Name: | Dr Buki Adeyemo, Medical Director | Approved by Exec | ☐ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| Research and Development (R&D) Annual Report is to present information on the R&D activity for the period 1st April 2017 to 31st March 2018. The report shares our research journey over the last 12 months, sharing our successes, performance and stories. | Approval | ☐ |
| | Information | ☒ |
| | Discussion | ☐ |
| | Assurance | ☒ |

| | | | |
|---|---|---|---|
| Seen at: | SLT ☐ Execs ☐<br>Date: | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☒<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☒<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Digital by Choice Board ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement.☐<br>2. To provide the highest quality services ☐<br>3. Create a learning culture to continually improve.☐<br>4. Encourage, inspire and implement research & innovation at all levels.☒<br>5. Maximise and use our resources intelligently and efficiently.☐<br>6. Attract and inspire the best people to work here.☐<br>7. Continually improve our partnership working. ☒ | | |
| Risk / legal implications:<br>Risk Register Reference | Reduction in funding from NIHR and impact on recruitment targets as noted in the report. | | |
| Resource Implications:<br><br>Funding Source: | N/A | | |
| Diversity & Inclusion Implications:<br>(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 for information and assurance purposes | | |

NHS
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2017-2018

Annual Report

# Research and Development (R&D) Team

# Contents

# Introduction

The purpose of this Research and Development (R&D) Annual Report is to present information on the R&D activity for the period 1st April 2017 – 31st March 2018. The report shares with you our research journey over the last 12 months, sharing our successes, performance and stories. We would like to thank our patients, clinical teams and our partners over the last 12 months for their support and contribution to research, evaluation and innovation.

North Staffordshire Combined Healthcare NHS Trust continues to strive to achieve its objective to 'encourage, inspire and implement research and innovation at all levels' and to meet its statutory duty for 'promoting research, innovation and the use of research evidence' (Health and Social Care Act, 2012).

# Why do Research?

# Our Finance

## National Institute for Health Research (NIHR)

The NIHR Clinical Research Network supports the initiation and delivery of research in the NHS, providing funding for research governance activity and staff recruitment to studies that form part of the NIHR portfolio of priority studies for the year.

Due to changes in the regional funding model in 2016, the Trust received £108,624, a 7.4% reduction from the previous year.

## Commercial Income

During 2017/18 the total commercial income exceeded our Trust target, achieving a total increase of 152% for external funding. We achieved this through undertaking training and delivery of a number of complex trials. Commercial income, in line with our Commercial Policy and Procedure, has enabled the funding of further bank staff and clinicians to work additional hours to support recruitment and generate additional capacity within the R&D team. The involvment from clinical teams has also enabled teams and clinicians to develop and gain experience of research skills and knowledge.

Our continued support from the Directorate has also enabled our part-time Dementia Research Nurse to to work closely with the research team - making a significant contribution to our recruitment and engagement in a number of a activities but in particular dementia research.

# Board Assurance Framework (BAF) 2017/18

## Board Assurance Framework (BAF) 2017/18

The Trust Board is responsible for ensuring that the Trust consistently follows the principles of good governance applicable to all organisations. The Board does this through the development of systems and processes. The BAF identifies the procedures for risk management against key strategic objectives and the controls and assurances in place.

R&D's BAF Objectives are mapped against the Trust objectives, namely to encourage, inspire and implement research and innovation at all levels. During 2017/18 the (BAF) identified objectives for R&D, and we are pleased to report that four out of six objectives were fully achieved:

- *Develop and agree partnership agreement with Higher Education Institutions, in areas of mutual interest;*
- *Increase number of research collaborations by 10% from baseline;*
- *Increase external funding for research by 10% from baseline;*
- *To refocus the strategy to incorporate innovation.*

An agreement was given the on-going work to take forward two in the 2018/19 BAF:

- *A strategic appointment is made with a local Higher Education Institution;*
- *Dragons Den is relaunched with a focus on innovation and Valuemakers, under auspices of the R&D team, co-led with the service user and carer council.*

# Our Performance

From April 2017 to March 2018 clinical teams and the R&D team worked together to recruit a total of 113 participants into 25 active portfolio research studies. While a slight reduction in recruitment due to a reduction of available studies for the year, there were a number of studies that did not recruit due to the rarity of condition or complexity of study design. Despite a reduction in recruitment, NIHR recruitment has remained stable over the last five years, with approximately 100 recruits per year.

We had 13 active Principal Investigators during 2017/18 and we continue to work with the Clinical Research Network West Midlands (CRN WM) to grow this further. We were also a Patient Identification Centre (PIC) for one study and there were also 13 active non-portfolio (student research) studies. The Trust met its obligation to report on research initiation and delivery activity to the Department of Health via the National Institute for Health Research (NIHR).

During 2017/18 there were 11 studies approved, with nine meeting the set-up metric of 40 days from date site selected to NHS confirmation of capacity and capability, two meeting the first patient metric of 30 days from NHS confirmation of capacity and capability to first patient consented at site, and two meeting the overall metric of 70 days from date site selected to first patient consented at site.

Delays in approval were related to external influences beyond our control, and delays in recruiting the first patient were related to both external and internal influences. Only one out of nine of our closed studies met recruitment target, with three very close to target. While this is disappointing, however three of the studies were not measurable, as no target is assigned to suicide and homicide studies. In the coming year the R&D team will be paying particular attention to target setting and advocating a range in the future walong with other measure in place to improve performance in this area.

# Our Governance

**Research Standards:** The new UK policy framework for health and social care research came into effect in November 2017. This replaced the Research Governance Frameworks (RGF) in England, Wales, Scotland and Northern Ireland. The new single policy framework supports good practice across the UK in the conduct and management of health and social care research that takes account of legal Requirements and other standards that underpin high-quality ethical research. During November/December 2017, the R&D team established an Action Plan to implement the new policy framework at Combined. Progress towards completion is continuing into 2018/19 overseen by the R&D Steering Group.

**Research Systems:** During 2017/18, the R&D team continued with implementation of the new local portfolio management system (EDGE) which went live at the Trust in June 2016. The R&D team continued to transfer study data, set-up data, recruitment data from the old systems to EDGE, and to validate data, and input new studies set-up and recruitment data. The plan for 2018/19 is to utilise EDGE to record key governance processes and store key study documentation for use by the local research teams and this work is progressing well.

**Educational Support:** The R&D team continued to support staff undertaking research as part of a higher educational qualification. During 2017/18, 23 students received support, with 13 receiving NHS approvals. The trend for support has doubled from 2016/17; this surge is primarily to do with students who deferred, and complete cohort (professional doctorate in clinical psychology at Staffordshire University) wishing to conduct their research at the Trust. The R&D team will continue to work with local universities to improve collaboration around support for students. R&D team continued to support staff undertaking research as part of a higher educational qualification.

# Our 2017/18

## April 2017

The start of the year saw the R&D team host an interesting and regarded as a successful one-day workshop on Realist Evaluation led by Dr Geoff Wong, clinical research fellow at the Nuffield Department of Primary Care Health Sciences and a GP in North London.

The workshop explored the essentials of realism, and provided an understanding of the principles and assumptions which underpin realist evaluation. The workshop well attended by Trust staff, researchers from the Centre of Health & Development (CHAD), Keele and Staffordshire University and scolleagues from University Hospitals of North Midlands NHS Trust.

**R&D Team welcome New Director of Research**

The R&D team started the new year welcoming Dr Chris Link to the team, who joined us as the new Director of Research. Dr Link stated that he was *"delighted to have been appointed as Director of Research for the Trust. Research is taking an increasingly important role in the modern NHS to ensure services deliver evidence-based, safe, effective, patient-centred care. I look forward to working with the team to raise the profile within the Trust and to establish collaborations with external Higher Education Instituions".*

# May 2017

In May 2017, our Neurodegenerative Active Partnership (NOGAP) team took research on the road for International Clinical Trials Day 2017. The team made up of researchers, clinicians and support services from the Trust and University Hospitals of North Midlands (UHNM) visited various locations, on the NOGAP bus, across Stoke-on-Trent and North Staffordshire promoting dementia research.



Working with our NOGAP Partner UHNM

## Funding extended for Research Coordinator post in 2017/18

# June 2017

In June, the National Centre for Mental Health (NCMH) study, Cardiff University, was adopted in the Trust. This study enabled patients within Older Peoples and Adult services, and staff across the Trust a chance to take part in a national research study. The NCMH a study aims to better understand the causes, triggers and course modifiers of mental disorders by looking at the genetic basis for common mental health problems, including bipolar disorder, depression, mood disorders, PTSD, schizophrenia and psychosis.

The NCMH study gave us a chance to engage with new teams and clinicians across the Trust, and going into 2018 we continue to work with clinicians and services to promote and recruit to the study.

**Working with the R&D Team**

***"I have recently completed my Good Clinical Practice (GCP) training and with the help and advise from the research team have begun to complete assessments for the NCMH study. The team are very supportive and accomodating and made the process much easier by being available to answer any queries. I would certainly recommend others to come forward and consider undertaking this as part of their clinical role" - Jackie Nolan (Advance Nurse Practitioner)***

# July 2017

**NOGAP Open New Trial:** Our clinical trials are a small but complex part of the work we do, often involving a range of support services, staff and strategies for recruitment. During 2017/18 the R&D team supported three clinical trials, a 300% increase from 2016/17. All three trials were supported by NOGAP and our Dementia Research Nurse, Lynn Forrester (pictured below), who has been instrumental in the delivery of these trials.

*"I am involved in the promotion and recruitment of patients to dementia studies, working alongside both Bradwell and Eaves memory clinics. In my role patients and families share that they take part as they feel they are doing something to help people in the future - even though it may not be beneficial to themselves".*

**Lynn Forrester**

# August 2017

**MOU**

Development of the Memorandum of Undestanding with Staffordshire University

**TARGET**

Trust CRN Research target increase by 305%, from 96 to 293 participants per year

**NCMH**

Inpatient & Community Staff trained in the NCMH study

**In August 2017, engagement with Staffordshire University was formalised in a Memorandum of Understanding (MoU) to explore research development, capability and capacity building. The Memorandum of Understanding links to three aspects of the BAF:**

- **Develop partnerships with Higher Education;**
- **Increase external funding;**
- **Increase the number of research collaborations.**

**The R&D team are now looking at how best to utilise the agreement and take work forward together and exploring collaborations with other Higher Education Institutions also.**

# September 2017

## NOGAP & Stoke City Football Club

A video created by the Neurodegenerative Active Partnership (NOGAP) team to raise awareness about the dementia research being undertaken locally between Combined and University Hospitals of North Midlands (UHNM) received recognition at Stoke City Football Club.

The video was played out during the pre-match show at the Stoke City vs Chelsea match at the Bet365 Stadium on Saturday 22nd September. The video was presented by Mike Pejic, and also included in the video were eight members of the Stoke City Old Boys Association (SCOBA).

Clinicians & researchers from the Trust and UHNM, all of whom contribute in some way to the delivery of dementia research where represented.


Video from the Stoke City Football Game

# Trust sponsored research published in International Journal

Research sponsored by the Trust, led by Professor Christine Roffe, Clinical Research Lead from Stroke at University Hospitals of North Midlands NHS Trust, and researchers from Keele University, the University of Oxford and the University of Birmingham was published in the Journal of the American Medical Association (JAMA).

The article titled 'Effect of routine low-dose oxygen supplementation on death and disability in adults with acute stroke'. The Stroke Oxygen study randomised controlled trial has revealed that giving oxygen to stroke victims make no difference to their recovery or chances of survival.

The research took place over a nine year period involving more than 8,000 patients across 136 Trusts nationally. Professor Roffe said "*It is common when a stroke patient first receives care that they are given an oxygen mask, the results provide clear and unambiguous evidence, that it remains important to monitor oxygen levels, patients admitted to hospitals with stroke do not need routine oxygen treatment*".

# October 2017

## At the top for Childrens study recruitment

The Children and Young People research team, led by Dr Joanne Barton, Consultant Psychiatrist, topped the leader board for recruitment into the Pre-School parenting interventions (COPPI) trial. The study funded by the National Institute for Health Research (NIHR), looked at comparing the efficacy and cost of specialised individually delivered parent training (PT) for pre-school children with attention-deficit hyperactivity disorder (ADHD) against generic group-based PT and treatment as usual (TAU). The results were published in October in the European Journal of Child and Adolescent Psychiatry (EJCAP).

The article titled "A comparison of the clinical effectiveness and cost of specialised individually delivered parent training for pre-school attention deficit hyperactivity disorder and a generic, groups based programme: A multi-centre, randomised controlled trial of the New Forest Parenting Programme versus Incredible Years" can be accessed on the EJCAP website.

The Trust was the top recruiting site nationally, having recruited 111 of the 307 participant's recruited in total. Dr Barton said *"This tremendous recruitment was a result of all our team coordinating to offer our patients and their families a chance to participate in potential 'treatment programme's of the future'.*

# November 2017

## Development of the an innovative App

The idea for a modular App that people with memory problems could use to assist with self-management of their Mild Cognitive Impairment, dementia and other vascular risk factor was a natural development from the Autographer plus Flo Work completed by Sue Molesworth (Research Associate) and Lisa Sharrock (Vascular Well Being Service). In February 2017, the Capital Investment Group reviewed a business care, prepared by the project team, to invest in the first stage of the BeAble App. £30,000 was agreed to begin to build a demonstrator BeAble App.

In November 2017 the App was piloted with clinicians in Combined, and also the local Take Hearts group. Alongside the BeAble Development, the R&D team have supported and worked alongside Lisa and BitJam to scope out an evaluation plan, which is planned to commence Summer 2018.

# December 2017

## NEW TEAM MEMBER

December 2017 saw our R&D team expand , in addition to inviting clinicians working in the Older Peoples, to work with the R&D team supporting NIHR portfolio research.

## SUPPORTING EDWARD MYERS

*The R&D team supported the development of the marketing materials for the Edward Myers Unit.*

*"The development of marketing material has become an important factor in securing the financial future of the Edward Myers Unit. Working with the EMU team, R&D staff were able to collate and creatively use material to develop a folder of information, which is attractively presented in a professional fashion, and can be suitable for service users, professionals and commissioners"* ***– Dr Derrett Watts***

## CJMHT EVALUATION

The R&D team where approached the work with the Criminal Justice Mental Health Team (CJMHT) to review a newly developed Outreach model. Funded for an evaluation was received to take the project forward into 2018/19.

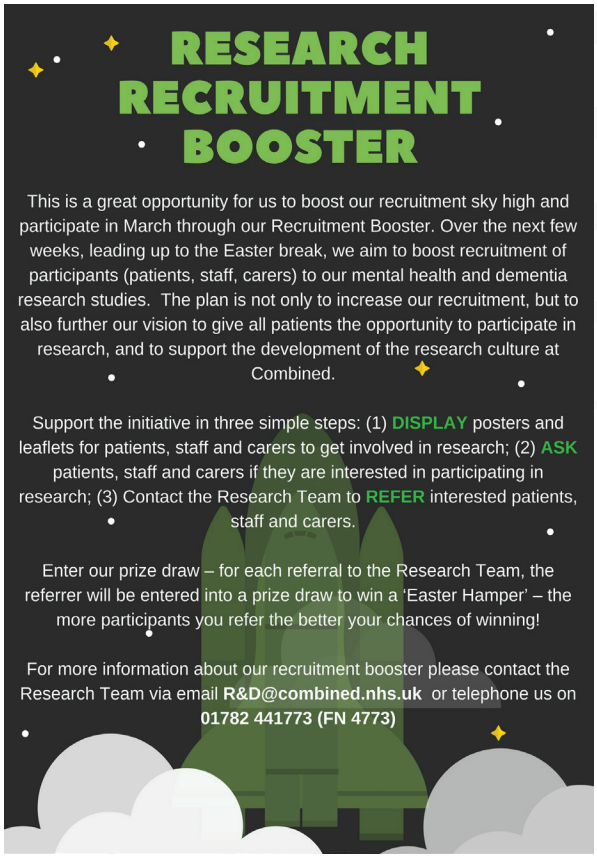
# January 2018

**Farewell to Sue:** In January 2018 the team said a fond farewell to Sue Molesworth, Research Associate, who left the Trust to take up an exciting new opportunity with Dementia UK. The team, want to sincerely thank Sue for the dedication, hard work and commitment to research and service evaluation over the past twelve years, and wish her every success for the future.

# February 2018

The NOGAP team opened their first joint Randomised Controlled Trial (RCT), Journeying through Dementia - a study to explore if attending a 12 week programme can help someone living with dementia to live a healthy and fulfilling life.

# March 2018



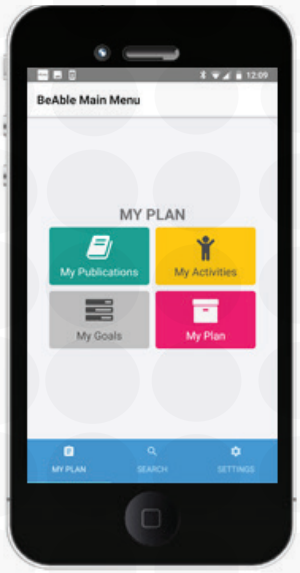

Our March recruitment booster aimed to increase the number of referrals to our NIHR portfolio and Commercial studies further. The recruitment booster asked clinicians and team to share our research posters, ask patients and refer into the team to boost recruitment.

# Our Projects

The R&D team supported clinicians in the development and evaluation of the following projects:

## Walking Football Evaluation - Dave Bloor

In 2017 a Walking Football group was established by our mental health nurse Dave Bloor, in the Vascular Wellbeing Service (MHVWS). The aim of the project was to establish the benefits and any disadvantages of walking football to participants. The evaluation has been designed around the framework of "Five Ways to Wellbeing.




## BeAble Project - Lisa Sharrock

In February 2017 the Capital Investment Group reviewed a business case submitted by Sue Molesworth and Lisa Sharrock for investing in a first stage demonstrator of the BeAble App.

In 2018 The BeAble project team held their first demonstration of the app, with both patients and clinicians. The BeAble team continue the work into 2018/19 exploring functionality and usability of the app.

## Ward 6 Multi-Discplinary Team (MDT) Review - Dan Platt

Previously the Ward 6 carried out an MDT review each week – varied across site but generally this was a set pattern of an afternoon or a morning dependant on the area.

The aim was to introduce an MDT style and mix this with one of the weekly handovers which would traditionally include both staff handing over from the early shift and staff coming on the late shift – aswell as mixing this with medics, OTs, activity workers, pharmacists.

# Looking forward to 2018/19

Our key objectives for 2018/19 are set out in the Trust's Board Assurance Framework and we are pleased to report the R&D team have made progress and continue to scope out how to take this exciting work forward:

**Convert good practice innovations that the Trusts into published articles.** As part of engagement work for 2018/19 we will aim to scope out how best to share good practice, including; taking forward our Innovation Nation event.

**Dragons Den is re-launched with a focus on innovation and value makers under the auspices of the R&D team co-led with the SUCC**. The exciting opportunity will allow staff to share their ideas and innovative practice - gaining support from the Trust to take this forward.

**Adopt consent to contact approach to informing service users about opportunities for participating in research.** The Consent for Research development will enable clinicians to record if patients wish to be contacted about current and future research projects. Consent for Research will act as a further recruitment method to support research recruitment activity and engagement with clinicians, patients and carers.

**Achieve the NIHR recruitment target for 2018/19: Implement monthly reporting of the number of referrals by directorate and utilise this to promote engagement of clinicians**. Over the next 12 months we will looking at how we can expand our portfolio of NIHR studies, working closely with Directorates and our R&D representatives to complete feasibility and recruit participants

# Thank you

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**Contributors:**

Dr Chris Link
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Kerri Mason
Sue Wood
Sue Molesworth
Louise Alston
Lynn Forrester
Jackie Nolan

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# REPORT TO OPEN TRUST BOARD

Enclosure No:7A

| | | | |
|---|---|---|---|
| Date of Meeting: | 26 September 2018 | | |
| Title of Report: | June 2018 Monthly Safer Staffing Report | | |
| Presented by: | Maria Nelligan, Executive Director of Nursing & Quality | | |
| Author: | Julie Anne Murray, Deputy Director of Nursing, AHP & Quality | | |
| Executive Lead Name: | Maria Nelligan, Executive Director of Nursing & Quality | Approved by Exec | ☒ |

| Executive Summary: | | Purpose of report | |
|---|---|---|---|
| This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during June 2018 in line with the National Quality Board requirements. The performance relating to fill rate (actual numbers of staff deployed vs numbers planned) during 2018 was 77% for registered staff and 106% or care staff on day shifts and 82% and 107% respectively on night shifts. Overall a 94% fill rate was achieved. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover and Ward manager supporting clinical duties. The data reflects that Ward Managers are staffing their wards to meet increasing patient needs as necessary. | | Approval | ☐ |
| | | Information | ☒ |
| | | Discussion | ☐ |
| | | Assurance | ☒ |
| Seen at: | SLT ☒ | Date: 14 Aug 2018 | |
| | Execs ☐ | Date: | |
| Committee Approval / Review | • Quality Committee ☒<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☐<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Digital by Choice Board ☐ | | |
| Strategic Objectives (please indicate) | 1. To enhance service user and carer involvement. ☐<br>2. To provide the highest quality services. ☒<br>3. Create a learning culture to continually improve. ☐<br>4. Encourage, inspire and implement research & innovation at all levels. ☐<br>5. Maximise and use our resources intelligently and efficiently. ☒<br>6. Attract and inspire the best people to work here. ☐<br>7. Continually improve our partnership working. ☐ | | |
| Risk / legal implications: Risk Register Ref | Delivery of safe nurse staffing levels is a key requirement to ensuring that the Trust complies with National Quality Board standards. | | |
| Resource Implications:<br><br>Funding Source: | Temporary staffing costs.<br><br>Budgeted establishment and temporary staffing spend. | | |
| Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups) | The recruitment action plan includes action in recruitment and retention for staff from all diverse groups. | | |
| STP Alignment / Implications: | None | | |
| Recommendations: | To receive the report for assurance and information | | |

| Version | Name/group | Date issued |
|---|---|---|
| 1 | Maria Nelligan | 02 Aug 2018 |
| | | |
| | | |
| | | |

## 1 Introduction

This report details the ward daily staffing levels during the month of June 2018 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. These are being progressed through the Safer Staffing Group.

## 3 Trust Performance

During June 2018 the Trust achieved a staffing fill rate of 77% for registered staff and 106% for care staff on day shifts and 82% and 107% respectively on night shifts. Taking skill mix adjustments into account an overall fill-rate of 94% fill was achieved. Where 100% fill rate was not achieved, staffing safety was maintained on in-patient wards by nurses working additional unplanned hours, cross cover, Ward Managers (WMs) and the multi-disciplinary team (MDT) supporting clinical duties and the prioritising of direct and non-direct care activities. Established, planned (clinically required) and actual hours alongside details of vacancies, bed occupancy and actions taken to maintain safer staffing are provided in Appendix 1. A summary from WMs of issues, patient safety, patient experience, staff experience and mitigating actions is set out below.

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

## 4 Care Hours per Patient Day (CHPPD)

The Trust is 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. The report will be reviewed and summarised going forward on a quarterly basis.

### 5.1 Impact on Patient Safety

There were 7 incidents reported during June 2018 relating to nurse staffing issues that had a potential impact on patient safety as detailed in the table below. There was no harm to patients reported.

| Ward | Incident |
|---|---|
| Assessment & Treatment | There were 6 occasions when staffing levels were reduced by one person and it was challenging to maintain observation levels. |
| Ward 2 | There was one occasion where it was challenging to maintain observation levels due to staffing levels being reduced by one person and increased acuity on ward. |

### 5.2 Impact on Patient Experience

Staff prioritise patient experience and direct patient care. During June 2018 it was reported that 1 activity was cancelled (and rearranged) due to nurse staffing levels. This occurred on A&T, which has an overall fill rate of 97% for the month. There was also an occasion on Ward 1 when section 17 leave could not be immediately accommodated.

### 5.3 Impact on Staff Experience

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

- 134 staff breaks were cancelled (equivalent to approximately 2.8% of breaks)

- 2 supervisions, 10 PDRs and 2 mandatory training sessions were cancelled

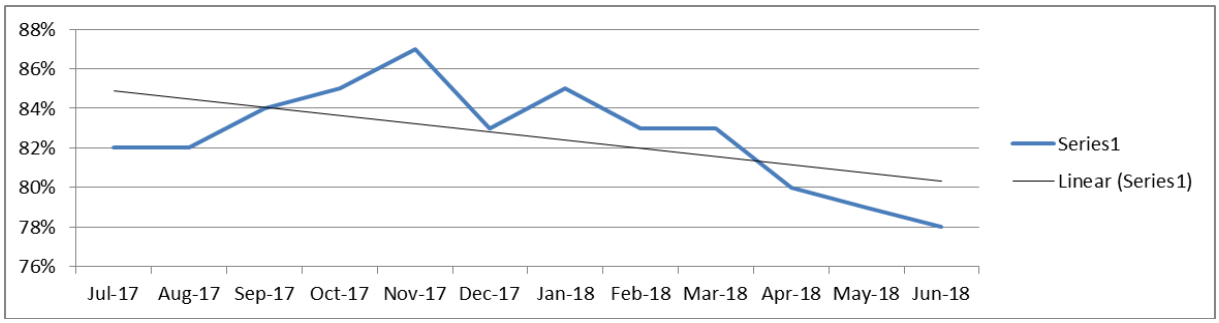
Any time accrued due to missed breaks is taken back with agreement of Ward Manager.

### 5.4 Mitigating Actions

Ward Managers and members of the multi-disciplinary team have clinically supported day shifts to ensure safe patient care. Skill mix has been altered to backfill shortfalls. A total of 463 RN shifts were covered by HCSW where RN temporary staffing was unavailable. A total of 99 HCSW shifts were covered by RN staff where HCSW temporary staffing was unavailable. Additionally, as outlined in section 4.3, staff breaks have been shortened or not taken (time is given in lieu) and wards have cross covered to support safe staffing levels.

### 5.5 RN Staffing

In line with the national picture RN recruitment is challenging. The RN 12 month fill-rate trend line is showing a decreasing trend although this is expected to rise once the newly qualified nurses commence in October 2018.




The following key actions have been taken to strengthen RN staffing:

- Twenty six third year Keele nursing students have accepted a conditional offer to commence with Trust in Oct 2018
- Shift patterns have been altered in response to staff feedback
- Recruitment opportunities for RNs continue to be advertised (including bank)
- The Trust has joined the NHSI MH recruitment and retention programme
- Recruitment campaign continues for PICU
- Senior Advanced Nurse Practitioner commenced on Ward 4 in June 2018

Additionally we are progressing following actions which were presented to the Board last month :-

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

## 6. Summary

Safe staffing reporting indicated challenges in staffing wards during June 2018. Over the past 2 years a significant number of RN vacancies have been filled by newly qualified RNs; a further 26 newly qualified nurses will be joining the Trust in October 2018. The Trust continues to employ alternate strategies with the support of the HR and communication teams to attract RNs during this national shortage.

The Trust has joined the NHSI Retention Support Programme. A project team visit has been completed and learning shared, this has been incorporated into the safer staffing Trust action plan.

## 7. Recommendations

The Trust Board is asked to:-

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

## Appendix 1 June 2018 Safer Staffing

| Jun-18 | Day | | | | | | Night | | | | | | DAY | | NIGHT | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Registered Nurses | | | Care Staff | | | Registered Nurses | | | Care Staff | | | | | | | | | |
| Ward name | Establishment hours | Clinically required Hours | Total monthly actual hours | Establishment hours | Clinically required | Total monthly actual hours | Establishment hours | Clinically required | Total monthly actual hours | Establishment hours | Clinically required | Total monthly actual staff hours | Average fill rate - registered nurses (%) | Average fill rate - care staff (%) | Average fill rate - registered nurses (%) | Average fill rate - care staff (%) | Overall RN fill-rate | Overall HCSW fill-rate | Overall fill-rate |
| Ward 1 | 1369 | 1372.5 | 998.39 | 1369 | 1320 | 1585.79 | 651 | 666 | 369 | 651 | 821.4 | 1140.8 | 73% | 120% | 55% | 139% | 67% | 127% | 98% |
| Ward 2 | 1369 | 1380 | 1015.55 | 1369 | 1566 | 1517.52 | 651 | 666 | 416.37 | 651 | 999 | 1151 | 74% | 97% | 63% | 115% | 70% | 104% | 89% |
| Ward 3 | 1369 | 1372.5 | 1253.13 | 1369 | 1281 | 1381.41 | 651 | 666 | 492 | 651 | 754.8 | 988.95 | 91% | 108% | 74% | 131% | 86% | 116% | 101% |
| Ward 4 | 1369 | 1620 | 1025.21 | 1369 | 1174.5 | 1761.9 | 285 | 666 | 444.4 | 856 | 999 | 1151.73 | 63% | 150% | 67% | 115% | 64% | 134% | 98% |
| Ward 5 | 1141 | 1507.5 | 972.5 | 913 | 1305 | 1506.23 | 285 | 333 | 355.2 | 571 | 999 | 954.6 | 65% | 115% | 107% | 96% | 72% | 107% | 91% |
| Ward 6 | 1369 | 1372.5 | 981.25 | 1141 | 1741.5 | 1871.65 | 285 | 333 | 410.78 | 856 | 1476.3 | 1347.6 | 71% | 107% | 123% | 91% | 82% | 100% | 94% |
| Ward 7 | 913 | 967.5 | 771.98 | 913 | 1363.5 | 1342.21 | 285 | 333 | 333 | 571 | 1065.6 | 1042.77 | 80% | 98% | 100% | 98% | 85% | 98% | 94% |
| A&T | 1369 | 981 | 1001.67 | 1369 | 1984.5 | 1842.38 | 327 | 666 | 500.05 | 654 | 1183.8 | 1327.7 | 102% | 93% | 75% | 112% | 91% | 100% | 97% |
| Edward Myers | 913 | 967.5 | 784 | 913 | 783 | 754 | 325 | 333 | 344.1 | 651 | 666 | 636.95 | 81% | 96% | 103% | 96% | 87% | 96% | 92% |
| Darwin Centre | 1369 | 1109.25 | 890.31 | 913 | 1336.5 | 1437.99 | 327 | 333 | 334.8 | 654 | 677.1 | 688.6 | 80% | 108% | 101% | 102% | 85% | 106% | 97% |
| Summers View | 913 | 900 | 593.75 | 456 | 870 | 923.75 | 325 | 321.6 | 324.63 | 651 | 643.2 | 611.04 | 66% | 106% | 101% | 95% | 75% | 101% | 90% |
| Florence House | 456 | 607.5 | 544.6 | 913 | 870 | 537.98 | 325 | 321.6 | 321.6 | 325 | 321.6 | 321.6 | 90% | 62% | 100% | 100% | 93% | 72% | 81% |
| **Trust total** | **13916** | **14158** | **10832** | **13003** | **15596** | **16463** | **4724** | **5638** | **4646** | **7741** | **10607** | **11363** | **77%** | **106%** | **82%** | **107%** | **78%** | **106%** | **94%** |

## June 2018 Safer Staffing (cont'd)

| Jun-18 | CHPPD | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Ward name** | Total Actual Hours PD | Cumulative Count over the month of Patients @ 23:59 | Care Hours Per Patient Day | **Safe staffing was maintained by:** | **RN Vacancies** | **HCSW Vacancies** | **Bed occupancy** | Movement |
| **Ward 1** | 4093.98 | 408 | 10.03 | Nurses working additional unplanned hours, cancelling non-direct care activities, MDT supporting the nursing team and altering skill mix. | 4.40 | 1.41 | 97% | ↑ |
| **Ward 2** | 4100.44 | 604 | 6.79 | Nurses working additional unplanned hours and altering skill mix. | 6.00 | 0.21 | 86% | ↑ |
| **Ward 3** | 4115.49 | 564 | 7.30 | Nurses working additional unplanned hours, cancelling non-direct care activities and altering skill mix. | 0.60 | 2.11 | 88% | ↑ |
| **Ward 4** | 4383.24 | 536 | 8.18 | Altering skill-mix. | 6.20 | 1.80 | 94% | ↓ |
| **Ward 5** | 3788.53 | 356 | 10.64 | Nurses working additional unplanned hours and altering skill mix. | 1.50 | -1.20 | 92% | ↓ |
| **Ward 6** | 4611.28 | 336 | 13.72 | Nurses working additional unplanned hours and altering skill mix. | 1.30 | 2.35 | 74% | ↓ |
| **Ward 7** | 3489.96 | 497 | 7.02 | Altering skill mix. | 2.80 | 0.00 | 81% | ↓ |
| **A&T** | 4671.8 | 180 | 25.95 | Nurses working additional unplanned hours, cancelling non-direct care activities, MDT supporting the nursing team and altering skill mix. One patient activity cancelled and rearranged. | 3.63 | 3.08 | 100% | ↓ |
| **Edward Myers** | 2519.05 | 340 | 7.41 | Altering skill mix. | 3.30 | 0.82 | 94% | ↔ |
| **Darwin Centre** | 3351.7 | 316 | 10.61 | Nurses working additional unplanned hours and altering skill mix. | 3.10 | 0.20 | 85% | ↑ |
| **Summers View** | 2453.17 | 252 | 9.73 | MDT supported the nursing team and altering skill mix. | 2.40 | 0.00 | 88% | ↓ |
| **Florence House** | 1725.78 | 168 | 10.27 | MDT supported the nursing team and altering skill mix. | 0.00 | 0.53 | 97% | ↓ |
| **Trust total** | **43304** | **4557** | **9.50** | | **35.23** | **11.31** | | |

**Appendix 2 Staffing Issues**

- Including PICU there are currently 48 WTE RN vacancies in in-patients (14.5 WTE are PICU). Twenty five newly qualified nurses are due to join the Trust within in-patient units in October 2018. We continue to advertise for the remainder of the vacancies in a variety of part and whole time roles.

- There are currently 11 WTE HCSW vacancies reported within in-patient wards. The majority of these are in the recruitment process.

- Ward 2 and 4 have the highest RN vacancies of 6 and 6.2 WTE respectively; the majority of these have been recruited to. The remaining posts have been advertised externally and have been included within the recruitment events with limited success. Therefore we are reviewing skill mix and shift patterns.

- Ward teams are supported by Modern Matrons and a Site Manager who are further supported by an on-call manager out of hours.

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

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

NHS
North Staffordshire
Combined Healthcare
NHS Trust

# REPORT TO OPEN TRUST BOARD

Enclosure No:7B

| | | | |
|---|---|---|---|
| Date of Meeting: | 26 September 2018 | | |
| Title of Report: | July 2018 Monthly Safer Staffing Report | | |
| Presented by: | Maria Nelligan, Executive Director of Nursing & Quality | | |
| Author: | Julie Anne Murray, Deputy Director of Nursing, AHP & Quality | | |
| Executive Lead Name: | Maria Nelligan, Executive Director of Nursing & Quality | Approved by Exec | ☒ |

| Executive Summary: | | Purpose of report | |
|---|---|---|---|
| This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during July 2018 in line with the National Quality Board requirements. The performance relating to fill rate (actual numbers of staff deployed vs numbers planned) during July 2018 was 77% for registered staff and 102% or care staff on day shifts and 80% and 111% respectively on night shifts. Overall a 94% fill rate was achieved. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover and Ward manager supporting clinical duties. The data reflects that Ward Managers are staffing their wards to meet increasing patient needs as necessary. | | Approval | ☐ |
| | | Information | ☒ |
| | | Discussion | ☐ |
| | | Assurance | ☒ |
| Seen at: | SLT ☒ | Date: 14 Aug 2018 | |
| | Execs ☐ | Date: | |
| Committee Approval / Review | • Quality Committee ☒<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☐<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Digital by Choice Board ☐ | | |
| Strategic Objectives (please indicate) | 1. To enhance service user and carer involvement. ☐<br>2. To provide the highest quality services. ☒<br>3. Create a learning culture to continually improve. ☐<br>4. Encourage, inspire and implement research & innovation at all levels. ☐<br>5. Maximise and use our resources intelligently and efficiently. ☒<br>6. Attract and inspire the best people to work here. ☐<br>7. Continually improve our partnership working. ☐ | | |
| Risk / legal implications: Risk Register Ref | Delivery of safe nurse staffing levels is a key requirement to ensuring that the Trust complies with National Quality Board standards. | | |
| Resource Implications:<br><br>Funding Source: | Temporary staffing costs.<br><br>Budgeted establishment and temporary staffing spend. | | |
| Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups) | The recruitment action plan includes actions in recruiting and retaining staff from all diverse groups | | |
| STP Alignment / Implications: | None | | |
| Recommendations: | To receive the report for assurance and information | | |

| Version | Name/group | Date issued |
|---|---|---|
| 1 | Maria Nelligan | 03 Sep 2018 |
| | | |
| | | |
| | | |

## 1 Introduction

This report details the ward daily staffing levels during the month of July 2018 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. These are being progressed through the Safer Staffing Group.

## 3 Trust Performance

During July2018 the Trust achieved a staffing fill rate of 77% for registered staff and 102% for care staff on day shifts and 80% and 111% respectively on night shifts. Taking skill mix adjustments into account an overall fill-rate of 94% fill was achieved. Where 100% fill rate was not achieved, staffing safety was maintained on in-patient wards by nurses working additional unplanned hours, cross cover, Ward Managers (WMs) and the multi-disciplinary team (MDT) supporting clinical duties and the prioritising of direct and non-direct care activities. Established, planned (clinically required) and actual hours alongside details of vacancies, bed occupancy and actions taken to maintain safer staffing are provided in Appendix 1. A summary from WMs of issues, patient safety, patient experience, staff experience and mitigating actions is set out below.

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

## 4 Care Hours per Patient Day (CHPPD)

The Trust is 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. The report will be reviewed and summarised going forward on a quarterly basis.

### 5.1 Impact on Patient Safety

There was 1 incident reported during July 2018 relating to nurse staffing issues that had a potential impact on patient safety as detailed in the table below. There was no harm to patients reported.

| Ward | Incident |
|---|---|
| Assessment & Treatment | One occasion where it was challenging to maintain safe staffing due to 2 members of short notice bank staff cancellations |
| Ward 3 | One occasion where it was challenging to maintain observation levels due to staffing levels |

### 5.2 Impact on Patient Experience

Staff prioritise patient experience and direct patient care. During July 2018 it was reported that 7 activities were cancelled (4 of which were rearranged) due to nurse staffing levels. These occurred on A&T where there have been high levels of observations required throughout July.

### 5.3 Impact on Staff Experience

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

- 102 staff breaks were cancelled (equivalent to approximately 2.1 % of breaks)

- 4 supervisions, 6 PDRs and 1 mandatory training sessions were cancelled

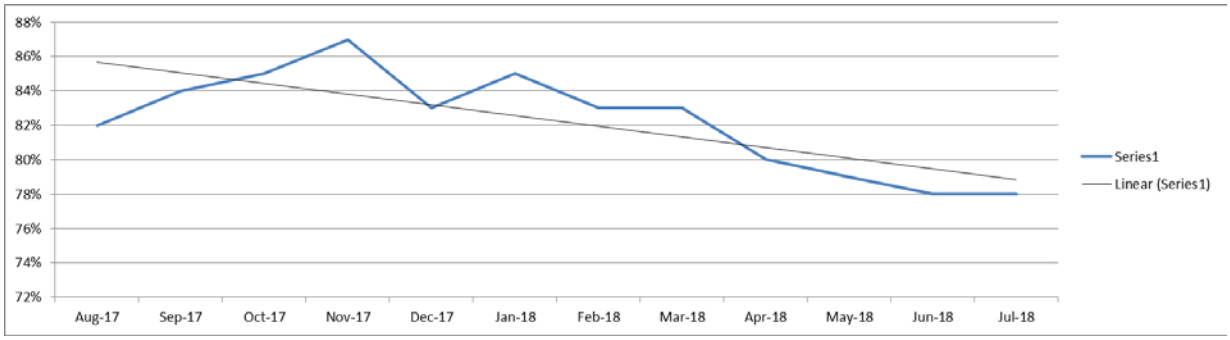
Any time accrued due to missed breaks is taken back with agreement of Ward Manager.

### 5.4 Mitigating Actions

Ward Managers and members of the multi-disciplinary team have clinically supported day shifts to ensure safe patient care. Skill mix has been altered to backfill shortfalls. A total of 480 RN shifts were covered by HCSW where RN temporary staffing was unavailable. A total of 101 HCSW shifts were covered by RN staff where HCSW temporary staffing was unavailable. Additionally, as outlined in section 4.3, staff breaks have been shortened or not taken (time is given in lieu) and wards have cross covered to support safe staffing levels.

### 5.5 RN Staffing

In line with the national picture RN recruitment is challenging. The RN 12 month fill-rate trend line is showing a decreasing trend although this is expected to rise once the newly qualified nurses commence in October 2018.




The following key actions have been taken to strengthen RN staffing:

- Twenty five third year Keele nursing students have accepted a conditional offer to commence with Trust in Oct 2018
- Shift patterns have been altered in response to staff feedback
- Recruitment opportunities for RNs continue to be advertised (including bank)
- The Trust has joined the NHSI MH recruitment and retention programme
- Recruitment campaign continues for PICU
- Senior Advanced Nurse Practitioner commenced on Ward 4 in May 2018

Additionally we are progressing following actions which were presented to the Board last month:

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

## 6. Summary

Safe staffing reporting indicated challenges in staffing wards during July 2018. Over the past 2 years a significant number of RN vacancies have been filled by newly qualified RNs; a further 26 newly qualified nurses will be joining the Trust in October 2018. The Trust continues to employ alternate strategies with the support of the HR and communication teams to attract RNs during this national shortage.

The Trust has joined the NHSI Retention Support Programme. A project team visit has been completed and learning shared, this has been incorporated into the safer staffing Trust action plan.

## 7. Recommendations

The Trust Board is asked to:-

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

# Appendix 1 July2018 Safer Staffing

| | Day | | | | | | Night | | | | | | DAY | | NIGHT | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Registered Nurses | | | Care Staff | | | Registered Nurses | | | Care Staff | | | | | | | | | | | | | |
| Ward name | Establishment Hours | Clinically required Hours | Total monthly actual hours | Establishment Hours | Clinically required | Total monthly actual hours | Establishment Hours | Clinically required | Total monthly actual hours | Establishment Hours | Clinically required | Total monthly actual staff hours | Average fill rate - registered nurses (%) | Average fill rate - care staff (%) | Average fill rate - registered nurses (%) | Average fill rate - care staff (%) | Average RN fillrate | Average HCSW fillrate | Average overall fillrate | Safe staffing was maintained by: | RN Vacancies | HCSW Vacancies | Bed occupancy | Movement |
| Ward 1 | 1560 | 1420.5 | 1047.8 | 1395 | 1263 | 1533.94 | 664.64 | 688.2 | 366.3 | 664.64 | 699.3 | 1087.8 | 74% | 121% | 53% | 156% | 67% | 134% | 99% | Nurses working additional unplanned hours, altering skill mix | 4.40 | 0.41 | 99% | ↑ |
| Ward 2 | 1560 | 1420.5 | 1067.13 | 1395 | 1674 | 1572.58 | 664.64 | 688.2 | 391.4 | 664.64 | 1032.3 | 1294.6 | 75% | 94% | 57% | 125% | 69% | 106% | 90% | Nurses working additional unplanned hours, altering skill mix | 6.00 | 0.21 | 89% | ↑ |
| Ward 3 | 1560 | 1420.5 | 1243.13 | 1395 | 1404 | 1300.53 | 664.64 | 688.2 | 479.3 | 664.64 | 810.3 | 1073.2 | 88% | 93% | 70% | 132% | 82% | 107% | 95% | Nurses working additional unplanned hours, altering skill mix, the MDT supporting the nursing team | 0.60 | 2.14 | 88% | ↔ |
| Ward 4 | 1560 | 1420.5 | 1076.21 | 1860 | 1363.5 | 1798.23 | 580.94 | 432.9 | 379.9 | 871.41 | 1032.3 | 1202.8 | 76% | 132% | 88% | 117% | 79% | 125% | 105% | Nurses working additional unplanned hours, altering skill mix , cancelling non-direct care activity | 6.20 | 1.00 | 76% | ↓ |
| Ward 5 | 1560 | 1560 | 1076.21 | 1395 | 1590.75 | 1798.23 | 290.47 | 344.1 | 379.9 | 871.41 | 1198.8 | 1202.8 | 69% | 113% | 110% | 100% | 76% | 108% | 95% | Nurses working additional unplanned hours, altering skill mix | 1.50 | -1.20 | 93% | ↑ |
| Ward 6 | 1560 | 1420.5 | 973.42 | 1395 | 1755 | 2033.65 | 290.47 | 344.1 | 364.3 | 871.41 | 1376.4 | 1370.45 | 69% | 116% | 106% | 100% | 76% | 109% | 97% | Nurses working additional unplanned hours, altering skill mix, the MDT supporting the nursing team | 1.30 | 2.35 | 66% | ↓ |
| Ward 7 | 1095 | 1002 | 756.23 | 1395 | 1390.5 | 1472.15 | 290.47 | 344.1 | 355.7 | 871.41 | 1065.6 | 984.8 | 75% | 106% | 103% | 92% | 83% | 100% | 94% | Nurses working additional unplanned hours, altering skill mix | 2.80 | 0.00 | 90% | ↑ |
| A&T | 1095 | 1002 | 1037.44 | 1860 | 2203.5 | 1727.13 | 666.5 | 688.2 | 355.2 | 999.75 | 1043.4 | 1392.1 | 104% | 78% | 52% | 133% | 82% | 96% | 91% | Nurses working additional unplanned hours, altering skill mix, cancelling patient activities and non-direct care activity | 4.23 | 3.08 | 85% | ↓ |
| Edward Myers | 1095 | 1009.5 | 797.73 | 930 | 837 | 795.73 | 290.47 | 344.1 | 355.2 | 580.94 | 688.2 | 676.2 | 79% | 95% | 103% | 98% | 85% | 97% | 91% | Nurses working additional unplanned hours, altering skill mix | 3.30 | 0.82 | 94% | ↔ |
| Darwin Centre | 1327.5 | 1164.75 | 876.19 | 1627.5 | 1437.75 | 1433.19 | 333.25 | 344.1 | 355.2 | 666.5 | 688.2 | 682.6 | 75% | 100% | 103% | 99% | 82% | 100% | 92% | Nurses working additional unplanned hours, altering skill mix | 3.10 | 0.20 | 85% | ↑ |
| Summers View | 930 | 930 | 623.5 | 930 | 900 | 967.75 | 332.32 | 332.32 | 332.32 | 664.64 | 664.64 | 471.68 | 67% | 108% | 100% | 71% | 76% | 92% | 85% | Nurses working additional unplanned hours, altering skill mix | 1.40 | 0.00 | 88% | ↑ |
| Florence House | 630 | 630 | 540.75 | 930 | 900 | 608.25 | 332.32 | 332.32 | 333.82 | 332.32 | 332.32 | 332.32 | 86% | 68% | 100% | 100% | 91% | 76% | 83% | Nurses working additional unplanned hours, altering skill mix | 0.00 | 1.06 | 100% | ↑ |
| **Trust total** | **15532.50** | **14400.75** | **11115.74** | **16507.50** | **16719.00** | **17041.36** | **5401.13** | **5570.84** | **4448.54** | **8723.71** | **10631.76** | **11771.35** | **77%** | **102%** | **80%** | **111%** | **78%** | **105%** | **94%** | | **34.83** | **10.07** | | |

## July2018 Safer Staffing (cont'd)

| | CHPPD | | |
|---|---|---|---|
| **Ward name** | Total Actual Hours PD | Cumulative Count over the month of Patients @ 23:59 | Care Hours Per Patient Day |
| **Ward 1** | 4035.84 | 404 | 9.99 |
| **Ward 2** | 4325.71 | 628 | 6.89 |
| **Ward 3** | 4096.16 | 598 | 6.85 |
| **Ward 4** | 4457.14 | 445 | 10.02 |
| **Ward 5** | 4457.14 | 397 | 11.23 |
| **Ward 6** | 4741.82 | 553 | 8.57 |
| **Ward 7** | 3568.88 | 553 | 6.45 |
| **A&T** | 4511.87 | 155 | 29.11 |
| **Edward Myers** | 2624.86 | 370 | 7.09 |
| **Darwin Centre** | 3347.18 | 263 | 12.73 |
| **Summers View** | 2395.25 | 299 | 8.01 |
| **Florence House** | 1815.14 | 186 | 9.76 |
| **Trust total** | **44377** | **4851** | **9.15** |

**Appendix 2 Staffing Issues**

- Including PICU there are currently 49 WTE RN vacancies in in-patients (14.5 WTE are PICU). Twenty five newly qualified nurses are due to join the Trust within in-patient units in October 2018. We continue to advertise for the remainder of the vacancies in a variety of part and whole time roles.

- There are currently 10 WTE HCSW vacancies reported within in-patient wards. The majority of these are in the recruitment process.

- Ward 2 and 4 have the highest RN vacancies of 6 and 6.2 WTE respectively; the majority of these have been recruited to. The remaining posts have been advertised externally and have been included within the recruitment events with limited success. Therefore we are reviewing skill mix and shift patterns.

- Ward teams are supported by Modern Matrons and a Site Manager who are further supported by an on-call manager out of hours.

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

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

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# REPORT TO OPEN TRUST BOARD

Enclosure No:8

| | | | |
|---|---|---|---|
| Date of Meeting: | 26TH September 2018 | | |
| Title of Report: | Safeguarding Annual Report 2017-2018 | | |
| Presented by: | Maria Nelligan, Director of Nursing and Quality | | |
| Author: | Amy Owen, Safeguarding Lead | | |
| Executive Lead Name: | Maria Nelligan, Executive Director of Nursing and Quality | Approved by Exec | ☐ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| The Safeguarding Annual Report 2017-2018 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 ☐<br>Date: 10th July 2018 | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☒<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☒<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Digital by Choice Board ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement.☐<br>2. To provide the highest quality services ☒<br>3. Create a learning culture to continually improve.☒<br>4. Encourage, inspire and implement research & innovation at all levels.☐<br>5. Maximise and use our resources intelligently and efficiently.☐<br>6. Attract and inspire the best people to work here.☐<br>7. Continually improve our partnership working. ☒ | | |
| Risk / legal implications:<br>Risk Register Reference | The report addresses the risk implementations for vulnerable children and adults | | |
| Resource Implications:<br><br>Funding Source: | None | | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | The report describes the systems processes and outcomes for vulnerable children and adults | | |
| STP Alignment / Implications: | None | | |
| Recommendations: | For information and assurance | | |

## Contents

## 1. Introduction

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

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

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

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

The purpose of this report is to outline the safeguarding work within the Trust for the period of April 2017 to March 2018, evidencing how we are making a 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 April 2015 and enshrined the safeguarding of adults with care and support needs, at risk of abuse/neglect, in law.

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

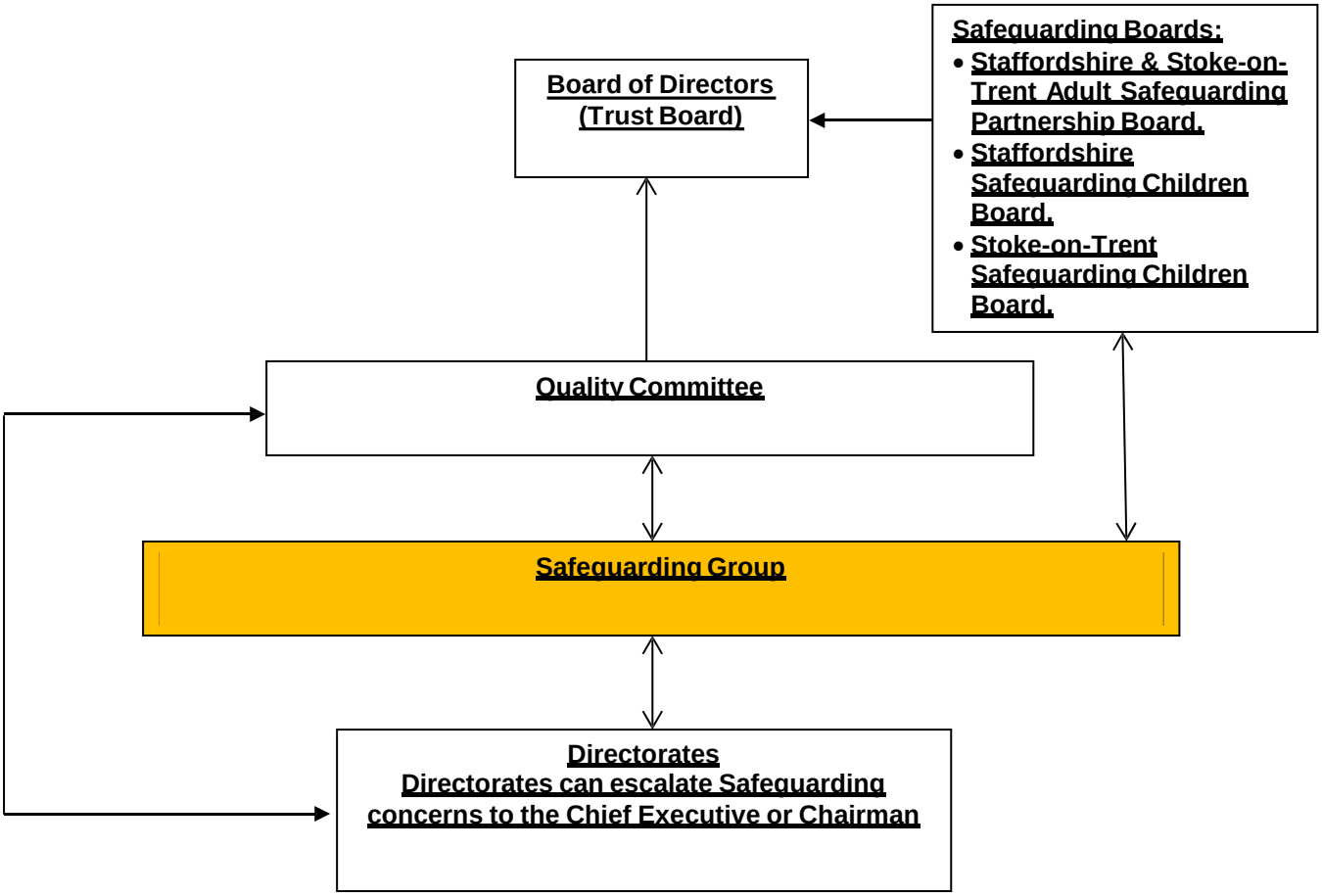
### 1.2 Safeguarding Children

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 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 (2004) and Working Together to Safeguard Children (2015).

## 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 2017-18 include Safeguarding Children Policy Statement, Safeguarding Adults Policy Statement, Preventing Harm, Children Visiting Mental Health Hospitals, Managing Visits to Trust Premises by Celebrities and VIPs, PREVENT and Domestic Abuse.

### 2.2 NSCHT Safeguarding Group

The Trust Safeguarding Group meets quarterly and provides an opportunity for representatives from key services to discuss issues, report progress and provide assurances against documented action plans and audit. Attendance includes: Executive Director of Nursing & Quality (Chair), Non-Executive Director/Safeguarding Champion, Safeguarding Team, Directorate Governance 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 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 easily accessible on the Trust intranet and are reviewed in line with the Trust schedule or as a result of significant legislative changes. Staff attend both mandatory internal training and training available through the various Safeguarding Boards as appropriate to their role.

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 protection of adults. Working together, they develop policies and procedures to protect adults from abuse, deliver training and seek assurance from partner agencies regarding the quality of safeguarding activity.

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

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

### 3.2 SSASPB Approved Strategic Priorities for 2016/2018:

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

In order to support these priorities work is ongoing within the Trust to improve the transition from CAMHS to adult services and the planned changes to locality working will further strengthen this transition. The Community Home Liaison Team supports individuals residing within residential and nursing homes and as part of their work liaises with staff in homes to improve outcomes for adults with care and support needs and participate in developing leadership by sharing best practice.

Internally engagement is sought by the Trust continually on service user experience and advice and support is offered by the safeguarding team as appropriate.

Safeguarding partnership engagement for adults is demonstrated through the input into the MASH both from an administrative role of completing lateral checks for adult safeguarding and MARAC referrals and the placement of a specialist safeguarding practitioner within Lindum House. This provides mental health leadership from NSCHT regarding adult safeguarding referrals where mental health needs are

identified, across Stoke-on-Trent and North Staffordshire, in a multi-agency environment in order to provide expertise, share information and nurture partnership working.

There is also active participation from the safeguarding team in multi-agency sub groups promoting safeguarding partnership engagement and enables a continued contribution across various work streams to the priorities of SSASPB.

### 3.3 Safeguarding Children

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

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

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

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

### 3.4 The Safeguarding Children Board's Priorities for 2015/2018

Both Staffordshire and Stoke-on-Trent Safeguarding Children Boards have agreed joint priorities for 2015/2018 and these are:

1. Child Sexual Abuse (including child sexual exploitation, child trafficking, missing children, female genital mutilation, forced marriage, honour based violence, youth violence and intra-familial abuse.

2. Neglect including the Toxic Trio (Domestic Violence, Substance Misuse, Parental Mental Health difficulties).

In order to effectively support these priorities practitioners, particularly those working with children and young people are encouraged to access local multi-agency training around child sexual abuse. The themes are discussed in team and individual supervision as appropriate. Lessons learnt from serious case reviews are

disseminated through the safeguarding quarterly meetings to directorates and through electronic lessons learnt updates.

As a Trust our internal level 3 training provides detailed information on the toxic trio and supports staff development in this area. External expert training is commissioned in order to provide training on domestic abuse and sexual violence. As discussed later in the report this training is well received by staff and feedback around learning outcomes is positive.

The Trust safeguarding lead also contributes to serious case reviews and various sub groups within the local safeguarding boards to ensure Trust representation and facilitate shared learning and development.

## 4. Inspections

### 4.1 External Inspections

During 2017/18 there were two external inspections by the Care Quality Commission of which safeguarding forms part of the safe domain. These were a comprehensive Trust inspection carried out from 2nd October 2017 – 2nd November 2017 and a responsive inspection of Ward Four on the 14th November 2017.

- The comprehensive inspection, although not particularly focused on safeguarding, made positive reference to the provision of safeguarding supervision in specialist community mental health services for children and young people.

- During the responsive inspection to Ward 4 all staff were found to have received safeguarding training to the appropriate level and knew how to identify and report any suspected abuse. There was also evidence of the Ward Manager acting responsively to concerns raised. No safeguarding concerns raised were upheld following the inspection.

## 5. Audit

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

### 5.1 External audits

i) <u>Adult Safeguarding Self-Assessment Audit</u>
This self-assessment has been changed to a biannual audit and as such has not been completed during the year 2017-2018. The previous audit in 2016-2017 identified two areas for improvement these were the need for increased robustness in the audit process and ensuring a clear standard of conduct for all members of staff. The audit is next due for completion in December 2018 and it is anticipated both areas will be fully addressed.

ii) Adult Safeguarding Case File Audit

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

We are awaiting clarification from the SSASPB following the introduction of the General Data Protection Regulations as to whether this multi-agency audit can continue.

iii) Section 11 Audit (this is a joint audit completed every two years for both Staffordshire Safeguarding Children Board and Stoke-on-Trent Safeguarding Children Board.)

This audit was last completed in January 2017 and as such there is no submission for this year. This audit identified a need to simplify child safeguarding referral process and this has been achieved by mirroring the already well established and effective adult process. It also identified the need to ensure all staff are appropriately trained for their role in line with the intercollegiate document, this action continues with ongoing training sessions provided for staff. The audit is due for completion again in the next financial year.

**5.2 Internal Audits**

i) Adult Safeguarding

In May 2017 twenty referrals were audited from both community and inpatient settings.

There was good evidence of timely referrals and of assessment of capacity at time of referral.

However the audit also identified gaps in the recording of service user engagement in the referral process. Although this does not necessarily mean that the service user was not engaged, as it was not recorded, the voice of the service user and their wishes was often lost. This was particularly evident in inpatient referrals.

This identified that further work was required through supervision, training and staff communications to ensure the standard of capturing the wishes and voice of the service user is embedded within practice throughout the organisation.
As a result of this developments have been made to the on-line level 1 and 2 adult safeguarding training package which is delivered as mandatory training every 3 years through LMS. The training focuses upon the importance of making adult safeguarding personal and emphasis the safeguarding principle of empowerment.

The audit will be repeated during Q1 of 2018/19 to assess if these interventions have been successful with a particular focus on inpatient areas.

ii) Children

The focus of the internal audit for safeguarding children and young people has again been the 'Think Family' Approach.

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

This approach has been a focus of the level three training that has been developed and delivered over the past two years. The audit was to ascertain the impact of this training upon culture and practice within the organisation.

The audit confirmed that in the majority of clinical notes basic information of any children the adult had contact with was recorded in the appropriate box on the assessment form; there does however remain further work to be done to ensure children and young people are consistently considered in staying well plans.

The audit also highlighted areas of good practice whereby the wider family relationships with children had been considered, particularly children living with grandparents and how this impacted upon grandparent's wellbeing and support needs.

This provides assurance that the current level 3 training is impacting positively upon clinical practice and the Think Family approach is becoming embedded into the culture of the organisation.

There are however areas for development and further level 3 training sessions are arranged. In addition to training sessions both team and individual supervision is available to all staff to continue to develop awareness and confidence, in order to ensure that parents and carers are supported and the voice of the child is heard.

## 6. Performance

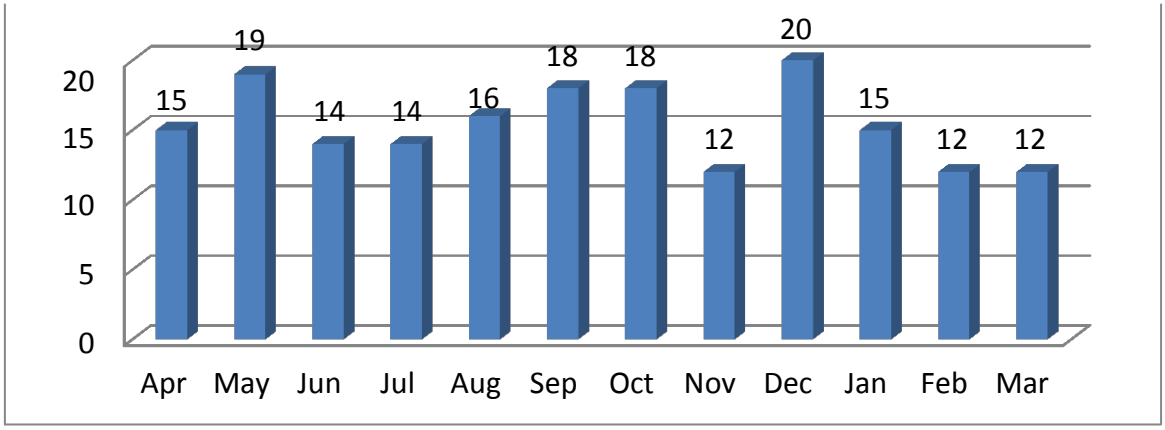
### 6.1 NSCHT Incident Reporting and Safeguarding

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 it is an ongoing risk that would require the safeguarding plan to be reviewed rather than a full referral to be made. The Trust monitor all safeguarding incidents and referrals in order to identify any trends and themes.

Total Number of Adult Referrals during 2017-2018: 185



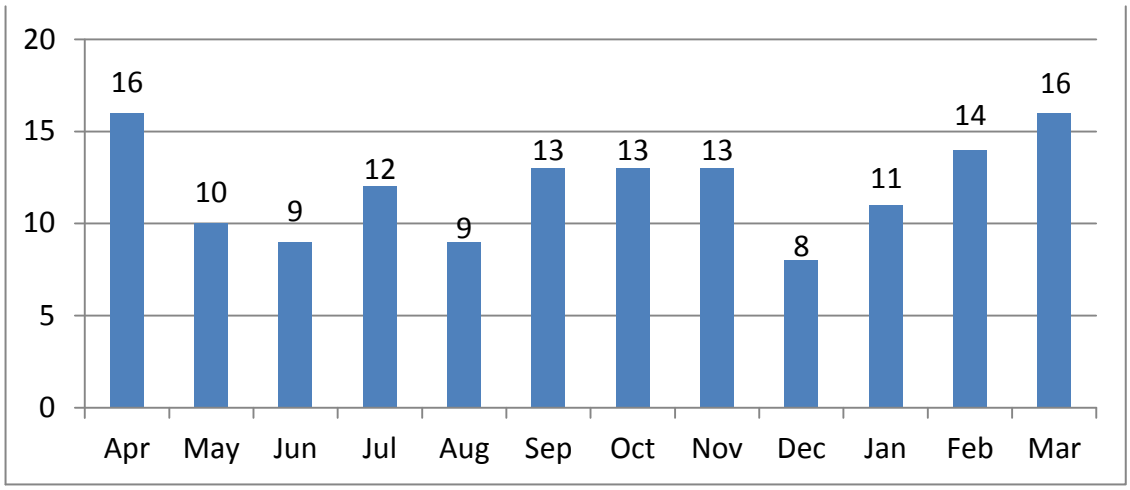

All referrals are reviewed on a weekly basis by the Incident Review Group, this provides cross directorate oversight of all incidents allowing incidents not previously identified under Safeguarding to be identified and acted upon appropriately.

The number of referrals (185) represents a decrease from 2016/17 (270). With the introduction and embedding of the Care Act (2014) a drop in referral rates was anticipated as Safeguarding risks that are ongoing are required to be managed under a safeguarding plan rather than repeat referrals being made for the same risk.

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 2017 - 2018: 144



As anticipated the Adult Directorate and Children & Young People's Directorate generate 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.

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

The number of referrals this year (144) is an increase in referrals from 2016/17 (108). The internal process of making child safeguarding referrals was streamlined in October 2016 to align with the referral process for adult safeguarding. The purpose of this alignment is to ensure that child safeguarding referrals are made in a way that is visible to the organisation and this has been successful. The implementation of the new process does not appear to have had any impact of the overall referral trend.

This provides assurance that the change process has been managed effectively ensuring that referrals are continuing to be raised where appropriate.

## 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 (2014) that 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.

During 2017-18 internal level 3 face to face mandatory training continued to be delivered for professionally qualified staff and other identified staff who caseload work. This continues to be well received and has had a high level of uptake as demonstrated in the table below. Two training sessions are offered per calendar month and this is delivered by the Safeguarding Team. A training strategy is in place and has been refreshed; this identifies which staff groups are required to participate in each level of training. This is in keeping with local and national guidelines to ensure that NSCHT staff receives appropriate training to meet their needs.

The table outlines the training figures for Mandatory Safeguarding Training by directorate as at year end 2017 – 18. 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 2017-2018 level 1 and 2 sessions were delivered via e-learning.

| Directorate | L1/2 Children % Compliance | L3 Safeguarding % Compliance |
|---|---|---|
| Adult Mental Health Community | 93% | 89% |
| Adult Mental Health Inpatient | 91% | 86% |
| Substance Misuse | 87% | 71%* |
| Children & Adolescent Mental Health | 96% | 94% |
| Neuro and Old Age Psychiatry | 93% | 81% |
| Learning Disabilities | 94% | 85% |
| **Trust Overall Compliance** | **90%** | **85%** |
| **Trust Compliance Target** | **85%** | **85%** |

* Training compliance figures within the Substance Misuse services are lower than target due to the transfer of staff into the Trust from another provider.

Level 3 training overall has reached the 85% Trust target in the second year of a three year plan. Both Stoke-on-Trent and Staffordshire Local Safeguarding Children Boards have a 90% target for compliance and therefore the Trust is currently performing 5% below target.

### 7.2 Local Safeguarding Children Board (LSCB) Level 2 & 3 Safeguarding Training

The Safeguarding Lead contributes to both Stoke-on-Trent and Staffordshire Local Safeguarding Boards to deliver LSCB level 2 & 3 multi-agency training as part of the Safeguarding Children Board Training Team. As such a number of Level 3 parental mental health sessions were delivered for both Children's Safeguarding Boards.

The Trust has developed and provided multi-agency training sessions for Stoke-on-Trent and Staffordshire Safeguarding Children Boards. This is LSCB level 3 training for parental mental health and the impact this will have on child safeguarding. This training has been delivered during 2017-18 and will continue to be delivered during 2018-19.

In addition to this staff are encouraged to access Local Safeguarding 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 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 Channel, the West

Midlands Regional Prevent Forum, for both Staffordshire and Stoke-on-Trent and in 2017 has been invited to attend the Stoke-on-Trent Prevent Board. The Safeguarding Lead 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 vulnerable people.

### 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 '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.

Training has been delivered twice a month throughout 2017-18 by the NSCHT Training Team with support from the Health and Safety Officer. In October 2017 this training became on on-line module delivered through LMS. The training is a once only requirement.

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

| **Directorate** | **% Compliance** |
|---|---|
| Adult Mental Health Community | 92% |
| Adult Mental Health Inpatient | 90% |
| Substance Misuse | 79% |
| Children & Adolescent Mental Health | 93% |
| Neuro and Old Age Psychiatry | 91% |
| Learning Disabilities | 94% |
| **Trust Overall Compliance** | **89%** |
| **Trust Compliance Target** | **85%** |

## 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 and honour based violence.

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 experiencing domestic abuse and are unable to protect themselves as a result of those care and support needs in addition to traditional criminal justice routes.

### 9.1 Domestic Abuse Policy

All NHS Trusts are required to have a Domestic Abuse Policy. This is clearly defined within the Government's Domestic Violence Strategy (Home Office 2005) and supported by the Department of Health (2005). The Trust has a Domestic Abuse Policy (Policy number 1.75) and is therefore complaint with this requirement. The policy is reviewed in line with Trust requirements and was last reviewed in February 2017.

### 9.2 Domestic Abuse Training

During 2017/18 the safeguarding team commissioned the local charity Women's' Aid to deliver Domestic Abuse training to frontline staff. This training has been well received by staff and as a result the same training has been commissioned for 2018/19 to ensure continued staff knowledge and skills development. As previously mentioned domestic abuse is a priority of both Safeguarding Children Boards.

### 9.3 Domestic Abuse Partnership

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

In late 2017 the Safeguarding Team began to contribute to lateral checks within the Multi Agency Safeguarding Hub for domestic abuse incidents. This has continued throughout 2017-18, supporting a more cohesive multiagency response to domestic abuse incidents across North Staffordshire.

### 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 ensures that when a Trust service user is being discussed at MARAC the appropriate frontline practitioner is aware of this 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 them has been developed for practitioners and is included with every invite. In addition to this individual support and supervision is available from the Safeguarding Team.

The Domestic Abuse partnership and local agencies including local authorities, police and health partners are currently reviewing the MARAC process.

## 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 SAR during 2017-18 neither of which have reached final report.

### 10.2 Domestic Homicide Reviews

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

There are currently two ongoing DHRs relating to service users who accessed the Trust's services. One of these relates to a homicide case and the other to suicide as a result of coercion and control.

### 10.3 Serious Case Reviews

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

The organisation has not been required to participate in any Serious Case Reviews during 2017-18.

### 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.

There is an ongoing MALR from 2017-18 initiated jointly by both Staffordshire and Stoke-on-Trent Safeguarding Children Boards relating to Operations Linear and Shade.

## 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:

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

Level 2
Safeguarding support and advice is available from the Named Professionals (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 Professional is accessed from the Local Authority Lead for Adult Safeguarding and Designated Nurse for Safeguarding Children

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

### 11.2 Safeguarding Supervision Sessions

During 2017/18 eleven teams received regular supervision from the Safeguarding Team.

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

The Head of Safeguarding and Senior Safeguarding Practitioner regularly provide safeguarding advice on an individual basis.

The Head of Safeguarding also received monthly supervision from Local Authority Lead for Adult Safeguarding and Designated Nurse for Safeguarding Children during 2017/18.

## 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 investigate concerns under Section 47 of the Children's Act 1989. The Head of Safeguarding and Named Doctor are the named officers for Trust LADO referrals.

During 2017-18, there have been seven LADO referrals. All have been investigated and reviewed within the Trust policy and through Local Authority LADO processes, all have been found to be unsubstantiated.

## 13. Examples of Good Practice

During 2017/18 there were a number of examples of good practice an example of which is detailed below:

An inpatient nurse raised concerns regarding a service user appearing to be in discomfort and not having received his prescribed pain relief, when medication records were checked the medication had been omitted by the dispensing nurse due to him being asleep. Observational reports from other staff reported he was not asleep. Trust policies and procedures were followed to address the issue with the member of staff and as part of this an adult safeguarding referral was made. Multi-agency lateral checks through the Multi-Agency Safeguarding Hub (MASH) identified previous concerns raised by Staffordshire Police related to the same nurse in regard to another individual with care and support needs and ensured Staffordshire Police were aware of current concerns.

This is an example of staff making appropriate adult safeguarding referrals and demonstrates the effectiveness of appropriate multi-agency working to ensure all partners are aware of concerns in order to protect the public.

## 14. Achievements & Priorities

### 14.1 Key Achievements 2017-18

In 2017/18 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.

- The specialist practitioner has ownership to the triage and investigation of adult safeguarding referrals for individuals with mental health needs under the age of 65 across Stoke-on-Trent and North Staffordshire. This ensures appropriate levels of expertise surrounding mental health in the investigation processes and reduces duplicate referrals into services.

- A new Head of Safeguarding (Named Nurse)/ and Named Doctor were appointed following the departure of the previous post-holders. During a period of significant clinical leadership change, the Safeguarding Team has continued to provide robust assurance to the board and provide frontline staff with training, support and supervision.

- Level 3 Safeguarding Children Training compliance has risen to 85% in the second year against a Trust target of 85% compliance for end of year three.

### 14.2 Key Priorities 2018-19

As part of the Trust journey towards outstanding and the programme of continued improvement for safeguarding within the organisation a number of key priorities have been identified for 2018/19.

- The publication of updated Working Together guidance, which is expected Summer 2018, its implications for both frontline practitioners and strategic safeguarding children involvement will become a key priority during 2018-19 in order to ensure the Trust remains fully compliant with their responsibilities.

- Further development of team safeguarding supervision across the organisation to ensure practitioners are supported and key messages regarding safeguarding are disseminated. This will positively influence both organisational culture and individual confidence and practice.

- Continue to strengthen practitioners' ability to complete Adult Safeguarding enquiries in order to ensure timely and effective responses alongside appropriate information sharing.

- Further embed Think Family approach to safeguarding in order to ensure the voice of the child is heard and that parent or carer's needs are recognised and addressed.

- A new annual audit schedule is to be planned in order to link effectively with wider Trust agendas and to provide evidence demonstrating a commitment to addressing Safeguarding Boards priorities.

- The three year Level 3 training plan will come to completion and this will be evaluated and reviewed for effectiveness and a strategic plan developed to meet continuing training needs in order to ensure an appropriately trained workforce regarding both child and adult safeguarding.

## 15. Conclusion

This has been a year of significant change for the safeguarding team with the appointment of both a new Named Doctor and Head of Safeguarding (Named Nurse). The service has continued to deliver both internal and external training packages resulting in compliance for internal Safeguarding Children level 3 training reaching 85% at the end of the second year of a three year project to raise compliance to a Trust target of 85%.

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

This has been 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.

Within our key priorities there is a strong drive from the new leadership of the team to provide a strong evidence base through audit and appropriate data gathering to both further provide assurance regarding safeguarding within the Trust and to drive forward continuous improvement.

Active participation and involvement with both Staffordshire and Stoke-on-Trent Children Safeguarding Boards 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 serious case 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:9

| | | | |
|---|---|---|---|
| Date of Meeting: | 26TH SEPTEMBER 2018 | | |
| Title of Report: | Infection Prevention & Control (IPC) Annual report for 2017/18 | | |
| Presented by: | Maria Nelligan, Executive Director of Nursing and Quality | | |
| Author: | Amanda Miskell, Consultant Nurse, Physical Health & Deputy Director of Infection Prevention & Control | | |
| Executive Lead Name: | Maria Nelligan, Executive Director of Nursing and Quality | Approved by Exec | ☐ |

| Executive Summary: | | Purpose of report | |
|---|---|---|---|
| The purpose and content of this annual report is to provide an overview of the Infection Prevention and Control (IPC) activities from April 2017 to 31st March 2018, and to highlight achievements and the progress made against the priorities outlined in the Infection Prevention and Control Group (IPCG) work programme 2017/2018 | | Approval | ☐ |
| | | Information | ☒ |
| | | Discussion | ☐ |
| | | Assurance | ☒ |
| Seen at: | SLT ☒ Execs ☐<br>Date: 10TH July 2018 | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☒<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☐<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Digital by Choice Board ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement.☐<br>2. To provide the highest quality services ☒<br>3. Create a learning culture to continually improve.☒<br>4. Encourage, inspire and implement research & innovation at all levels.☐<br>5. Maximise and use our resources intelligently and efficiently.☐<br>6. Attract and inspire the best people to work here.☐<br>7. Continually improve our partnership working. ☒ | | |
| Risk / legal implications:<br>Risk Register Reference | The report describes the system in place to prevent HCAI | | |
| Resource Implications:<br><br>Funding Source: | None<br><br>None | | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | The report describes systems in place to prevent infection in vulnerable adults. | | |
| STP Alignment / Implications: | None | | |
| Recommendations: | For assurance | | |

| Version | Name/group | Date issued |
|---|---|---|
| 1 | Maria Nelligan | 06.07.18 |

# Infection Prevention & Control (IPC) Annual Report for 2017/2018

June 2018 v4

## Contents

## 1. Introduction

The purpose and content of this annual report is to provide an overview of the Infection Prevention and Control (IPC) activities from April 2017 to 31st March 2018, and to highlight achievements and the progress made against the priorities outlined in the Infection Prevention and Control Group (IPCG) work programme 2017/2018.

High standards of infection prevention and control are crucial to ensure prevention of infection/s in all health care facilities within Combined. To support this, the IPC team, working collaborative with directorates and other corporate continues to work hard to prevent all avoidable infections and the risk of resistant organisms across our Health & Social Care footprint.

The team use the trust values (6Cs) in all areas of their work on a daily basis.

***We encourage communication with our staff by being visible across the directorates, carrying out daily surveillance of IPC/Physical Health (PH) risks, offering a service between 8am - 5pm and attending key meetings.***

***We are committed to providing evidence based care.***

***We have the courage to challenge ANY behaviour that puts our patients, carers, visitors or staff at risk.***

***We are dedicated to maintaining the competence required by our staff in relation to preventative IPC practice.***

***We are compassionate in all our contact with patients, carers and colleagues.***

***We are committed to preventing ANY avoidable infection.***

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

- **No** preventable Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia infections within our services
- **No** preventable Clostridium Difficile Toxin (CDT positive) infections within our services
- **Achieved** a zero number of Healthcare Associated Infections (HCAIs) cross infection cases in patients or staff (excluding small round structured virus outbreaks)
- **Regional** conference speaker and poster presentations for the Infection Prevention Society (IPS)
- **National speaker and Active** members of the national Mental Health IPS Special Interest Group
- **Successful** appointment to the Trent IPS Education Officers role for a two year term
- **Member** of the West Midlands Antimicrobial group
- **National Host for the Mental Health IPS Special Interest Group** raising our profile for IPC
- **Health Education** WM key players in developing competencies for MH and LD nurses.
- **Maintained** exceptionally high PLACE scores
- **IPC speaker** for Keele nursing students
- **Health Foundation** Q Community membership

- **Achieved** Influenza vaccine target of 72%
- **Developed** new Trust intranet site as a central hub for electronic resources, news and training dates for IPC and PH.
- **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.
- **Development** of a Trust standardisation list for all areas
- **Development** of multiple Standard Operating Procedures (SOP) to support Trust staff
- **Development** of good working relations with multiple Trusts and organisations both locally and nationwide.
- **Development** and implementation of Trust wide IPC audit
- **Development** of Trust surveillance database for the monitoring of clients / service users with IPC and physical health issues
- **Review and streamlining** of multiple policy and service level agreements (SLA) throughout the Trust
- **Implementation** of a Tissue Viability service as part of the IPC & PH team

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

### 2.1 Frequency/nature of reporting

In addition to delivering the annual report, the DIPC delivers a quarterly report produced by the Deputy DIPC. During 2017/8 the Board received concise reports in accordance with the business cycle, which highlighted areas of practice and development, including arrangements for IPC.

### 2.2 Decisions made by the Board of Directors

The approval and any recommendations from the Board are communicated directly to the DIPC following presentation of Quarterly and Annual Reports and are actioned accordingly**.**

## 3. Care Quality Commission

The Care Quality Commission (CQC) inspection during 2017 did not highlight any IPC gaps and the physical health work in relation to sepsis etc. was acknowledged by the CQC to Board. The CQC assess IPC standards against 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. In addition to this are the key lines of enquiry. Combined was one of the first organisations to be assessed against Well Led, and gave sufficient assurance to the CQC inspectors.

In addition to the above CQC Regulation 12 and 15 shown below are also addressed within the 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”.

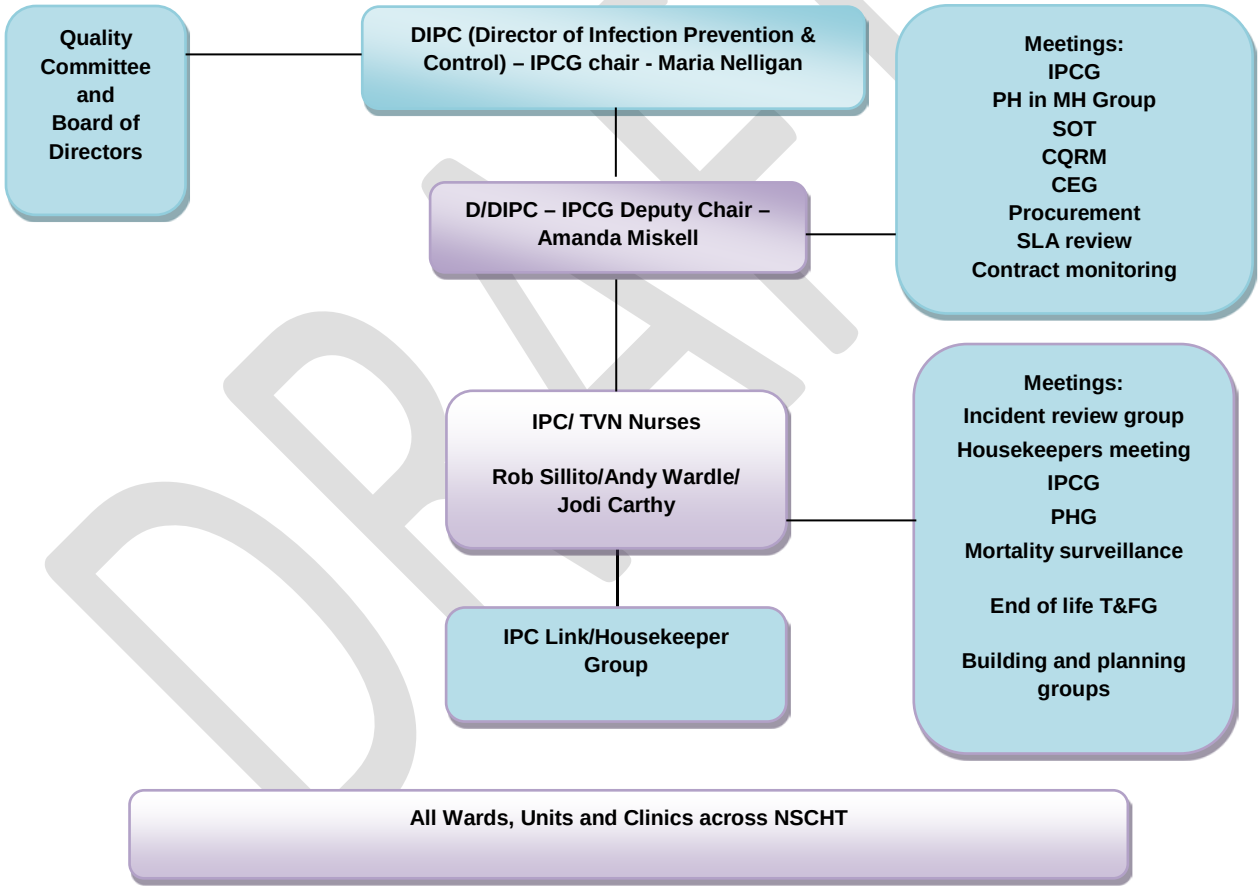
Section 15.2 – “The registrant must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used”.

## 4. Infection Prevention and Control (IPC) governance arrangements

### 4.1 Arrangements for IPC

The IPCT have a high profile within clinical and support services across the Trust.

Diagram below shows our “Ward to Board” structure and attendance at meetings.




### 4.2 Infection Prevention and Control Group (IPCG)

The IPCG reports directly to the Quality committee, and is chaired by the DIPC or D/DIPC. Meetings take place six times per year, and all services and directorates are represented.

### 4.3 The IPC team (IPCT)

Following a review of service, the structure of the IPC team began in June 2017 for mental health, learning disabilities and drug & alcohol services. The DIPC (Maria Nelligan) is

supported by the IPC team which is led by the D/DIPC, supported by two 0.5 WTE IPC nurses.

### 4.4 IPC/Housekeeper group

Modern Matrons, Facilities and Estates, including the housekeeper/IPC staff throughout the trust are supported by the IPCT to deliver the IPC agenda corporately and locally. The IPC/Housekeeper group is well established and is coordinated by our facilities manager. These groups meet on a monthly basis, with one of the IPC team, and provide an excellent opportunity to cascade and disseminate key IPC guidance to staff.

### 4.5 IPC resources

The following resources are available to all staff and carers:

- The 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 feedback on areas for development actioned as required.
- Access to microbiology advice
- Standardisation lists for products and medical devices
- Information leaflets
- Regular stands and IPC promotions
- Coordinate trails of new products and processes for clinicians
- Safer sharps
- Influenza vaccination
- Detailed training programme
- Sepsis cards

### 4.6 NSCHT commitment (Strategy) to Infection Prevention and Control 2018 -2020

The commitment has been produced to support the Trusts person centred framework 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 commitment will support effective and meaningful infection prevention and control practice of all employees within Combined. It will also ensure that effective measures for prevention and control of infection are integrated in the trusts 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 a work programme which is approved by the Board and reviewed at each IPCG meeting. Areas of concern are highlighted and escalated where required.

### 4.8 Programme of Policy Review

All IPC policies were reviewed during the 2016/17/18 period, in line with the policy review programme which forms part of the IPCG work plan. The focus for 2018/19 is to amalgamate these into an IPC portfolio supported by SOPs that is more accessible and succinct.

## 5. Refurbishments and New Builds

The IPCT provide advice and support during refurbishments and new builds across the trust, including advice for primary care premises to ensure compliance with national guidance and the audit programme. The IPCT have continued to work in partnership with Estates in relation to the plans and works carried out for the young person's inpatient unit, PICU, Place of safety and Assessment & Treatment, ensuring compliance with Hospital Building Note 00-09. The team have also supported the works required to transfer properties from successful tenders, and advised on tender properties.

## 6. Standardisation of products

The team have standardised the top IPC related items used in Combined. This includes hand decontamination resources, gloves, aprons, disinfectant and patient wipes, dressing packs and cleaning agents as a minimum. The team have also advised our PFI facilities department on standardised products including single use gloves. To facilitate this we provide IPC training to all Carillion staff. 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.

In addition to this our Tissue Viability Nurse has undertaken a Trust wide audit of pressure relieving products with an aim to standardising these and ensuring the most appropriate equipment is available.

## 7. Safe systems for Sharps and exposure incidents

The team review all incidents to reduce risk and promote good practice in relation to needle stick injuries (NSI) and have provided training and posters to all staff to support safer processes. Exposure incidents are potentially high risk, and preventative training and resources are ongoing. Venepuncture training now includes safe system butterflies. The community staff have been supported to purchase safe sharp trays which can be carried within their bags reducing NSI risk.

## 8. Hand Decontamination

The IPCT continues to actively promote hand hygiene, via observational activities in the workplace, trust induction, mandatory training and at all other events and opportunities.

The IPCT have been working closely with colleagues from the estates and facilities teams, along with "DEB" representatives to complete site surveys in response to the standardisation work for soap, alcohol hand foam and moisturiser. This work has standardised and updated the hand hygiene products across the Trust for both in-patient and community settings. The aim of this work is to streamline the number of products used, and therefore achieve the maximum cost savings afforded as a result of bulk ordering. This will ensure effective hand hygiene is accessible to all staff, patients and visitors.

## 9. Education activity

### 9.1 Induction and Mandatory Training

The IPC team have facilitated 12 Induction sessions during 2017-2018, and 28 mandatory training sessions plus the access to our e-learning package. The team strive to improve compliance by providing extra sessions, targeting low compliance areas and attending key clinical meetings. Specific training has been given to our colleagues in short stay, Estates and Facilities (including Carillion). The team continuously aims to improve their training by ensuring packages are current and in-line with the latest evidence and guidance available.

The IPCT also provide the foundations of physical health training and its accompanying competency document which includes the deteriorating patient, the correct use of NEWS and the deteriorating patient, including Sepsis.

Our aim for 2018/2019 is to achieve a higher compliance rate, refreshing training resources and delivery methods as well as offering new training sessions covering ECG, Injection techniques, ANTT and venepuncture.

### 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. One of the IPC nurses who holds a degree in IPC is currently completing their Holistic health assessment course at Keele University and is working closely with clinical colleagues both within the Trust and at UHNM to gain clinical experience. Another is currently completing the M.I.C.S (Management of an Infection Prevention & Control Service) at the University of Manchester.

One of the team is currently the educational officer for the Trent Branch of the Infection Prevention Society. The team present at conferences both regionally and nationally for the IPS and Combined hosted the national IPS Mental Health Specialist Interest Group for 2018.

Our Tissue Viability Nurse has undertaken their debridement module at master's level during the 2017/18 financial year and is also planning to undertake their prescribing course in the 2018/19 financial year. They have been instrumental in helping to streamline the tissue viability referral process, the creation of a wound care formulary and the delivery of tissue viability training throughout the Trust including prevention of pressure damage.

The team have been actively involved in the hand decontamination product events for mental health and the surveillance programme for IPC and physical health including MRSA screening.

The D/DIPC has an MSc in Health Improvement & Wellbeing (PG cert Public Health) and is an Honorary Lecturer at the University of Chester. We are currently working on Sepsis in Learning Disabilities and the national work in MH moving to NEWS2.

## 10. IPC standards reviews

### 10.1 Modern Matron Walkabouts

The IPCT supported a review of the modern matron programme across the trust, resulting in the development of a revised document for use on the monthly walkabouts. These include staff from IPCT, Facilities and either the MM or Ward Manager. Standardising this process has released the time that clinical and support staff who were expected to dedicate to this, and ensures we have joined up assurances for the mandatory Premises Assurance Model (PAM)

### 10.2 IPC Audits

During the period this report covers the team carried out audits on all inpatient and community clinical areas. These results and the audit programme for 2018/19 is available in appendix one.

All inpatient areas achieved above the compliance score of 90%, with exception of one area who the team are 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.

## 11. Integrated Working and Support

The IPCT support investigations and reports for directorates, and patient safety and have undertaken several local investigations.

## 12. Service User Involvement

We have service user representation on the IPCG, and always on our PLACE visits. In the coming year we are hoping to involve our volunteers to become our 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 IPCT will support.

## 13. Health Care Associated Infection (HCAI)

During 2017/18 there were no cases of MRSA Blood Stream infections in our inpatient areas.

There were no cases of Clostridium Difficile Toxin infections

This figure assures the Board that excellent IPC standards exist in inpatient services, and patients are not harmed unnecessarily by 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 IPCT 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, bank staffing office, occupational health, estates personnel and facilities managers from both Combined and Carillion.

## 15. Surveillance

Surveillance or an intention to review activity in relation to IPC was commenced in June 2017. 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 issues or invasive devices (including those patients who will be cannulated on EMU) are screened for MRSA, with consent.

The IPCT support and collate all the information in relation to the above, including those who self-harm and inject. 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 and post-operative surgical sites. Our Tissue Viability service (SLA) was reviewed late

2016/17, and a change to the SLA ensured we had a triage system and onsite accessibility and training. The TV nurse is part of the IPC/PH team. The IPC team have had numerous interactions with staff and service users throughout the year. Each episode involves contact, advice to staff and patients were appropriate and documentation on Lorenzo. There has been significant increase in IPC contact in comparison to previous years, and accessibility and extended hours appear to have stimulated this.

The collection of surveillance data is an ongoing process in which the team are working to streamline by utilising multiple resources throughout the Trust.

### 15.1 Catheter Associated/Urinary Tract Infection (CAUTI)

UTIs contribute to a large proportion of our AM prescribing. More recently these have been caused by gram negative organisms, E.coli and Klebseilla. The majority of these are totally resistant to our 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 IPCT have developed and supported the response to the implementation of NICE guidance EPIC 3 (2014) and CQC requirements with regards to Catheter Associated Urinary Tract Infections. We report all of these via exception and have not reported any CAUTIs that have developed from care at Combined.

The team have also worked to help improve education and knowledge around urinary catheters as well as helping staff to identify the need for silver tip catheters where infection is recurring.

### 15.2 Peripheral Vascular Devices

Every patient on EMU admitted for alcohol detoxification is cannulated for the administration of *Pabrinex* and artificial hydration. Although there has been no infections related to the insertion of vascular devices, the review of clinical practice and the SOP has been carried out. 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. EMU will trail the new packs and evaluate early 2018.

### 15.3 Chest Infections

These infections were significant over the winter months both Q3 & Q4. Some of these were possibly due to secondary infection following normal viral infections over the winter period including RSV etc.

From the information below and the collaborative work with our pharmacy department, we can see the increase in AM prescribing to address the activity in relation to infections in Q3 & Q4. However, only 46 patients from all the contacts we had were transferred across to acute services.

The categories in the table (1) below show approximate contacts and rationales:

**Table 1.**

| Quarter | | Q1 | Q2 | Q3 | Q4 | Total |
|---|---|---|---|---|---|---|
| Cases | Total | 21 | 66 | 159 | 169 | 415 |
| Indwelling device | Peripheral cannula | 0 | 0 | 3 | 3 | 6 (excludes EMU) |
| | Urinary catheter | 0 | 3 | 9 | 4 | 16 |
| | Other (PEG etc.) | 0 | 0 | 0 | 14 | 14 |
| Wounds / Skin condition | Excoriation | 1 | 0 | 1 | 0 | 2 |
| | Moisture lesion | 0 | 0 | 1 | 4 | 5 |
| | Self-harm wound | 0 | 2 | 5 | 4 | 11 |
| | Trauma wound | 1 | 4 | 2 | 0 | 7 |
| | Leg ulcer | 2 | 4 | 2 | 6 | 14 |
| | Pressure sore - Non Trust Apportioned | 2 | 2 | 3 | 2 | 9 |
| | Pressure sore - Trust Apportioned | 0 | 0 | 0 | 2 | 2 (Ward 4) |
| | Chronic wound | 1 | 1 | 5 | 0 | 7 |
| | Other (surgical, CA etc.) | 3 | 5 | 3 | 4 | 15 |
| Infection | Sepsis | 0 | 1 | 0 | 1 | 2 (Ward 1 and 4) |
| | Skin infection | 5 | 5 | 12 | 16 | 38 |
| | Wound infection | 0 | 0 | 5 | 5 | 10 |
| | Chest infection | 0 | 8 | 30 | 37 | 75 |
| | UTI | 1 | 3 | 19 | 30 | 53 |
| | C.diff | 0 | 1 | 0 | 1 | 2 (Not toxin +ve) |
| | Norovirus | 0 | 0 | 5 | 4 | 9 (Outbreak related) |
| | Influenza | 0 | 0 | 4 | 3 | 7 (Outbreak related) |
| | Multiple | 0 | 0 | 1 | 5 | 6 (Across) |
| | Other (HAP etc.) | 3 | 1 | 6 | 10 | 20 |
| ABX px | Yes | 9 | 12 | 49 | 101 | 171 |
| Acute Trust admission? | Single | 3 | 18 | 4 | 21 | 46 |
| | Multiple | 1 | 5 | 0 | 3 | 9 |

## 16. 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 IPC/PH team have developed a Physical Health and Deteriorating Patient education programme. In addition to this we have worked closely with Health Education England (WM) in developing and publishing a competency document to support this with workplace support in place. Combined has had an Early Warning Score (EWS) system in place across all inpatients areas since 2016. In 2017 this has been reviewed and evidence based National and Paediatric EWS, along with Maternity EWS has replaced the Modified EWS in

Combined. The team have also worked to implement Sepsis pathways based upon guidance from the Sepsis Trust.
In the community setting staff must adhere to policy if a patient is assessed visually as deteriorating from a PH aspect and call the patients GP or 999.

This assessment alone gives inpatients a “parity of esteem” in terms of assessment for sepsis, and a process to refer and transfer responsibly to acute physical health services.

Combined have introduced the following to support the identification and management of sepsis:

- Sepsis is included in all PH in MH training and IPC Training
- A communication bulletin in relation to the key points for considering sepsis on SEPSIS day September 2017, including the development, printing and distribution of SEPSIS alert cards for staff
- Review of all the NICE guidance once published and include in a DIPC quarter report
- Review ALL transfers to acute PH services from COMBINED with Sepsis and for returning patients
- All CAMHS clinical nursing and medical staff to complete e learning package, once Available (April 2018)

## 17. Influenza Immunisation Activity

Influenza activity has been different this year in relation to healthcare contacts and confirmed cases stretching into April 2018. Overall across healthcare 68.7% of frontline staff were vaccinated. CQUIN, Immform and NHSI submissions for us were all 72.1% with the CQUIN target achieved, 70% by the end of February 2018.

This year we had 1591 staff overall, of which 1212 were front line (including all bank staff), and 379 not. 1016 vaccinated or declaration forms, of which 874 were frontline (including bank), and 142 not.

Team prevent confirm this is our final submission for CQUIN and Immform, and this is what I last submitted to NHSI.

Two members of the IPCT completed the Baxter three day Immunisation training, in order to train internally and be able to support the annual staff influenza vaccination campaign during 2017/18. The team worked in partnership with Team Prevent Occupational Health to deliver the vaccine across all areas**.**

The team also endeavoured to develop new ways in which to engage with staff to deliver the flu jab. This included the 24 hour jabathon and dial-a-jab.

During the year we experienced three outbreaks, one with RSV and two with confirmed Flu (A&B strains). One patient transferred to acute care, and all others were treated successfully with Tamiflu and made a full recovery. We have had over 50 affected patients with Influenza like illness.

For the 2018/19 programme we have already ordered our Quadrivalent vaccines for this year via UHNM pharmacy at NHS rates, 1050, to achieve our CQUIN as per PHE guidance at 75%.

During February 2018 in Geneva, the World Health Organization (WHO) has agreed on the recommended composition of the trivalent influenza vaccine for the northern hemisphere 2018-2019 influenza season as:

- an A/Michigan/45/2015 (H1N1)pdm09-like virus;
- an A/Singapore/INFIMH-16-0019/2016 (H3N2)-like virus;
- a B/Colorado/06/2017-like virus (B/Victoria/2/87 lineage).
- a B/Phuket/3073/2013-like virus is recommended. (Quadrivalent)

In addition PHE guidance is that the adjuvant trivalent vaccine (aTIV) is used for 65s and over. Given aTIV was only licensed for use in the UK in August 2017; this was not an option for the 2017/18 season. However the JCVI advice is that this is now the best option for 2018/19 for 65+ age group.

For our staff the Quadrivalent vaccine (QIV) for 18 – under 65s at risk. In light of an independent cost-effectiveness study into QIV undertaken by Public Health England and considered by JCVI, the Green Book was updated in October 2017 to provide the advice that QIV is the best option for 18 - 65 at-risk groups in the 2018/19 season. It is also used for the childhood programme.

In addition we have registered as a trust to input into Immform this year, and we will coordinate our own campaign and submissions supported by Team Prevent. Training will be completed in-house again.

## 18. Antimicrobial (AM) Resistance (R) Strategy

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.

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 was jointly issued by Health Education England, NHS England 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. We do not use the Start Smart Then Focus (SSTF) toolkit as this is more relevant to intravenous treatment with antimicrobials which we do not use at Combined.

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 our pharmacy colleagues have been proactive in raising awareness in judicious prescribing of all antimicrobials across inpatient settings. The Code of Practice states that as a registered provider with the Care Quality Commission, Combined has several specific responsibilities including;

- 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, advice on choice of therapy

- 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

- The DIPC/appropriate other, have the authority to challenge inappropriate practice and inappropriate antimicrobial prescribing decisions

- Have a monthly review of antimicrobial prescribing decisions

- Benchmarking should be used to demonstrate progress in antimicrobial stewardship

- Raise awareness of AMR through posters and displays throughout the Trust as well as creating a stand in the Harplands main reception area for antimicrobial awareness week.

Similarly this will be the same for our NMPs prescribing.

### 18.1 Inpatient Services antibiotics audit 2017/18

Since April 2017 the IPCT has monitored and responded where necessary, to every antimicrobial prescription with all our inpatients as a benchmark towards our commitment to the national antimicrobial strategy 2013 – 2018

Q2 saw the highest prescribing for UTI's which reflects the activity within the IPCT regarding dehydration and the numbers of multi resistant (ESBL) UTI's. Prescribing within Q3 shows the highest for respiratory infections (Oct, Nov, and Dec)

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

## 19. Estates Department contribution to the IPC work programme

### 19.1 Legionella compliance with legislation

The Trust continued to follow its Legionella policy, ensuring that appropriate systems and procedures are in place to minimise the risk of legionella within the Trust's hot and cold water systems. There are now two members of the Estates Team who have undertaken the Legionella Role of the Responsible Person course. This will ensure that there is always adequate cover within the team to manage the water systems.

In agreement with the Deputy Director of Infection Prevention Control, the Water Safety Group, has now been incorporated into the Infection Prevention and Control Group. An agreed reporting format has been designed and this now forms the basis of the Water Report which is presented to the group.

Regular sampling and testing for Pseudomonas aeruginosa continued on a quarterly basis and the results, including any remedial action taken, were reported back to the IPC Group.

A documented twice weekly flushing regime for all outlets continued. The Trust's Support Services Manager manages these records. It has been agreed to review this process during 2018/19 to reduce the number of records kept, whilst still providing assurance that the outlets are being used on a regular basis.

The Bi-Annual Water Risk Assessments were completed on the following properties:

Ashcombe Centre
Bennett Centre
Broom Street Clinic
Darwin Centre
Greenfields/ Summer View
Hope Centre
Lymebrook Centre
Parent & Baby (Victoria Surgery)
Roundwell First Steps
Sutherland Centre/Florence House

At the Harplands site (Carillion PFI responsibility) the following issues have been actioned and resolved to support the IPC AF. In March 2017 Ward 4, room 44 hot tap test results for TVC's came back positive. Street level 1 Housekeeping room cold tap test results for TVC's came back positive. Street level 2 Housekeeping room cold tap test results for TVC's came back positive. Management room 6 water fountain test results for TVC's came back positive. All of these were cleaned and re-tested and came back clear.

In June 2017 Ward 6 room 59 test results for legionella came back positive on the TMV. The TMV was removed and disinfected. Re-tested and came back clear
Ward 7 room 32 TMV test results for TVC's came back positive. Ward 3 room 6 water fountain test results for TVC's came back positive. Ward 3 room 19 shower test results for TVC's came back positive. EMU room in 5 shower test results for TVC's came back positive. All of these were cleaned and re-tested and came back clear.

In November 2017 Ward 1 room 8 test results for pseudomonas came back positive. This was cleaned and re-tested and came back clear.

In December 2017
Central therapies room 16 test results for TVC's came back positive and Jarrold suite room 14 water fountain test results for TVC's came back positive. These were was cleaned and re-tested and came back clear.

### 19.2 Capital programme works

The Trust continues to balance the anti-ligature requirements for sanitary ware in patient areas by reviewing the inclusion of sensor no touch taps, whilst considering flow rates as the reduced flow from these outlets have caused concerns. Where anti-ligature sanitary ware has been installed it has included new systems that operate behind the sanitary ware which are linked to computers that operate regular automated flushing regimes and provide electronic reports of when these were completed.

Refurbishment projects completed this year include:

- Refurbishment of the Darwin Children's Centre to include a High Dependency Unit, increased day space, new kitchen and outside play area.
- Environmental works to the lower floor of Broom Street.
- Both bathrooms at Short stay

- Conversion of Lymebrook Bungalow from former inpatient area to clinic and office space to aid the decanting of the NOAP team from Maple House.
- Refurbishment of the main reception and entrance at Lymebrook. Works included the replacing of a large glass atrium roof, with a traditional slate roof with roof-lights.
- Ward 1 PICU – The creation of a 6 bedded PICU unit at Harplands Hospital.

The plans for a new urgent care centre, including Place of Safety are near completion and IPC have been involved, as with the proposals for Assessment & Treatment.

## 20. 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.

The Trust achieved an overall average performance of 96.91% for all areas and risk categories.

During the same period, our Private initiative PFI partners, Carillion who provide the support services provision at the Harplands site, achieved an average of 95% or above each month for cleanliness in line with their KPI's.

### 20.1 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.

An annual external validation of our cleanliness scores was completed at the Harplands site on Wednesday 28th March 2018 by Mrs Janet Walker, Facilities Manager from the Royal Wolverhampton NHS Trust. She quoted "I am pleased to validate the cleaning scores for the Hospital of an overall performance score of 96.37%. This is an excellent standard and is a reflection of the teams"

### 20.2 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 0701 and to also ensure that waste segregation standards meet the requirements for waste handling and storage.

During 2017 the IPCT and our facilities team reviewed the waste categorisation including pharmaceutical waste streams. Following several contract meetings we re-categorised our all waste streams in line with HTM 07-01. This has also reduced costs, and further review will take place early 2018/19.

Waste auditing forms part of a planned programme of waste management and any issues or outstanding actions is followed up by IPCT and/or Facilities team. Where a new service is introduced, a full "Pre-acceptance" waste audit would be 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.

Some of the actions from the 2017/2018 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

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

**Trust's overall score for 2017:**
Cleanliness - 99.61%
Food and Hydration - 97.19%
Organisation Food - 93.02%
Ward Food - 99.84%
Privacy, Dignity and Well-Being - 96.33 %
Condition, Appearance and Maintenance. - 98.78%
Dementia - 93.63%
Disability - 97.24%

**Cleanliness**
The cleanliness scores which included hand hygiene and equipment cleanliness were excellent. Dragon Square, 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

Harplands Hospital, Darwin Centre and Summers View each scored 100% in the ward food assessment.

**Privacy and Dignity**
The Privacy, Dignity and Wellbeing scores ranged between 93.75% at Darwin Centre and 100% at A&T Unit. The lack of observation panels with integrated blinds in all patient bedrooms at Dragon Square and Darwin impacts on 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 98.46% and 100%. Darwin Centre and Summers View both scored 100%. This is a real credit to the Estates Team, PFI partners and our Hospital Cleanliness Technician.

**Dementia**
This section was assessed on WD 4, WD 5, WD 6, WD 7, the Access Team area and the Communal areas on the Harplands site, with an overall Trust Score of 93.63% being achieved. This is a slight reduction on last year's score and reflects the changes to the questions

**Disability**
As an organisation we have achieved a score of 97.24%. The scores ranged between 96.44% at the Harplands and 100% been achieved at both Dragon Square and Summers View.

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

***Florence House*** *– Well maintained building. Excellent staff who take care of the clients and encourage independence i.e. garden project and social activity. The proposed scheme to paint the adjoining garden wall with a mural depicting the seasons will greatly improve the outside space.*
*The development of the garden increasing the size is a vast improvement that has been made since last year's inspection.*

***B4/5 Dragon Square*** *– Building clean and well maintained. Decoration and artificial lighting improved since 2016. Modern artwork adds to the décor and the ambiance of the building. Staff very amenable and provided information when requested.*

***A & T Unit*** *– Pleasantly decorated, calm environment. A lovely tidy site. Only 3 clients on site at the time, but all were well supported by staff and protected their privacy and dignity well. The team were made to feel very welcome.*

***Summer View*** *–. All patients treated with dignity and respect.*
*A noted improvement on last year's inspection. The building inside is clean, fresh and bright. Gardens and outside social areas are well maintained, litter free and the clients take an interest in growing plants, fruit i.e. strawberries, tomatoes etc.*
*.*
***Darwin*** *– The building work that has taken place over the last 12 months has vastly improved the facilities. The extended dining area/lounge is a big improvement on last year facilities. Generally very impressed with the building as a whole. The unit provides a comfortable, pleasant environment which allows for sufficient personal choice for privacy or participation*.

***Harplands Hospital****– The building is well cared for and well maintained where patients are treated with dignity and respect as individuals.*
*Excellent food service.*
*Grounds are well maintained, litter free and gardens are tended and colourful.*
*Tranquil surroundings and excellent art work. Approach to wards is welcoming and environment improves year on year.*

## 22. Conclusion

Infection prevention and control remains a priority for Combined. The IPCG and IPCT 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 2018/19 is set out below for Board approval Appendix Three.

## 23. Recommendations

The Board is asked to approve the Infection Prevention and Control Annual Report for 2017/18 and the work programme for 2018/19.

## 24. Appendices

### Appendix One

IPC&PH annual audit program 18 - 19.xlsx

### Appendix Two

IPC Glossary.doc

### Appendix Three

IPC WP 2018-19.doc

## 25. References and associated documents.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# REPORT TO OPEN TRUST BOARD

Enclosure No:10

| | | | |
|---|---|---|---|
| Date of Meeting: | 26TH September 2018 | | |
| Title of Report: | Management of Health and Safety Annual Report | | |
| Presented by: | Maria Nelligan, Executive Director of Nursing and Quality | | |
| Author: | Frazer MacDonald, Health and Safety Advisor | | |
| Executive Lead Name: | Maria Nelligan, Executive Director of Nursing and Quality | Approved by Exec | ☒ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| The purpose of this Annual Report is to provide details of the current management arrangements in place for health and safety and to give assurances that we are meeting our statutory requirements for health and safety. The report also summarises key areas associated with good practice and successful health and safety management for the period 1st April 2017 – 31st March 2018. | Approval | ☒ |
| | Information | ☐ |
| | Discussion | ☒ |
| | Assurance | ☐ |

| | | |
|---|---|---|
| Seen at: | SLT ☒ | Date: 10.07.18 |
| | Execs ☐ | Date: |
| Committee Approval / Review | • Quality Committee ☒<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☐<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Digital by Choice Board ☐ | |
| Strategic Objectives (please indicate) | 1. To enhance service user and carer involvement. ☐<br>2. To provide the highest quality services. ☒<br>3. Create a learning culture to continually improve. ☒<br>4. Encourage, inspire and implement research & innovation at all levels. ☐<br>5. Maximise and use our resources intelligently and efficiently. ☐<br>6. Attract and inspire the best people to work here. ☐<br>7. Continually improve our partnership working. ☒ | |
| Risk / legal implications: Risk Register Ref | The report addresses the risk implications of safety in the workplace. | |
| Resource Implications:<br><br>Funding Source: | None | |
| Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups) | The report describes systems in place to support staff and prevent discrimination | |
| STP Alignment / implications | None | |
| Recommendations: | For approval | |

| Version | Name/group | Date issued |
|---|---|---|
| 1 | Maria Nelligan | 06.07.18 |
| | | |
| | | |

## 1. Introduction

The North Staffordshire Combined Healthcare NHS Trust was created under a statute provision, and as such legal accountably for health and safety passed to the board of North Staffordshire Combined Healthcare NHS Trust. The ultimate responsibility for health and safety management throughout North Staffordshire Combined Healthcare NHS Trust is vested in the Board of Directors and Chief Executive Officer (CEO). The board delegates executive lead responsibility of health and safety (including patient safety) to the Executive Director of Nursing & Quality.

## 2. Purpose

The purpose of this Annual Report is to provide details of the current management arrangements in place for health and safety and to give assurances that we are meeting our statutory requirements for health and safety. The report also summarises key areas associated with good practice and successful health and safety management for the period 1st April 2017 – 31st March 2018.

## 3. Structures

In accordance with the requirements set out in section 2(7) of the Health and Safety at Work Act 1974, the Board of Directors of North Staffordshire Combined Healthcare NHS Trust has established a Health, Safety and Well-being (HSWB) group which is a sub-group reporting to the Quality Committee. The HSWB group thus aligns with the Trust's organisational and governance structures and framework; there is no requirement for this function to report directly into the Trust board.

The Health, Safety and Well-being Group (previously known as the Organisational Safety Group) meets bi-monthly and focuses on significant health and safety issues and seeking wider assurances around health and safety management issues. All actions generated from the group are monitored to ensuring timely completion and compliance.

## 4. Reporting

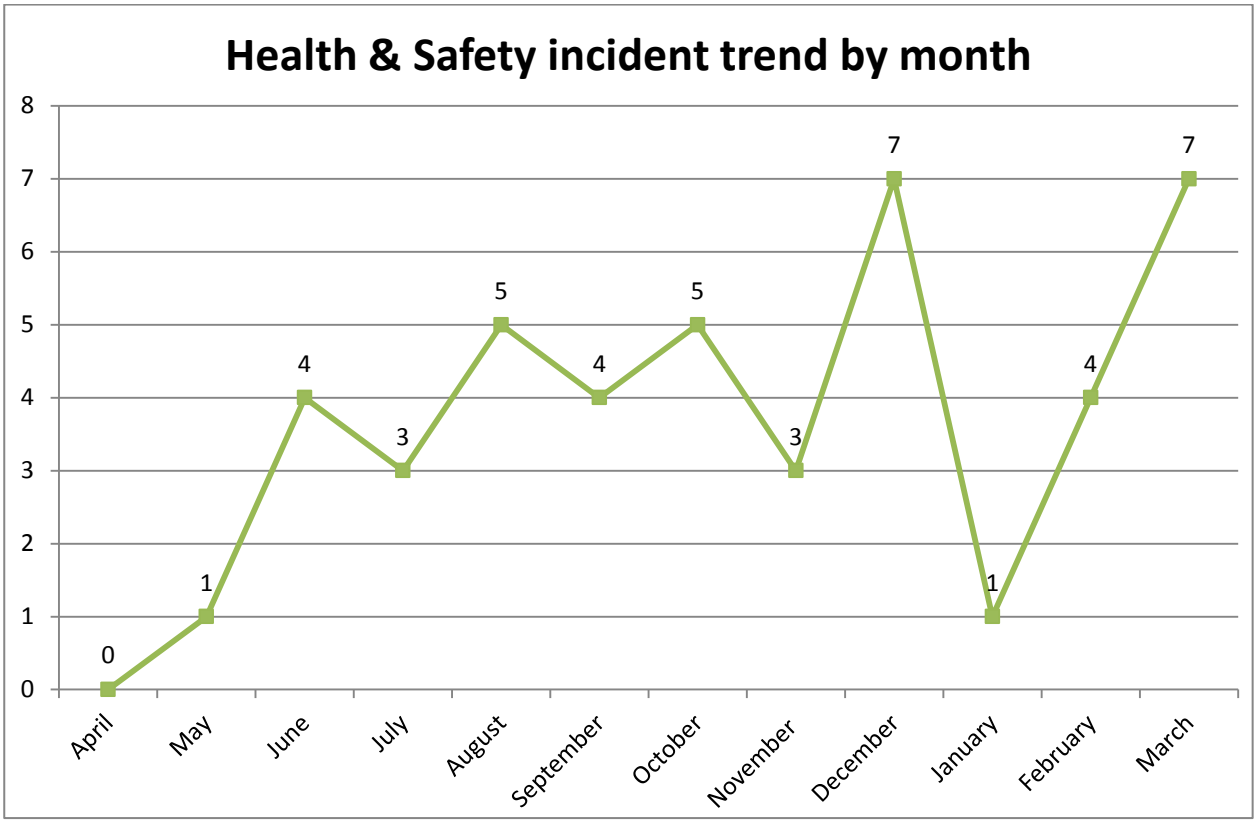
The Ulysses (Safeguard) Risk Management System is used in the Trust to manage incident reporting, including accident reports, complaints, claims, inquests and risk registers.

The incident reporting module is used to report and record adverse events, incidents and near misses. It is also used to report on performance in terms of overall levels of reporting, the quality and accuracy of incident reporting. Staff are required as part of their roles to report all incidents or near misses via the online incident reporting module within Ulysses.

There were over 4500 incidents reported via Ulysses, of which only 44 of these are attributed to a staff health and safety incidents. This equates to less than 1% of the total number of incidents reported, demonstrating the positive health and safety culture within the Trust. Health and Safety Incidents have reduced from previous years with the below table providing year on year totals for health and safety incidents since 2015/16.

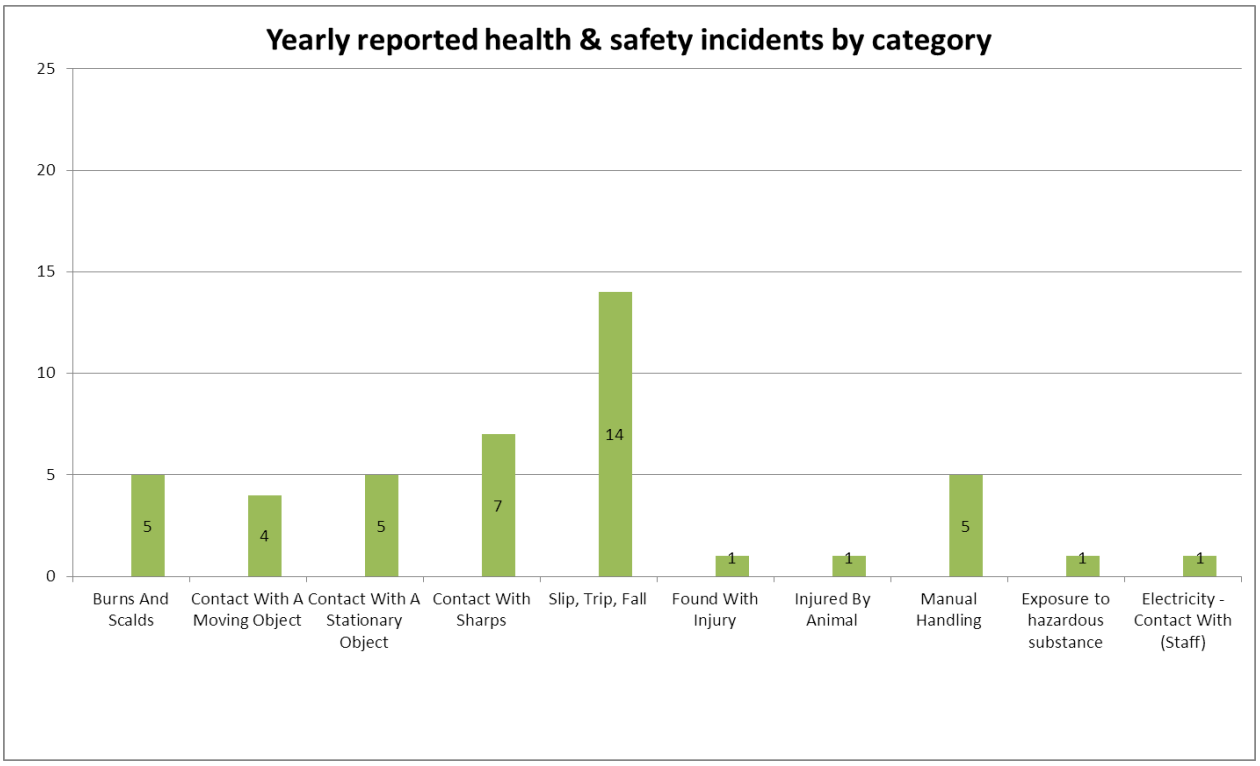
| Year | Total Health and Safety incidents reported |
|---|---|
| 2015/16 | 65 |
| 2016/17 | 64 |
| 2017/18 | 44 |

The below graph provides a month on month trend of these health and safety incidents.




- There has been an average of 4 incidents per month, with the prevalence of health and safety incidents fluctuating throughout the year with a peak of 7 incidents in December 2017 and March 2018.

The graph below provides a breakdown health and safety incidents according to their category.



- Slips, trips, and falls were the most prevalent health and safety incident with 14 incidents reported over the year. Although the most prevalent incident the 14 incidents reported was less than previous years where there were 21 (2015/16) and 24 (2016/17) incidents reported.
- There were 7 incidents reported under the category of contact with sharps, however only 3 of these incidents related to needle stick injuries. This is a reduction on the previous year and shows the positive effect of the work around needle safety.

Detailed information and analysis of incidents is undertaken by the Health, Safety & Well-being Group which receives 2 monthly reports on a range of areas including:

- Health and safety - reports on accidents and incidents, including trends and themes.
- Incidents reportable to the Health and Safety Executive, under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)
- Estates management - including asbestos, legionella and fire safety
- Security
- Fire
- Workforce training and development
- Reports on specific issues, for example lone-working

## 5. Health & Safety Arrangements

Areas of compliance or concern highlighted from the information it receives is managed and progressed through the Health, Safety & Wellbeing Group. Assurance is then reported to the Quality Committee and to the board. Details of 2017-18 activity are included within this report.

Investigations in regard of incidents have been undertaken by the Health and Safety Advisor where these are deemed appropriate. The learning from investigations are disseminated through the weekly incident review group and to the necessary teams within the Trust.

Quarterly health and safety audits are completed by each team within the Trust. There continued to be a very high percentage completion rate for these audits over all 4 quarters of 2017-18. These audits are co-ordinated by the Health and Safety Advisor, who initiates the process and further collates all the information and any gaps identified through the audits. A plan was implemented which focussed on resolving the identified gaps within each service and with the support of the Health and Safety Advisor actions were completed or escalated where necessary. The quarterly audits were reviewed at the start of the year and amendments made to create more focussed audits selecting specific health and safety topics each quarter. This has been further reviewed for the coming year and the audits have been reduced in length to support clinical teams in completing these, however still capturing the necessary information required.

## 6. Administrative Sanctions and Warning Letters

Administrative sanctions, including verbal warnings and warning letters, were originally highlighted by NHS Protect as being possible responses to violent behaviour when a criminal justice route is neither possible or appropriate, but it is necessary to draw attention to an individual's unacceptable behaviour and support our staff. This is referenced in the Trust Violence and Aggression Policy (5.19 Health and Safety Folder).

This would not be appropriate where a service user is seriously mentally unwell and/or lacks mental capacity. Warning letters have only therefore been issued in a small number of cases, usually to community patients and on one occasion this last year to an inpatient following serious homophobic abuse being directed towards a member of staff.

Warning letters are designed to identify the unacceptable behaviour and the impact it had on staff, stress the importance of working together with mutual respect and highlight possible ramifications should the behaviour re-occur.

## 7. Diversity and Inclusion

The Trust is committed to encouraging equality and diversity among our workforce, and eliminating unlawful discrimination. Our aim is for our workforce to be truly representative of all sections of society and for each employee to feel respected and able to give their best. To this end the Trust takes very seriously all reports of abuse and unlawful victimisation of its staff whilst fulfilling the course of their work activities, on the basis of their race, culture, religious beliefs, gender or sexuality. Any reports of such abuse are thoroughly investigated and appropriate actions taken based on the perpetrator's level of cognitive function. All staff are aware of the need to give a very clear message that such behaviour is not acceptable and does not fit the values of the organisation. Protected characteristics in relation to staff assaults are closely monitored.

## 1. Competent Advice

The Management of Health and Safety at Work Regulations 1999 requires employers to appoint one or more competent persons to assist in health and safety management. North Staffordshire Combined Healthcare NHS Trust has a designated Health and Safety Advisor post within the Patient Organisational Safety Team. The Health and Safety Advisor is formally designated as North Staffordshire Combined Healthcare NHS Trust "Competent Person".

Throughout the year continual advice has been sought and provided in relation to the development of the new psychiatric intensive care unit. The Health and Safety Advisor has been a member of all groups relating to the development and where health and safety concerns have been raised advice has been given and situations monitored to ensure compliance.

## 9. Policy

All organisations employing five of more people must have a written Health and Safety Policy. The policy should cover all aspects of the organisation and be of an appropriate length and relevance to the activities and size of the organisation.

North Staffordshire Combined Healthcare NHS Trust has an approved Health and Safety Policy, which has been produced and revised in accordance with the general requirements of Section 2(3) of the Health & Safety at Work Act 1974 and HSG 65. The Policy has been fully reviewed during 2017/18 and compiled to provide guidance to Directors, Managers, Supervisors and Employees on the arrangements and procedures for managing Health & Safety throughout the Trust. The Policy contains details of roles and responsibilities for the management and planning of Health and Safety throughout the Trust and is supported by a suite of specific policies related to Health and Safety.

Additionally policies developed, reviewed and implemented during the year include:

- First Aid at Work
- Control of Substances Hazardous to Health
- Management of Asbestos
- Environmental Ligature Risk Assessment

## 10. Compliance

The Health and Safety Executive (HSE) is the national independent regulator and act in the public interest to reduce work-related death and serious injury across Great Britain's workplaces. HSE will investigate and, where appropriate, prosecute breaches of health and safety law.

The Trust was issued with the improvement notice on 17th January 2017 in respect of the Control of Vibration at Work Regulations 2005 and given until 17th March 2017 to address the identified breaches. Following a significant programme of work to remedy the identified contraventions, the HSE re-inspected the Trust on 16th March 2017. The Trust was deemed to have completed and implemented excellent work by the HSE inspector, however the improvement notice was extended for 3 months until 16th June 2017 to allow time for the estates team to gather evidence of staff's exposure during work activities.

The HSE inspectors returned on 16th June 2017 to assess the Trusts compliance in relation to the Control of Vibration at Work Regulations (2005) and the improvement notice. The Trust was deemed to have fully complied with the improvement notice which was signed off as completed by the lead inspector. There has been no further contact from the HSE and the Trust maintains compliance in all aspects of the Health & Safety at Work Act (1974).

## 11. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) related incidents

RIDDOR regulations are made under the Health and Safety at Work Act 1974; they apply to a set of reporting requirements to work related accidents or incidents. The main purpose of the regulations is to provide timely reports directly to the HSE in the event of specific accidents or incidents. There is a wide range of events which are reportable to the HSE under these regulations. The main reportable events which apply and occur in healthcare settings are as follows;

- Reportable major injuries
- Over 7 day injuries (unable to complete normal work duties for more than 7 days)
- Specified diseases (Hand Arm Vibration Syndrome)

### 11.1 Trust reported RIDDOR incidents

For the 2017-18 reporting year, there have been 9 RIDDOR reportable incidents which have been reported to the HSE. These incidents fall into the following general categories –

- 3 instances of slip, trip or fall by staff
- 5 instances of physical assault on staff by patient
- 1 instances of reportable industrial injury (hand arm vibration syndrome)

Detailed reports on RIDDORs and other health and safety incidents are reported and monitored through the Health, Safety and Well-being Group and individual management teams.

**Staff assaults requiring RIDDOR**

There were 4 staff assault incidents during 2017-18 which required reporting to the HSE in line with Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). RIDDOR requires deaths and injuries to be reported only when:

- there has been an accident which caused the injury
- the accident was work-related
- the injury is of a type which is reportable

Accidents must be reported where they result in an employee being away from work, or unable to perform their normal work duties, for more than seven consecutive days as the result of their injury.

The 4 staff assaults reported resulted in staff members being absent from work for over 7 days. Two of these incidents caused moderate harm and two minor harm.

The two minor harm incidents occurred on the Assessment and Treatment Unit in April and September 2017 respectively:

All of the incidents were reviewed to establish causes and wider learning which may support in preventing and reducing further incidents.

### 11.2 Violence against staff

NHS Protect defined physical assaults as:-

“The intentional application of force against the person of another without lawful justification resulting in physical injury or personal discomfort”.

The graph below details the assaults against staff since 2016-18.

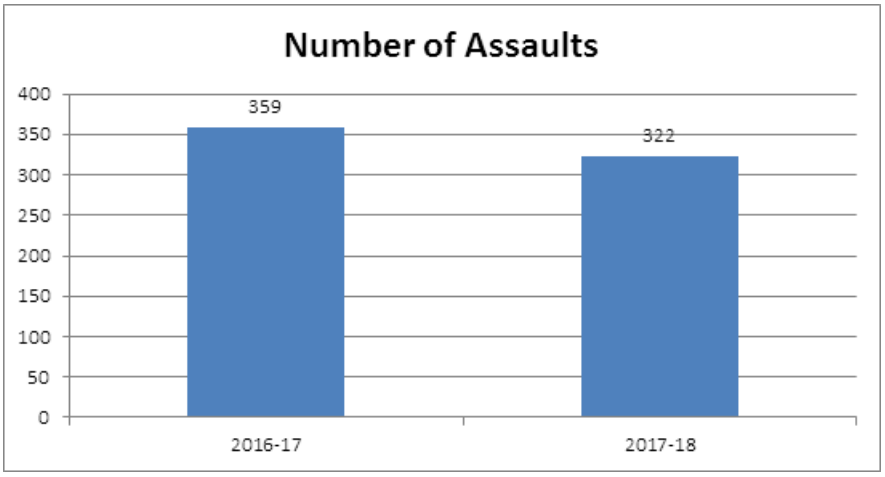



Figure 1 Graph detailing Patient to Staff Assaults since 2016-18

Positively there has been a small reduction this year of just over 10% (322 in 2017-18). Adult inpatient remains the directorate with the highest number of patient to staff assaults with 121 although this is a significant drop from 2016-17 (158). The figure for the adult inpatient directorate represents a decrease of approximately 24%. Learning Disability (LD) services were the second highest reporters with 105 assaults on staff. This represented a substantial increase on the previous year of around 53%. The figure for NOAP fell from 104 staff assaults in 2016-17 to 84 this year. This represented a decrease of around 24%. Scrutiny of the figures shows that in LD services a relatively small number of patients are responsible for a high number of incidents. This is particularly true regarding A&T where of the 56 incidents of assault on staff, 40 (71%) involved just three patients. There were also a significant number of incidents of patient to staff assault reported this year by the Intensive Support Team (IST), but again one patient being supported by the team in external placements accounted for 17 (61%) of the 28 incidents.

The number of assaults resulting in harm to staff also fell in accordance with the overall figure from 155 in 2016-17 to 143 in 2017-18. The vast majority of harm incidents were rated as minor (141) with 2 rated as moderate harm representing 44% of the total number of incidents. Strategies adopted by the Trust to attempt to reduce violence against staff will be discussed at the end of the report.

### 11.3 Comparison of 2017-18 NSCHT Data with the National Picture

In previous years it has been possible for the Trust to make a comparison against other mental health trusts nationally but this has not been possible since 2016 due to the withdrawal of NHS Protect involvement. The Trust Local Security Management Specialists (LSMS's) are seeking to benchmark this information via the regional LSMS forum.

### 11.4 Strategies to Reduce Staff Assaults

The Trust takes seriously all assaults on and its responsibility in ensuring both staff and patient safety. A number of ongoing initiatives have been introduced in order to ensure the safety of both staff and patients which include:-

- The introduction of the Safeguard Incident reporting system in October 2013 enabled significant work to be undertaken on ensuring that incidents were categorised correctly, meeting NHS Protect's definition of assault. This also re-focused staff attention on the importance of incident reporting and data quality. This is an ongoing initiative in terms of data quality control and maintaining staff focus in this important area.
- Timely review of all incident forms relating to violence and aggression by the workforce safety team has allowed for targeted support to be given to clinical areas in relation to the care planning and implementation of violence reduction initiatives.
- All staff who are victims of an assault are contacted by the workforce safety lead to ensure they are being supported, and to offer additional support should this be required.
- The "Learning Lessons" initiative has enabled early dissemination and sharing of information and learning from incidents of violence and aggression.
- Violence and aggression training for staff ensures that the focus is on proactive management strategies geared to avoiding violence.
- Although now "re-badged" as the Restraint Reduction Group, the former Violence Reduction Group has created a forum for the staff from inpatient areas to harness ideas and share good practice with regard to violence and restraint reduction initiatives.

- Ongoing support from Workforce Safety team to areas encountering difficulties with particularly challenging clients. We have tried to make this support more structured and proactive rather than reacting to calls for advice when difficulties have already been encountered.
- Introduction of Positive Behaviour Support training for staff working with particularly challenging clients. This is an area that has been strengthened over the past year following the appointment of an LD Consultant Nurse. This has improved training provision and support/supervision of teams utilising PBS approaches.
- The Local Security Management Specialist (LSMS) forging stronger links with our local police force to ensure that where necessary and subject to the patient's capacity, suitable and appropriate sanctions are applied to those who assault our staff thus giving a clear message to both patients and staff of the Trust's commitment towards reducing incidents of this nature.
- The Workforce Safety Lead has also worked with some teams regarding the development of administrative sanctions outlining acceptable and unacceptable behaviour.
- Critical Incident Debrief Training for staff is provided for senior staff to allow for timely debrief following incidents.
- The Trust recently updated its "RESPECT" posters (initially an NHS Protect initiative). The message has been changed subtly to reflect working together in partnership with mutual respect and depicts images of our own staff.
- There has been a focus on "person centred approaches" across the Trust to improve the patient experience and enhance the relationship between staff and patient.

## 12. Specific HSWB group activity

The following are notable areas of work which have been led by the HSWB group over the last year:

- Commissioned ligature review
- Medical device compliance
- Activity monitoring compliance and risks associated with legionella, asbestos, waste, fire safety and security management
- Development and review of a considerable number of health and safety related policies
- Management of Health and safety action plans (HSE, Estates)

## 13. Risk Management

Risk assessments are the keystone of successful health and safety management, and are a legal requirement. Template non-clinical risk assessments have been developed to ensure all areas have the necessary assessments under health and safety legislation and as prescribed by the Trusts Health and safety policy. These risk assessments are provided to managers as guides to support in the completion of an appropriate suite of health and safety risk assessments. Included are risk assessments for violence and aggression, lone working, and slips, trips and falls (list not exhaustive).

## 14. Training

An e-learning module for health and safety has been implemented and became part of the mandatory training requirements for all staff from June 2017. The e-learning package has been developed to

create a positive health and safety culture, where safe and healthy working becomes second nature to everyone. The session provides key information on health and safety law, risk assessing and safety topics providing staff with the necessary knowledge to create a healthy and safe environment. The initial feedback from staff completing the training has been positive, however we will continue to monitor the sessions and update these where deemed necessary.

The Trust recognises that effective training is part of safe clinical and non-clinical working practice and encourages employees to undertake courses designed to improve their performance and understanding. Training relating to core health, safety is a legal requirement and as such is designated as mandatory for North Staffordshire Combined Healthcare NHS Trust staff. Staff are required to complete mandatory health and safety training on a 3 yearly basis.

Within healthcare there is a considerable range and number of training requirements and expectations to be met. It is a formidable challenge to ensure that the entire workforce has undertaken all required training, particularly when service demands are high. Managers are responsible for ensuring their staff have all completed a local induction and that their annual mandatory training is up to date (including health and safety related topics).

Health and safety related training and attendance figures are presented and monitored at the People and Culture Development Group. Health and safety training compliance is also reported on as part of the wider essential training stats that are part of each directorate's performance monitoring.

Supplementary training in ligature risk assessments has been developed and sessions organised for managers and senior clinical staff. The environmental ligature risk assessment workshop will provide staff with the necessary information to on the policy and processes involved and further support in completing the assessments.

## 15. Future Development

The health and safety advisor, closely supported by the patient and organisational safety team will focus on embedding revised health and safety related polices and continuous health and safety improvement throughout the trust.

One such area will be health and safety inspections. Health and safety inspections will be undertaken on an annual basis. The health and safety advisor will initiate the process and contact the ward managers or team leaders to inform them of the proposed date for inspections.
Inspections will be completed by the health and safety advisor and the ward managers or team leaders, additionally trade union appointed safety representatives will be invited.

## 16. Conclusion

As with any large and complex healthcare organisation, adverse events will occur and the Trust will have areas where improvements can and will be made. The Board is asked to accept this report as assurance that the Trust has adequate policies, systems and procedures in place for the identification and management of health and safety issues across the organisation.

North Staffordshire Combined Healthcare NHS Trust

# REPORT TO TRUST BOARD

Enclosure No:11

| | | | |
|---|---|---|---|
| Date of Meeting: | 26 September 2018 | | |
| Title of Report: | Patient Experience Feedback (PALS & Complaints) Annual Report 2017/18 | | |
| Presented by: | Maria Nelligan, Executive Director of Nursing & Quality | | |
| Author: | Kevin Daley, Complaints Manager | | |
| Executive Lead Name: | Maria Nelligan | Approved by Exec | ☐ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| During 2017-18 the Patient Experience Team have continued to provide a more holistic, patient experience approach to providing support to service users, their families and carers. There has been a very positive response to what has been implemented with strong support from directorates at all levels. This has resulted in fewer formal complaints and more issues being resolved to the satisfaction of the complainant through local resolution or the PALS process. There has been a significant increase in the number of compliments received and recorded which is another indicator that the Trust is improving the experience of service users and their families. | Approval | ☐ |
| | Information | ☒ |
| | Discussion | ☐ |
| | Assurance | ☒ |

| | | | |
|---|---|---|---|
| Seen at: | SLT ☐ Execs x☐<br>Date: | Document Version No. | |
| Committee Approval / Review | • Quality Committee x☐<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☐<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Digital by Choice Board ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement. x☐<br>2. To provide the highest quality services x☐<br>3. Create a learning culture to continually improve. x☐<br>4. Encourage, inspire and implement research & innovation at all levels. ☐<br>5. Maximise and use our resources intelligently and efficiently.☐<br>6. Attract and inspire the best people to work here.☐<br>7. Continually improve our partnership working. ☐ | | |
| Risk / legal implications:<br>Risk Register Ref | | | |
| Resource Implications:<br><br>Funding Source: | None<br><br>None | | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups) | From April 2017protected characteristics have been monitored and reported upon in relation to service user and carer experience through PALS and complaints. | | |
| STP Alignment / Implications | None | | |
| Recommendations: | To note the report. | | |

| Version | Name/Group | Date |
|---|---|---|
| 1 | SLT | 10/07/18 |
| 2 | Maria Nelligan | 13/08/18 |
| | | |

## 1. Introduction

Welcome to the 2017/18 Annual Report of North Staffordshire Combined Healthcare NHS Trust's Patient Experience Team which incorporates Patient Advice and Liaison Service (PALS), Complaints and Patient Experience. This report summarises the quarterly reports submitted to Quality Committee during the course of 2017/18 and supplements information contained within the Trust's Statutory Annual Report and Quality Account.

In addition, those elements of the report that are specific to complaints handled under the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 (the Regulations), are presented in accordance with the requirements of the Regulations.

North Staffordshire Combined Healthcare NHS Trust is keen to listen and respond to questions, requests, comments and concerns. We value the feedback and points of view of the people who use our services, their carer's and loved ones and seek to continue improve also in the ways in which we work alongside people to resolve complaints and learn lessons. During the year 2017/18 our staff provided services to thousands of people; only a very small percentage expressed dissatisfaction by making a complaint as detailed later in this report. This annual report provides an insight into the number and types of enquiries, concerns, comments and complaints responded to by our patient experience team and directorate staff during the course of the year.

*Every concern or compliment we receive is taken seriously and is seen as an opportunity to learn and improve care.*

Our commitment to the above statement is demonstrated throughout this report with examples provided of how we listen, respond and learn from patient feedback.

## 2. Overview of PALS and Complaints

The Trust has a single point of access to Patient advice and liaison service (PALS) and Complaints through the Patient Experience Team. This approach provides service users, relatives, carers and the general public with access to PALS and Complaints via:

- Freephone telephone number
- Freepost address
- Dedicated text phone
- Dedicated Email address

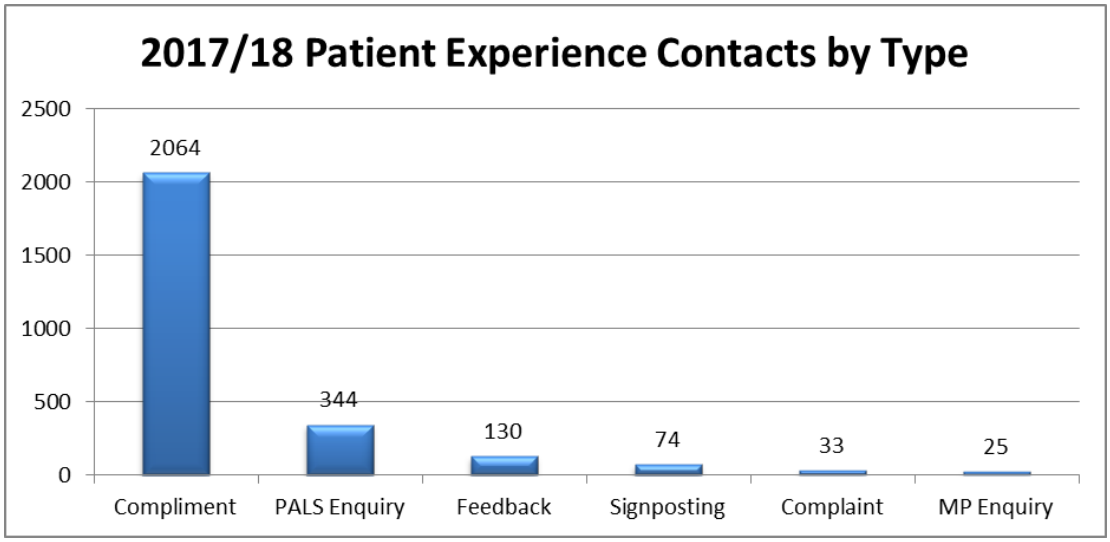
This joined-up service offers clients easy access whether they wish to offer a comment, pass on a compliment, make an enquiry, get support when navigating services, or make a complaint.

Additionally 'Listening, responding & improving' training is provided to front line practitioners. This training is regularly reviewed and brought up to date with emerging trends and themes along with best practice from the Parliamentary and Health Service Ombudsman, in respect of managing complaints and how we listen to, and deal with concerns.

We ensure that staff are aware of how to deal with issues as they arise offers patients a seamless and consistent response from the Trust and ensures we are making the best use of available resources.

**3. Patient Experience Activity 2017/18**

During the course of 2017/18, there were 2670 contacts recorded with the Patient Experience team. These contacts related to a combination of issues arising across most of the services provided by the Trust; the vast majority of which were compliments. The graph below illustrates the numbers and types of contacts received.

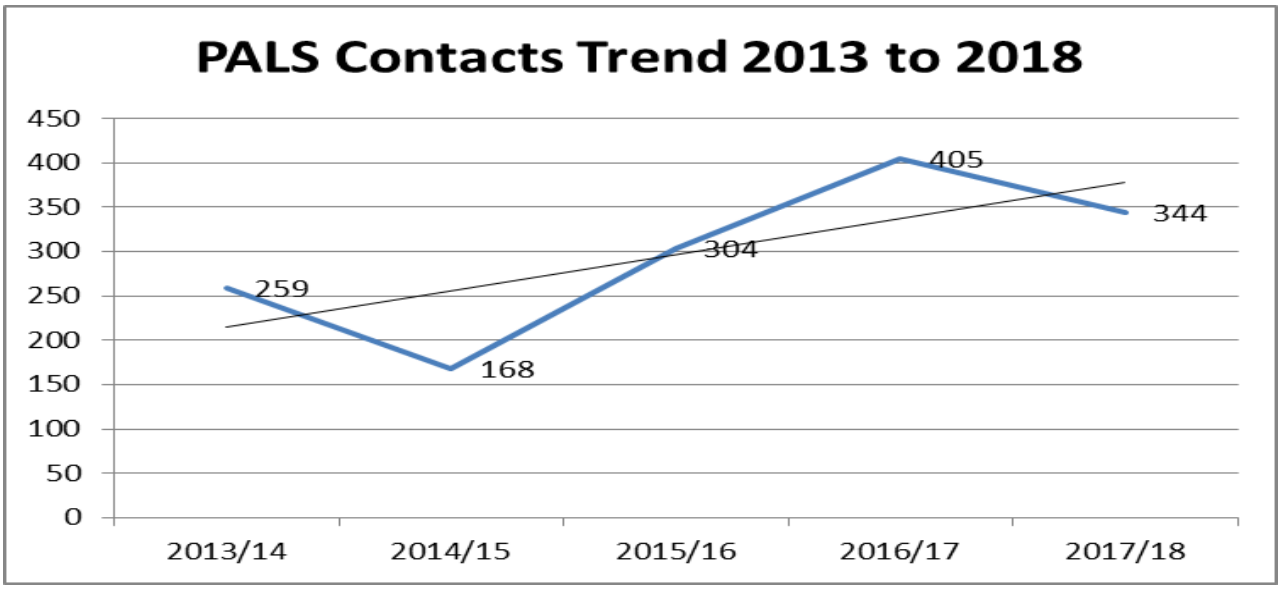



During 2017/18 formal complaints have reduced to 33 from 43 in the previous year. This is partly due to the Trust engaging with people raising concerns at a much earlier stage in order to resolve matters locally without recourse to the formal complaints process. This is a further reduction in formal complaints from 2015/16. A new holistic approach has been implemented to concerns raised whereby the Patient Experience Team engage with people to determine the outcome they are seeking and which approach is best suited to achieving the desired outcome. This has resulted in more issues being resolved, to the satisfaction of the person raising the concern, in a prompt and timely manner via the PALS process.

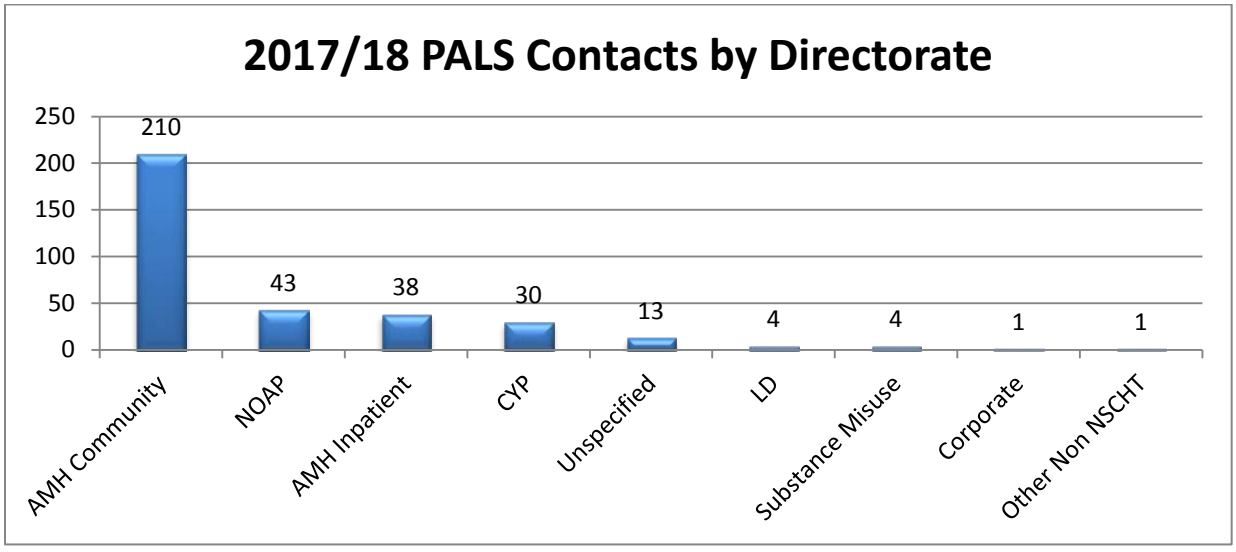
**3.1 PALS**

We recognise the importance of the PALS service in being a key source of information for service users, feedback for the Trust and an early warning system for emerging issues and concerns. PALS offer advice, help and support for patients, their relatives, carers and friends at times of need. We expect all staff to be open and responsive to concerns when issues are raised by

those who come into contact with, or use, our services. This demonstrates our commitment to providing the best service possible and shows that we are keen to learn and improve. We believe that all our staff have a duty to listen and respond to the best of our ability in order to assist patients, carers and families. To ensure that concerns raised are addressed and actioned by the right person in a timely way, the relevant Head of Directorate and team manager initially respond to outline the action taken to the individual concerned.



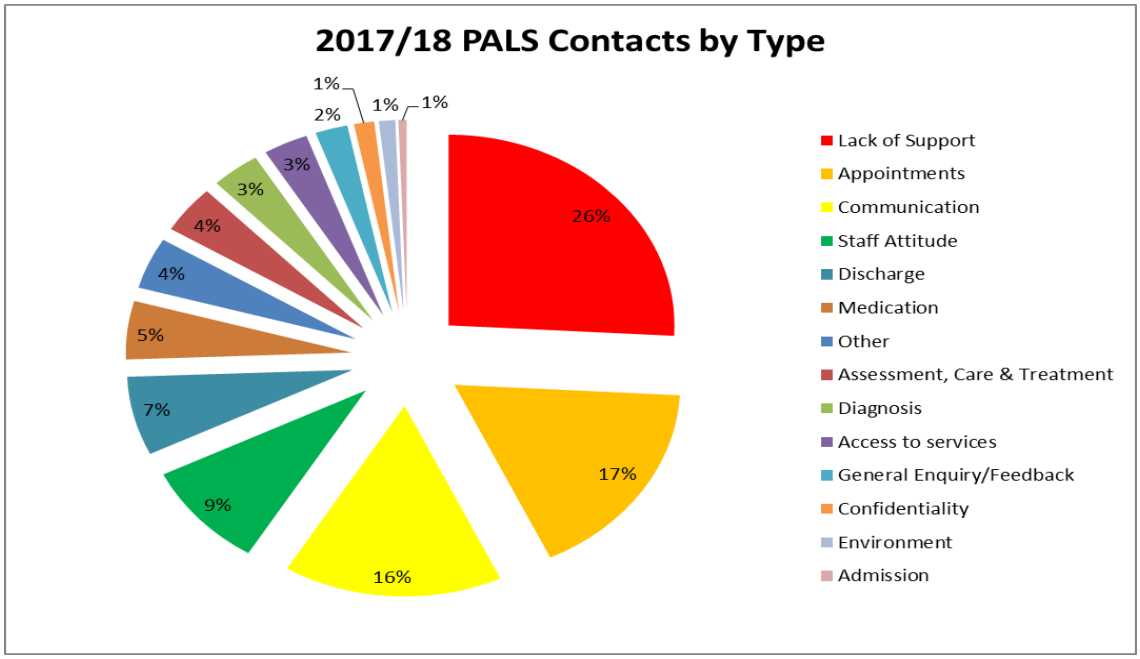

We welcome and encourage feedback from patients, their relatives, carers and friends about their experiences of our services; listening is at the centre of our philosophy. The majority of feedback to the Trust is received directly by care teams; nevertheless, there are times when comments and compliments are made via PALS. PALS received 344 contacts during 2017/18 compared to 400 in the previous year. People who contact this service often have several concerns or requests and this feedback helps to drive improvement. The breakdown by Directorate of PALS contacts during 2017/18 is shown below:



As AMH Community are by far our largest directorate it is expected that they have the highest number of PALS enquires as demonstrated in the graph above.

Each PALS contact is categorised and documented individually. It is then responded to by the PET; team managers are made aware of any PALS contacts and are required to provide a response to the person raising the concerns. If the contact is not resolved it is escalated to the Head of Directorate (HoD) with the aim of achieving resolution without the need to escalate to the formal complaints process.

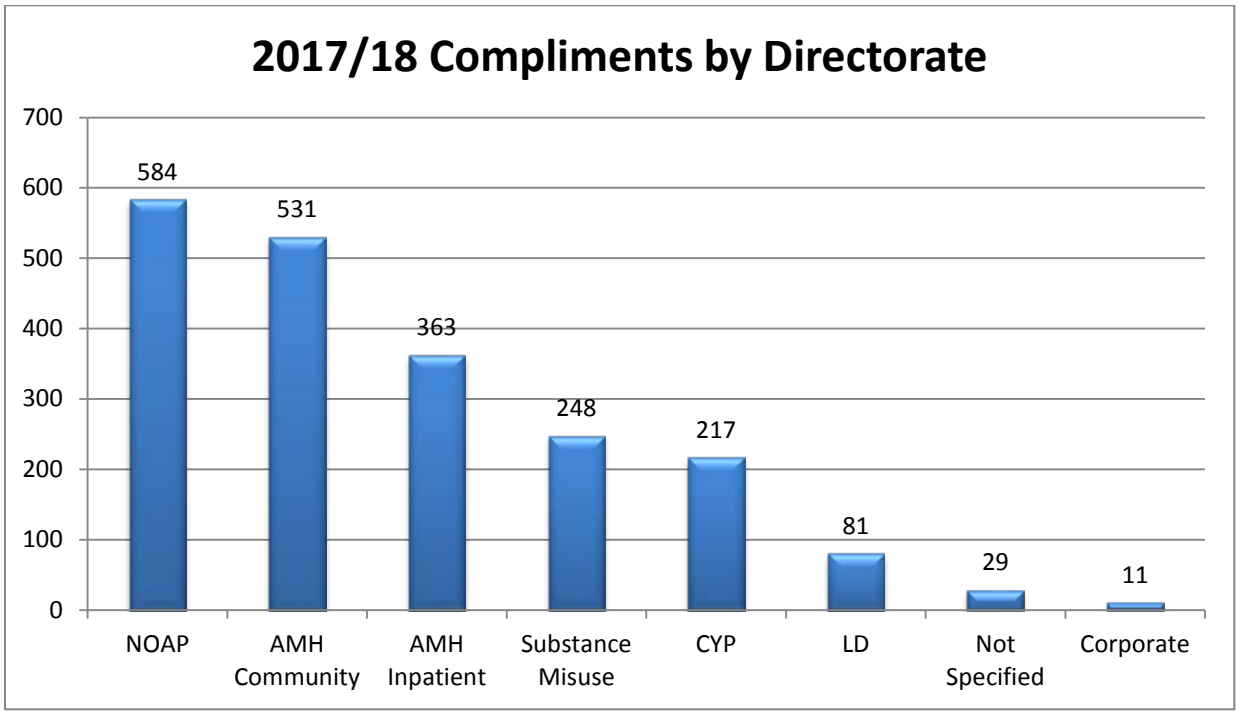
Key themes from PALS issues raised during 2017/18 are summarised as follows:

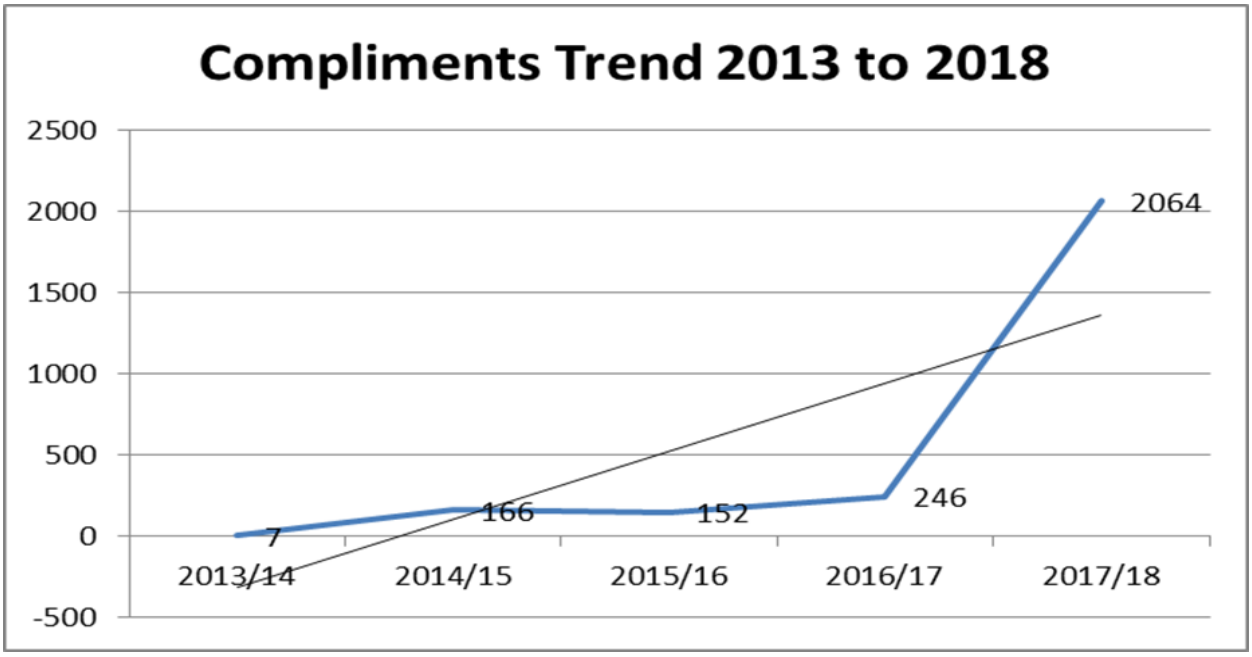



During 2017/18 the top 3 themes were identified relating to appointments, lack of support and lack of or poor communication. These were escalated to relevant HoD and actions taken to improve target these areas (e.g. bespoke team customer care training).

### 3.2 Compliments

During 2017/18 the Trust received 2064 compliments from service users and their families compared to 244 in the previous year. The graph below details the directorates and services who have received compliments. The significant increase is partly due to the Patient Experience Team capturing and recording positive comments from Friends and Families Test cards as compliments.



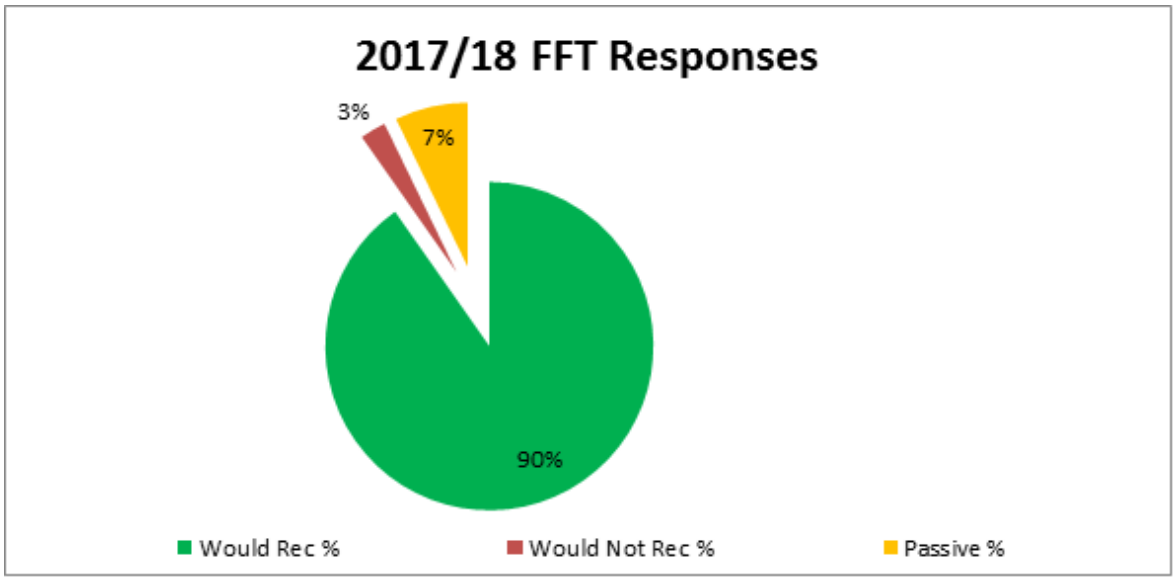




General themes include support given by staff delivered with kindness and sensitivity. Staff being willing to offer support to families and carers. There have been many examples of individual staff members being complimented for their professionalism and kindness. Compliments are routinely included in the bimonthly Learning from Experience report and the Quality Account. The Patient Experience Team attends the directorate quality forums and team meetings in order to discuss the learning from complaints and compliment. Examples of good practice are also shared through the Compliments Corner facilitated by the Communications team and the Learning

Lessons bulletin which is emailed to all trust staff.

### 3.3 Friends and Family Feedback

FFT is an important feedback tool that supports the principle that people who use NHS services should have the opportunity to provide feedback on their experience. We are pleased to report a significant increase in FFT returns across the Trust. In 2015 we were averaging 50 returns per month. In April 2017, this had increased to 550 per month as a result of the positive impact of a Trust-wide campaign and, importantly, provides a sense check of the service user experiences of our service. The graph below illustrates the 2017/18 responses and reflects that 90% of people using our services would recommend us as a place to receive care, 7% were undecided and only 3% would not recommend the Trust. Themes for dissatisfaction were perceived lack of support, poor communication and access to services/waiting times. All feedback received from the FFT process, both positive and negative is fed back to the directorates on a monthly basis in order to inform them of the things people are saying about their directorate and the actions required to inform improvements.




### 3.4 NHS Choices Feedback

NHS Choices is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

Forty seven people left comments during 2017/18 relating to the Trust on the NHS Choices website.

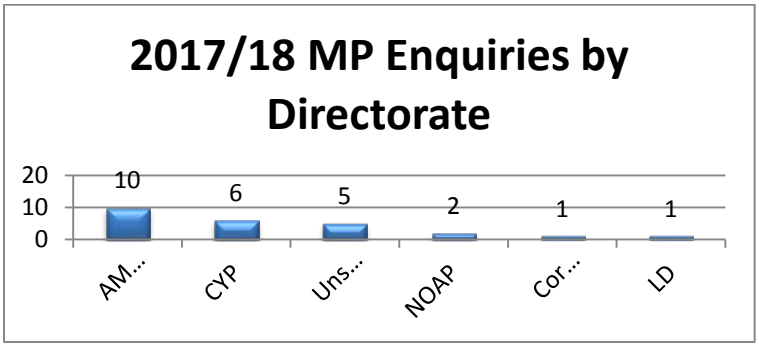
Of the 47 comments 17 reflected a positive experience and 30 reflected a negative experience. All comments were responded to by the respective directorates and the comments discussed at directorate meetings.

Adult Mental Health community Directorate received 42 comments (12 positive and 30 negative), the Greenfield and Sutherland Centres received most negative comments citing poor

communication and perceived lack of support as reasons for the negative comments. Adult Mental Health Inpatient Directorate received 2 comments which were both positive. NOAP, CYP and Substance Misuse Directorates each received 1 positive comment.

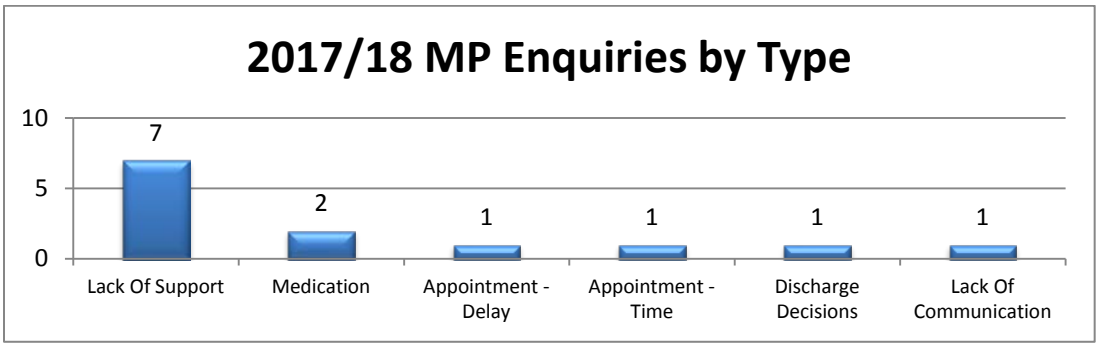
### 3.5 MP Enquiries

The Trust also receives enquiries from local Members of Parliament raising concerns which they have received from meeting their constituents. The graph below details the services involved in these enquiries during 2017/18:




Similar to Complaints, during 2017/18 there has been a reduction in MP enquiries with the Trust receiving 25 compared to 34 in the previous year. The highest number of MP enquiries relate to AMH Community services which is to be expected as it is the largest directorate, providing the most diverse range of services and with the highest volume of activity. The second highest relate to the Children and Young Peoples Directorate where most of these enquiries have related to waiting times for access to services. The Trust has recognised these difficulties and has been working with Commissioners to address the underlying issues and reduce waiting times. This has been successfully achieved and all children now have an initial assessment within 18 weeks.

The graph below illustrates the type of concerns which are being raised by constituents with their MPs:




The Patient Experience Team continue to host quarterly meetings with caseworkers from our local MP surgeries to review current trends in their wards and share with them Trust initiatives designed to address concerns raised by constituents with their MPs.

### 3.6 Complaints

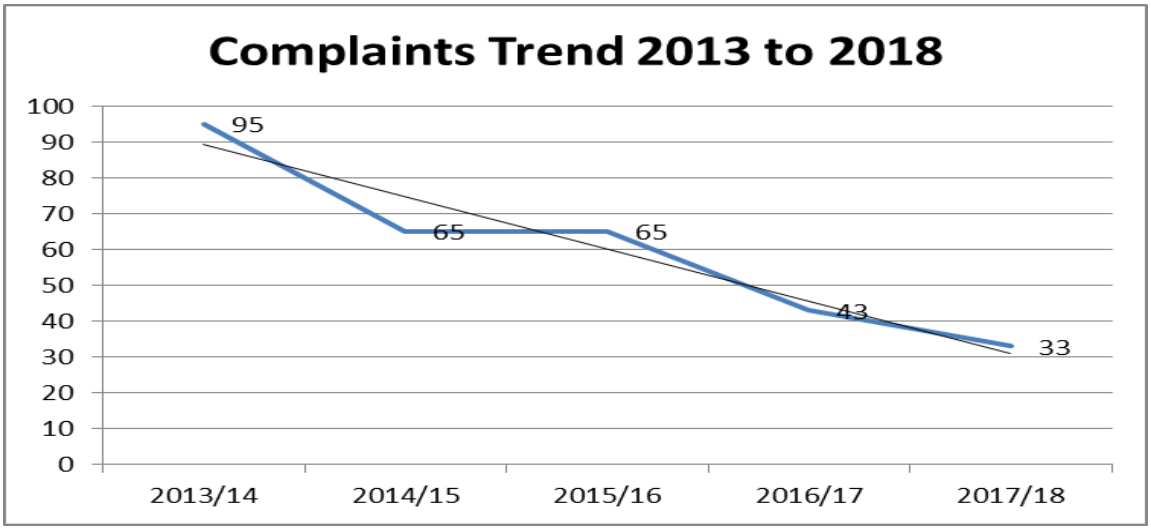
During 2017/18 all complaints were handled in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. A summary of the complaints was provided, on a quarterly basis, to our Quality Committee. Additionally, the Trust continues to adhere to the Patients Association published 12 NHS good practice standards for complaints handling.

The Trust has encouraged staff to attempt to resolve issues more quickly for service users by attempting early local intervention and resolution or by using the PALS process; this approach has proven to have been successful, as whilst our PALS contacts have stabilised, our formal complaints figures have reduced from 43 in 2016/17 to 33 in 2017/18.

Each of these complaints was investigated by the Trust and each complainant received a response that was personally reviewed by the Chief Executive.

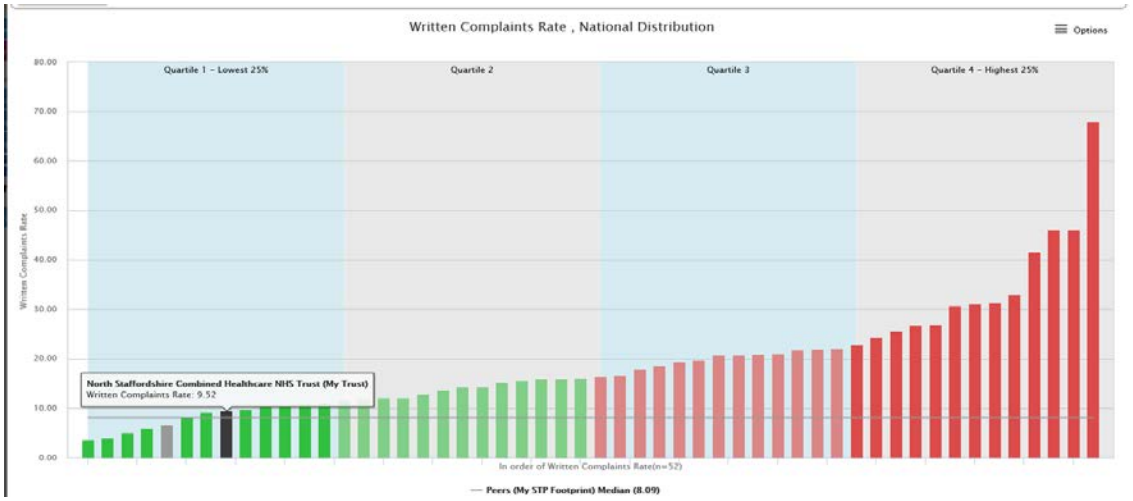
In the majority of these complaints a face to face meeting, with the Investigating Officer, was offered to the complainant during the review of the complaint, and a meeting with a Senior Manager to discuss any outstanding issues where appropriate.

The trend over the 5 years April 2013 to March 2018 shows a steady decrease in the number of complaints received. There remains a very low number of complaints when compared to the circa 25,000 patient contacts which are logged every month on the clinical information system.

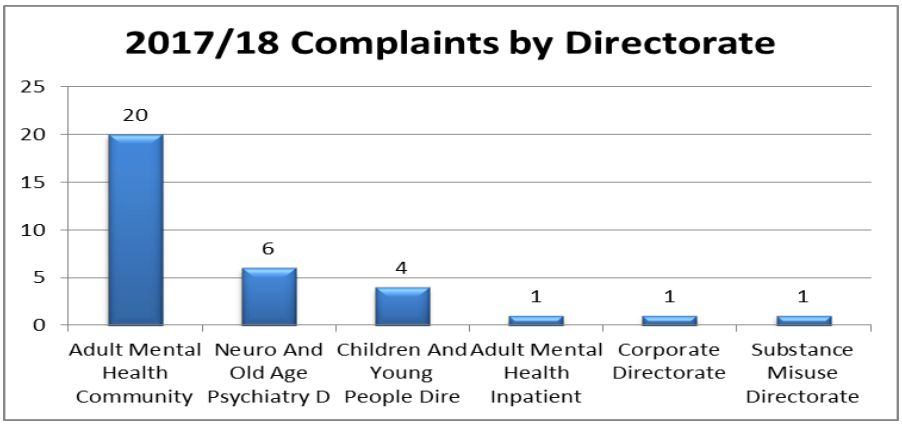



During 2017/18 the Trust received 33 formal complaints which when set against the 290,000 face to face and telephone clinical patient contacts equates to 0.01% of the clinical activity undertaken.

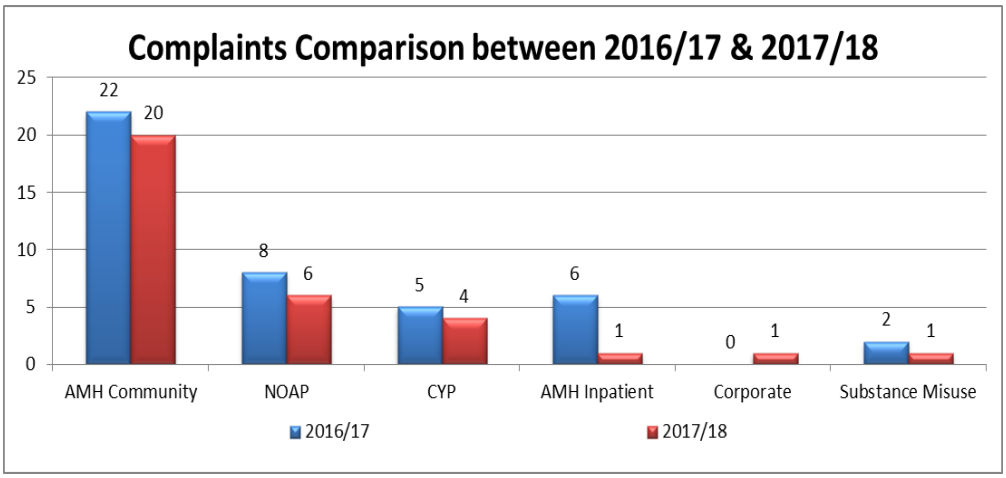
In comparison to other Mental Health Trusts the number of complaints we received during 2017/18 are very low as evidenced by the NHS National Mental Health Benchmarking Network data below. The network collects detailed information from members which allows for comparisons to be made between participating trusts. All Trust's in England are members of the Benchmarking Network along with most of the Welsh and Scottish Health Boards. Data is collated into weighted and unweighted reports which are published along with a toolkit which allows Trusts to undertake their own comparisons.

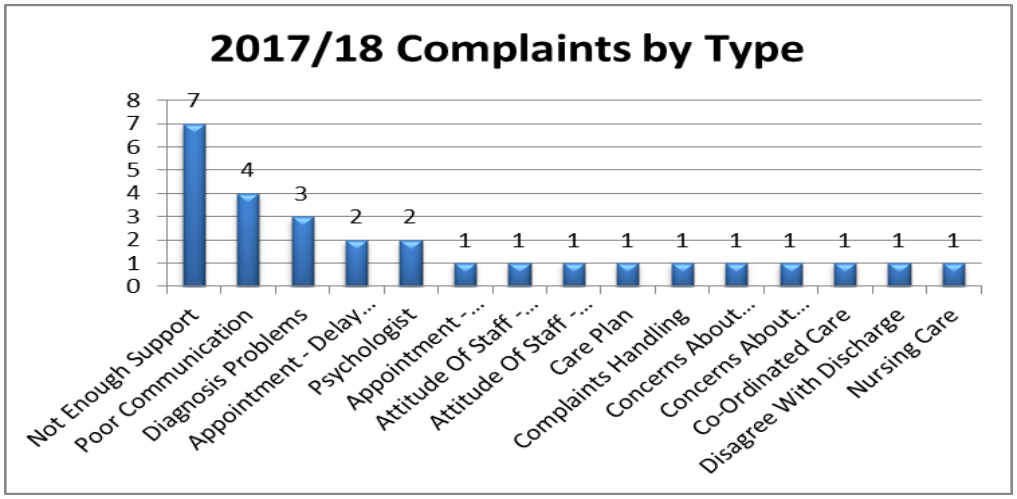



The above graph illustrates that the Trust (indicated by the black bar) has the eighth lowest number of formal complaints when compared to all other Mental Health Trusts who submitted data to the 2017 NHS Benchmarking Network, Adult Mental Health Benchmarking project. This graph takes into account varying trust sizes to give an overall weighted rating.




The graph above details the Directorates responsible for providing the services where complaints arose during 2017/18. It is to be expected that AMH Community services would generate the most complaints given that they have the highest volume of clinical activity which was circa 138 thousand clinical contacts during 2017/18 which is a percentage complaints to activity of 0.01%. Not enough support and poor communication being cited as the reasons for the AMH Community complaints. AMH community complaints have decreased from 22 in 2016/17 to 20 in 2017/18 as illustrated in the graph below. Complaints relating to AMH in-patients, NOAP, CYP, and LD have also decreased in 2017/18.




The graph above details the types of complaints received during 2017/18. Not receiving enough support and poor communication are continuing themes which have emerged from complaints which when analysed relate to AMH Community Directorate with the highest number being received in relation to the Sutherland and Greenfield Centres. Further work is being undertaken in collaboration with the AMH Community directorate to improve patient experience in these areas. Directorates receive a monthly report containing details of all their Patient Experience contacts and these are discussed at the AMH Community Quality Forum.

Due to the small number of complaints received it is not possible to identify themes in relation to any of the other directorates.

The Patient Experience Team has proactively worked with all teams during 2017/18 to try to address the issues detailed above. This has been through a revision of the monthly Listening, Responding and Improving training and the delivery of bespoke training for individual teams. Additionally we continue to deliver training sessions for the Preceptorship programme and for student nurses training programme.

Feedback from training sessions evidences that the training is generally well received with a high satisfaction rate reported. The PET team canvass and receive suggestions on future improvements for complaint handing and training in order to keep the training current and

relevant.

As a result of complaint investigations there are often actions which need to be incorporated into action plans. These action plans are drafted by the PET team and the directorate governance leads who are responsible for ensuring that all learning from the complaints is implemented, monitored and that learning is shared and embedded across their directorate. Additionally the Trust also monitors any complaint actions in the monthly Directorate meetings. This review and examination of the outcomes of investigations enables Senior Managers and clinical staff to reflect on their complaints. Assurance that learning from complaints is addressed and embedded is monitored by the Patient Experience Team.

**3.7 Complaints referred to the Parliamentary Health Services Ombudsman (PHSO)**

Should a complainant be unhappy with the way their complaint has been managed by the Trust they have the right to refer their complaint to the Parliamentary Health Service Ombudsman (PHSO) who will review all the relevant facts and make a judgement as to whether the complaint has been managed appropriately. The PHSO is the final stage for complaints about the NHS in England and public services delivered by the UK Government. They review complaints where someone believes there has been injustice or hardship, because an organisation has not acted properly or fairly or has given a poor service and not put things right.

During 2017/18 two complaints were reviewed by the PHSO. The Trust co-operated fully with the PHSO and provided all of the information they requested within the prescribed timescales.

Both complaints referred to the PHSO were from 2017/18. They have been reviewed by the PHSO and draft reports were received and commented upon by the Trust. The final report for one of the complaints has been received and had no recommendations for the Trust to consider. The Trust is awaiting the second final report from the PHSO which is likely to be partially upheld and the Trust will respond accordingly to any recommendations.

**4. Learning from feedback**

The Trust has facilitated a Learning Lesson's programme for over 7 years and this is a well-established forum for staff to share learning. This programme includes a bi monthly Learning Lessons bulletin and Learning Lessons Sessions for all staff to meet and share the learning from both complaints and incidents.

Two hundred and thirty staff attended a Learning Lessons Session during 2017/18. The team were delighted to welcome our Chairman David Rogers and other senior managers to some of

these sessions recognising the importance of Trust Board involvement in incident learning. The sessions have included learning from the National PHSO annual report as well as our local complaints, incidents and feedback. The emphasis for Learning Lessons this year has also been learning from excellence so the focus on what we do well to build on good practice as well as learning from incidents and complaints.

Staff feedback in relation to Learning Lessons continues to be 100% positive with staff generating ideas for future sessions and new staff attending every session showing the spread of the learning lessons initiative. As planned, we have utilised social media to spread the word of the initiative and the benefits of wider learning.

Any learning shared via the Learning Lessons programme is cascaded with each team by an identified Learning Lessons Lead who is responsible for sharing learning and publicising any Learning Lessons events. Additionally learning from complaints is discussed at the AMH Community Quality Forum.

Patients and carers contribute to the Learning Lessons programme by telling their story, either via attendance at the sessions or through the bulletins.

**5. Protected Characteristics**

In line with the national agenda the team have been gathering, and are able to report on, protected characteristic data from 2017/18. This information can be used to inform managers about hard to reach patient groups and to tailor services to meet the needs of specific groups.

Of the 33 complaints in the report 19 were from Females and 14 from Males, 32 were white British with 1 white Irish, 32 had no disability 1 had physical disability.
However, during 2017/18 there have been no themes arising in relation to protected characteristics. The PET team will continue to monitor and analyse protected characteristics and highlight any emerging themes or trends.

**6. Conclusion**

The Trust continues to seek and utilise service user and carer feedback in order to improve patient care. There has been a positive response to the holistic patient experience approach which has been strengthened over recent years. There has also been strengthened collaborative working with directorates who have invested valuable time in trying to resolve issues at a much earlier stage. This has resulted in fewer formal complaints and more issues being resolved to the satisfaction of the complainant through local resolution or the PALS process. There has been a significant increase in the number of compliments received and recorded which is another indicator that the Trust is improving the experience of service users and their families.

# REPORT TO: TRUST BOARD

Enclosure No: 12

| | | | |
|---|---|---|---|
| Date of Meeting: | 26 September 2018 | | |
| Title of Report: | Allied Health Professions (AHP) Trust Strategy | | |
| Presented by: | Maria Nelligan, Executive Director of Nursing & Quality | | |
| Author: | Don Walsh, AHP Lead | | |
| Executive Lead Name: | Maria Nelligan, Executive Director of Nursing & Quality | Approved by Exec | ☒ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| The development of an AHP Strategy is intended to describe how the Trust will harness the collective strengths and unique contributions of the AHP workforce to transform care, increase quality and embed a culture of improvement. The document describes how it will deliver the key themes of the national AHP framework as stated within the NHS England AHP Strategy (AHP's into Action 2017). It will require commitment and involvement at all levels including senior leaders, our AHP leads, our AHP's, stakeholders and from our communities. | Approval | ☐ |
| | Information | ☒ |
| | Discussion | ☐ |
| | Assurance | ☒ |

| | | |
|---|---|---|
| Seen at: | SLT ☐ | Date: |
| | Execs ☐ | Date: |
| Committee Approval / Review | • Quality Committee ☐<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☒<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Digital by Choice Board ☐ | |
| Strategic Objectives (please indicate) | 1. To enhance service user and carer involvement. ☐<br>2. To provide the highest quality services. ☒<br>3. Create a learning culture to continually improve. ☐<br>4. Encourage, inspire and implement research & innovation at all levels. ☐<br>5. Maximise and use our resources intelligently and efficiently. ☒<br>6. Attract and inspire the best people to work here. ☒<br>7. Continually improve our partnership working. ☐ | |
| Risk / legal implications: Risk Register Ref | None identified | |
| Resource Implications:<br><br>Funding Source: | None identified | |
| Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups) | Not directly as a result of this strategy | |
| STP/Alignment Implications | As part of our commitment to working with neighbouring Trusts and HEI to realise our ambition, working to professional strategies are encouraged within the STP workstream. | |
| Recommendations: | For Assurance | |

| Version | Name/group | Date issued |
|---|---|---|
| 1 | CHC AHP Network | 24.08.17 |

| | | |
|---|---|---|
| 2 | PCD | 06.12.17 |
| 3 | CHC AHP Network | 12.04.18 |
| 4 | CHC AHP Network | 28.06.18 |
| 5 | Maria Nelligan | 15.08.18 |

# North Staffordshire Combined Healthcare NHS Trust
# Allied Health Professions Strategy 2018 – 2021

Within our services, we are committed to working with neighbouring Trusts and HEI to realise our ambition.

This Strategy will be supported by an annual action plan taken forward by the AHP Network.

*Maria Nelligan*
*Executive Director of Nursing, AHP & Quality*

**Contents** **Page**

**Foreword**

It gives me great pleasure to introduce the Trust`s first AHP Strategy. AHPs are an essential part of the workforce in delivering the recovery agenda and specialist interventions to the people we serve.

This Strategy has been developed by AHPs to support the Trust to enhance MDT working for the benefit of service users, colleagues and the organisation. AHPs bring a wealth of knowledge and experience to individuals and teams and are an essential part of the Towards Outstanding programme. Recognising the valuable contribution AHPs bring to the organisation in 2017, we have made a commitment to strengthen AHP leadership both at corporate and Directorate level. We are also ambitious to develop a career pathway for newly registered AHPs and are keen to combine learning at all levels. This work is led by the AHP Network.

This strategy reflects the national AHP document and sets out the priority areas for development 2018-2020. Each year a work programme will be devised to take forward the Strategy. This will be implemented and monitored by the AHP Network. Through an annual CPD event, developments and learning will be shared with AHPs and the wider multi-disciplinary team.

This strategy sets out the vision for AHP's it aims to put the needs of service users at the centre of what we do at Combined. It aligns with the Trust`s vision and values in delivering outstanding client services.

*Maria Nelligan, Executive Director of Nursing, AHP & Quality*

## 1 Introduction

North Staffordshire Combined Healthcare NHS Trust (NSCHT) Allied Health Professions (AHP) strategy describes how we will harness the collective strengths of the AHP workforce, to transform care, increase quality and embed a culture of improvement. This strategy sets out the strategic AHP vision for AHPs.

### 1.1 Who are AHPs?

Allied Health Professions (AHPs) are the third largest national workforce in our health and social care system and have the influence, ability and scope to shape the future NHS (NHS England, 2017). AHP`s are well placed to deliver on the ambitions set by the Five Year Forward View (NHS England, 2014), the Care Act (legislation.gov.uk, 2014) and the Children and Families Act (Legislation.gov.uk, 2014) by improving health and wellbeing, driving improved quality and care across the health and social care system and delivering efficiencies to support an improved financial model.

Allied Health Professions are a diverse group of clinicians who deliver high-quality care to patients and clients across a wide range of care pathways and in a variety of different settings. AHPs work pro-actively using people centred interventions, promoting self–management and self-care where possible, with the aim of developing or maintaining physical, mental and social functioning. 'Framing the contribution of Allied Health Professionals' (DOH, 2008) noted that:-

*"These characteristics are essential for transforming health and social care. The knowledge, skills and experience they bring will be crucial if we are to continue to provide a sustainable service that not only 'adds years to life' but 'adds life to years'"*

**AHPs** are a group of **12 distinct professions** that form a critical part of healthcare delivery and include the following professions:-

Physiotherapists, Speech and Language Therapists, Occupational Therapists, Dieticians and Art, Music and Drama Therapists, Radiographers, Orthoptists, Podiatrists, Paramedics, Orthoptists

### 1.2 National AHP Strategy

In 2017 NHS England published a blueprint for Allied Health Professions, 'AHPs into Action'.

This strategy informs and inspires health and social care system's to best utilise allied health professions to support the delivery of future health, care and wellbeing services. It provides a framework for the way AHPs impact the wider health and care system and highlights the commitments and priorities required to achieve this ambition. The Trust`s AHP Strategy sets out our vision for the future, our aims, our collective responsibilities and our plan of delivery to achieve 'AHPs into Action' and support the Trust delivering its strategic objectives.

The National Strategy for `AHPs into Action` is set out in 3 key areas:-

**Impact** of the effective and efficient use of AHP`s for people and population.
**Commitment** to the way services are delivered.
**Priorities** to meet the challenges of changing care needs.

*Figure 1: NHS England, AHP Strategy AHP`s into Action*

Critically it defines how AHPs can support Sustainability and Transformation Plans (STPs), driving improvements in **health** and **wellbeing**, restoring and maintaining **financial balance** and delivering **quality standards** as set out in the **Five Year Forward View.**

*"The breadth of AHPs skills and reach across people's lives and organisations make them ideally placed to lead and support transformative change….therefore vital that this workforce is utilised to best effect to deliver the triple aim and address the three challenges facing the system."(AHPs into Action 2016)*

**AHPs: Adding Value to the Health and Care provision**

The enabling ethos of AHPs is geared towards building personal capability, community resilience and empowering people to take control of their own lives.

**AHP's are able to provide the following *unique* contributions:**

- Skills and expertise that help people to make changes to improve and maintain independence and quality of life.
- Add value to the health and care of the patients under the care of Combined Healthcare through appropriate skill mix, integrated working, economically sustainable services supporting people through Recovery and maximising optimum function in activities of daily living.
- Ensure economically sustainable services which support children, young adults and older adults to realise their full potential and improving life chance.
- Enable quality of life focus, supporting transitions between services and stages of health including the transition from child to adult.
- Cost effectiveness-Reduce demand and dependency through a person centred approach; AHPs contribute to the prevention of ill-health, prevention of in-patient admission, speed up recovery and diagnosis and support people of all ages and their families across the lifespan.
- Deliver improved outcomes – by understanding peoples abilities, needs and interests so that they can be supported to make informed choices and decisions affecting their lives.
- Maintain, improve and safeguard the health and well-being of people and the population.
- Work within an ethos which embeds health promotion and prevention as central to our services.
- Pro-actively work as part of a multi-disciplinary team.

### 1.3 AHPs @Combined

Within the Trust there are currently 4 AHP groups directly employed by the Trust working across the Trust Directorates. These professions are:

- Physiotherapy
- Occupational Therapy
- Speech and Language Therapy
- Art Therapy

The Trust also currently maintains Service Line Agreements (SLA`s) for the delivery of Dietetic and additional Speech and Language services.

### 1.4 Brief definition of AHP professional roles with the Trust:

**Physiotherapist**
Assess and treat people with physical problems caused by accident, ageing, disease or disability, using physical approaches in the alleviation of all aspects of the person's condition.

**Occupational Therapist**
Assess, rehabilitate and treat people using purposeful activity and occupation to prevent disability and promote health and independent function and recovery.

**Speech and Language Therapist**
Work with people with communication and/or swallowing difficulties.

**Art Therapist**
Provide a psychotherapeutic intervention which enables clients to effect change and growth by the use of art materials to gain insight and promote the resolution of difficulties.

For a broader description of AHP roles refer to Appendix 1 of the national Strategy `Allied Health Professionals into Action`: Using Allied Health Professionals to transform health, care and wellbeing. 2016/17 - 2020/21

https://www.england.nhs.uk/wp-content/uploads/2017/01/ahp-action-transform-hlth.pdf

## 2 Our Vision

This strategy aims to set out a vision for AHP staff in the Trust, demonstrating the clear links between AHP professional roles, the vision, values and objectives of the Trust.

*'In alignment with the local STP and the Trust vision, NSCHT AHPs, working in partnership with our communities, will support people to achieve their ambitions for how they choose to live their lives within safe, sustainable and economically viable services`*

## 3 Our Aims

Through the delivery of this AHPs will:

- Promote the ethos of person centeredness.
- Develop and challenge professional practice.
- Develop their professional skills to deliver high quality, productive and efficient models of care.
- Develop Trust wide shared professional role identity and ensure professional role clarity.
- Develop the workforce to be flexible, pro-active and agile to respond to the changes in demand or need from the local populations.
- Promote and develop AHP leaders.

- Be actively involved in the development of organisational systems and service redesign.
- Increase AHP influence and profile across the Trust.
- In collaboration with the Higher Education Institutions, design education pathways to ensure we have the right AHP workforce for the future.

## 4 Key Strategic Themes

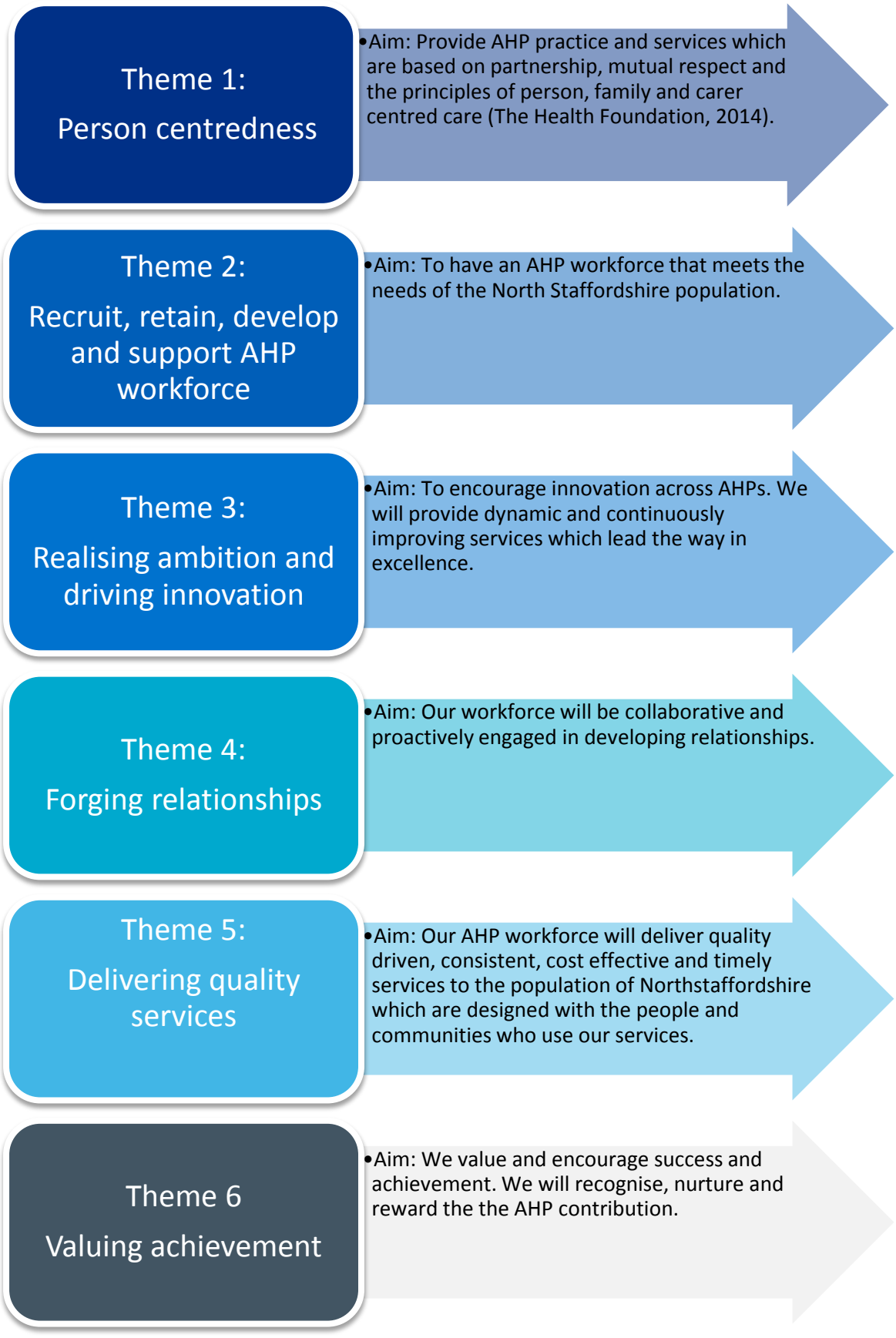
This strategy has been developed in consultation with the AHP workforce who has identified 6 key strategic themes, namely:

- Person centeredness
- Recruit, retain, develop and support AHP workforce
- Realising ambition and driving innovation
- Forging relationships
- Delivering quality services
- Valuing achievement

These themes are aligned to support our commitment to work together and to each individual Allied Health Professions own professional standards.

The themes, alongside the key principles of prevention, assessment, diagnosis, recovery, rehabilitation and enablement will define how AHPs and their teams deliver care within the MDT setting. The delivery of the action plan contained in Appendix 3 will necessitate strong leadership, commitment and collective endeavour to support and lead the transformation of our services across the Trust and the wider North Staffordshire Health and Social Care System.

**Table 1: Combined Healthcare Allied Health Profession's Strategic Themes**



This strategy describes how we will harness the collective strengths of the AHP workforce, to transform care, increase quality and embed a culture of improvement. It will achieve this by demonstrating how each theme will deliver the national AHP framework as described in the NHS England AHP strategy (AHPs into Action 2017)

It will require commitment and involvement at all levels including our system leaders, stakeholders, our AHP leads, our AHPs and from our communities.

## 5 Senior Trust Leaders Commitment

1. To ensure that AHP's are involved at all levels of system change, service design and transformation of our health and social care system by giving support and authority to use their collective professional expertise for positive service change and workforce planning.
2. To provide the conditions in which AHPs are able to lead on, and work in partnership, to dissolve barriers across the spectrum of health and social care system and embed a culture of continuous learning and improvement as outlined in the Developing People - Improving Lives (NHS England, 2016).
3. Use AHPs as major contributors in the development of a culture focused on prevention, diagnosis, recovery and rehabilitation.
4. Support continued professional development, research generation, implementation and evaluation of AHPs.

## 6 AHP Leaders Commitment

1. To work together to implement this strategy, collectively pursuing shared goals and actively encouraging AHPs to engage at all levels.
2. Actively engage at a national, regional and a local level to ensure local alignment with national, regional and local programmes of work, including; local NSCHT System Transformation Plans, the National AHP Strategy (NHS England, 2017) and the programmes originating from NHS England, NHS Improvement, Health Education England and the National AHP Informatics Strategy.
3. Champion the AHPs contribution to system change towards an enabling culture, particularly contributing towards the prevention, assessment, diagnosis, recovery, rehabilitation, enablement, self-management and return to work agendas as described in the National Rehabilitation Commissioning Guidelines (NHS England , 2016).
4. To lead on and contribute to workforce planning, recruitment and retention including development of valued support worker roles and career pathways.

## 7 Individual AHP Staff Commitment

1. To work together with professional colleagues and the community, across service and organisational boundaries to maximise the opportunities to implement this to improve all aspects of service delivery and embed a culture of MDT working, collective learning and improvement.
2. To take personal responsibility to ensure that practice meets the highest standards, meeting Health and Care Professions Council (HCPC) standards and underpinned by research based evidence.
3. Ensure delivery of Safe, Personalised, Accessible and Recovery focussed care.

4. To demonstrate both the quality and cost effectiveness of the services they provide individually and collectively.

5. To take on a collective responsibility for, and actively support the Trust values and STP delivery to transform care.
6. To demonstrate a commitment to lifelong learning, to continuously improve and challenge practice standards.
7. Demonstrate a commitment to Student education.

## 8 Summary/Conclusion

To allow us to understand that the vision and aims of this strategy are achieved, we will develop an annual work plan which will be implemented and overseen by the Trust-wide professional AHP Network.

We will share achievements by holding an annual event to share practice and celebrate achievements.

## References

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Royal College of Speech and Language Therapy. (2006). *Communicating Quality 3*. Royal College of Speech and Language Therapy.

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The Health Foundation (2014) Person-centred care made simple. The Health Foundation.
The Kings Fund (2016) Support integration through new roles and working across boundaries. London: The Kings Fund.

## Appendix 1: High Level Action Plan

**Theme 1: Person centredness**

- Aim: Provide AHP practice and services which are based on partnership, mutual respect and the principles of person, family and carer centred care (The Health Foundation, 2014).

| **Objective :** | **Action:** | **Measured by:** |
|---|---|---|
| We will support people to make informed decisions about, and to successfully manage, their own health and care. We will enable people to use information related to themselves and their services and choose when to invite others to act on their behalf.<br><br>Ensure the provision of timely and effective person centred interventions and care.<br><br>We will commit to care for those who care.<br><br>We will work in partnership to deliver care responsive to people's individual abilities, preferences, lifestyles and goals. | • Standardise practice within professions and ensure professional outcome measurement with collaborative care plans with goals negotiated and set with the person.<br>• Work with service user groups, communities and carers to design and develop services.<br>• Increase feedback from people who use our services.<br>• Develop and design communication materials alongside people who use our services, ensuring that these are relevant, accessible and that they provide the information people need and want in a language they understand. | • Outcome measures and service user goal attainment.<br>• Audit /Evidence of AHPs profession specific supervision and appraisals.<br>• Audit /Evidence of collaborative, partnership working with service users, third sector organisations and community groups.<br>• Continuing practice development programmes reflecting person centred principles.<br>• Implementation of service user feedback systems across AHP services<br>• Evidence of action plans from service-user feedback |

## Theme 2:

## Recruiting, retaining, developing and supporting our AHP workforce

- Aim: To have an AHP workforce that meets the needs of the population of North Staffordshire.

| **Objective:** | **Action:** | **Measure by:** |
|---|---|---|
| We will develop a clear understanding of the current and future AHP workforce needs for NSCHT.<br><br>To ensure an AHP workforce that meets the needs of the service users. We will provide support and professional practice structures which embed a culture of excellence and proactivity.<br><br>To develop flexibility we will develop boundary-spanning skills across the AHP workforce (The Kings Fund, 2016)<br><br>We will ensure that AHP professional roles are protected and recognised as essential to delivery of effective and pro-active care delivery. | • Development of a robust professional leadership structure and embed professional leadership capability within and across the trust.<br>• Undertake an AHP workforce review.<br>• Develop our future AHP workforce including establishing new roles across all staff levels including extended scope, consultant level, advanced practitioner, rotational programmes, bank posts, support staff development opportunities and supported by outreaching into schools and colleges, including exploring new options by developing a plan for AHP apprenticeships working with academic institutions.<br>• Build continued professional development and service improvement capability based on the highest standards of professional and clinical practice supported by robust professional supervision and appraisals. | • Evidence of a clear professional and clinical AHP leadership structure.<br>• Senior AHP staff structure providing leadership, advocacy to ensure strong governance systems and process at all levels.<br>• Appointment of substantive AHP Trust Lead<br>• AHP engagement in Leadership development.<br>• Establishment and recruitment to a range of AHP innovative and flexible roles across professions including apprenticeships, extended scope roles and establishment of senior clinician role at consultant level.<br>• Recorded standardised Professional supervision and appraisals for all AHPs.<br>• Improved staff survey results<br>• Recruitment and retention of staff<br>• Evidence of and commitment to ensuring access to range of professional CPD opportunities for all AHP staff. |

## Theme 3:

## Realising ambition and driving innovation

- Aim: To encourage innovation across AHPs. We will provide dynamic and continuously improving services which lead the way in excellence.

| **Objectives:** | **Action:** | **Measured by:** |
|---|---|---|
| We will develop an AHP workforce which is, research active, who publish readily and work within a culture of evidence based practice, continual learning and improvement | • Develop clear professional structures and career frameworks<br>• Promote active engagement in continuous improvement and active learning.<br>• Collaboration across the system and professions to learn together, share skills, and develop clinical effectiveness based on evidence based practice and professional standards. | • Leaders at all levels, with an AHP voice, ensuring diversity and multi-professional to decision making about care. Increased number of AHPs completing leadership programmes.<br>• A robust career structure with the development of new ways of attracting people into our services e.g. AHP apprenticeships, AHPs seeking to join the system.<br>• Improvements we make to the clinical outcomes and experience of our service-users, their carers' and families and the local population<br>• Clinical Audit programmes which demonstrate service improvement.<br>• Increased numbers of AHPs publishing in professional publications and journals |

## Theme 4: Forging relationships

- Aim: Our workforce will be collaborative and proactively engaged in developing relationships.

| **Objectives:** | **Actions:** | **Measured by:** |
|---|---|---|
| AHPs will work together and with others across the system placing the person at the centre of care. | • To work across professions, care groups and organisations to ensure seamless transitions.<br>• Develop a network between community groups and AHPs.<br>• Strengthen links with universities to develop undergraduate education programmes and apprenticeships that deliver a workforce that meets the needs of the population.<br>• Link with external establishments to establish Continuous Professional Development, research opportunities and networks. | • Evidence of seamless care between services and organisations.<br>• Evidence of AHP services co produced with the community and service users.<br>• Clearly defined person centred and shared goals. |

## Theme 5:

## Delivering quality services

- Aim: Our AHP workforce will deliver quality driven, consistent, cost effective and timely services to the population of North Staffordshire which are designed with the people and communities who use our services.

| **Objective :** | **Actions:** | **Measured by:** |
|---|---|---|
| We will achieve consistent, high quality services across all areas of care. | • Develop intelligence on the value we bring in terms of improved health outcomes.<br>• Systematic use of evidence based practice, outcome measures.<br>• AHP documentation integrated into IT systems.<br>• Develop a culture of service improvement to increase efficiency and value.<br>• Co-design services with services users focused on quality and effectiveness.<br>• Develop our staff so that they have the right capability, training and skills to deliver safe and high quality care.<br>• Promote a positive risk taking approach. | • Increased service-user satisfaction measures and quality of life measures.<br>• Outcomes evidencing effectiveness of AHP services.<br>• Reduction in services/practice which do not add value.<br>• The right staff doing the right job, in the right place, every time.<br>• Increased service user, third sector and community collaboration.<br>• Decreased duplication across the system. |

## Theme 6: Valuing achievement

- Aim: We value and encourage success and achievement. We will recognise, nurture and reward the the AHP contribution.

| **Objectives:** | **Actions:** | **Measured by:** |
|---|---|---|
| We will develop a system wide leadership capability to create a culture in which AHPs flourish.<br><br>Our AHP workforce will have an improvement, development and research culture embedded into everyday practice.<br><br>We will recognise and reward AHP's contributions.<br><br>Events to promote AHP workforce , which will include annual AHP Conference. | • Develop a internal and cross professional mentorship capability.<br>• Nurture learning forums and establish clinical networks.<br>• Encourage a culture of research active practitioners – using, implementing and developing evidence as standard.<br>• Commit to developing, using and embedding improvement methodology across the AHP workforce.<br>• Promote a collaborative AHP culture by establishing mechanisms for sharing and working together and creating opportunities to communicate success and shared learning. | • Staff surveys which show increasing levels of satisfaction at work.<br>• Establishment of inter and cross professional networks.<br>• High numbers of AHPs with improvement methodology expertise.<br>• Establishment of collaborative events to celebrate success and create a shared learning platform.<br>• Use of technologies to share knowledge and learning.<br>• Annual AHP conference event.<br>• Regular AHP Engagement in Schwartz Round |

NHS
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Combined Healthcare
NHS Trust

# REPORT TO OPEN TRUST BOARD

Enclosure No:13

| | | | |
|---|---|---|---|
| Date of Meeting: | 26th September 2018 | | |
| Title of Report: | Medical Appraisal and Quarterly Update Sept 2018 / 2017/18 Annual Organisational Audit | | |
| Presented by: | Dr Darren Carr, Clinical Director, NOAP | | |
| Author: | Robert Walley, Medical Staffing Manager | | |
| Executive Lead Name: | Dr Adeyemo, Executive Medical Director | Approved by Exec | ☐ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| This paper outlines the review of the Medical Appraisal and Revalidation action plan in 2018/19. Also attached is the review of the AOA for Medical Appraisal and Revalidation for 2017/18 for information. | Approval | ☐ |
| | Information | ☒ |
| | Discussion | ☐ |
| | Assurance | ☒ |

| | | | |
|---|---|---|---|
| Seen at: | SLT ☒ Execs ☐<br>Date: Sept 18 | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☐<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☒<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Digital by Choice Board ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement.☒<br>2. To provide the highest quality services ☒<br>3. Create a learning culture to continually improve.☐<br>4. Encourage, inspire and implement research & innovation at all levels.☐<br>5. Maximise and use our resources intelligently and efficiently.☒<br>6. Attract and inspire the best people to work here.☒<br>7. Continually improve our partnership working. ☐ | | |
| Risk / legal implications:<br>Risk Register Ref | N/A | | |
| Resource Implications:<br><br>Funding Source: | N/A<br><br>N/A | | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups) | There is no direct impact on the protected characteristics as part of the completion of this report; | | |
| STP Alignment / Implications: | None | | |
| Recommendations: | For assurance | | |

# 1. Introduction

This is the first quarterly report to SLT following on from recommendations to monitor the medical appraisal process in May 2018.

The Trust has, in 2017/18, achieved a 100% appraisal and revalidation rate. One Doctor's appraisal was completed after 31st March deadline, which resulted in a 97.5% appraisal rate for the Trust's Annual Organisational Audit.

# 2. PCD Recommendations

After reviewing the 2017/18 Annual Organisational Audit, one Doctor had missed their appraisal. In order to prevent this from happening in future, PCD recommended:

1) SLT receive a quarterly update on medical appraisal details, and
2) PCD will receive an annual report.

# 3. Action Plan Update

The first monthly appraisal and revalidation monthly report has gone to the Trust lead appraiser and medical director in September.

The medical staffing department are offering support to appraisees where they may have difficulty using the Allocate appraisal system.

# 4. Medical Appraisal Rates in September 2018

As of September 2018, out of 39 doctors:

- 8 had completed their appraisal between April and September 2018
- 21 have booked dates for their appraisal (5 of which have been delayed)
- 11 are yet to confirm an appraisal date with their appraiser

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# Quality Assurance for Responsible Officers and Revalidation

## Annual Board Report 2017-18

## Contents

## 5. Executive summary

This is the sixth annual board report since the introduction of medical appraisal and revalidation in 2012. The Trust has, in 2017/18, achieved a 97.5% appraisal and revalidation rate.

## 6. Purpose of the Paper

This report outlines the overall appraisal and revalidation rates of medical staff in the Trust, the governance procedures and policies in place to support and maintain high quality appraisals.

## 7. Background

Revalidation is the process by which all doctors will satisfy the GMC (at 5 yearly intervals) that they are fit to practice and should retain their license. Strong medical appraisal systems (and application) are the bedrock of this process, as is a culture which fosters good professional practice. Revalidation is about making a positive statement of assurance about a doctor's fitness to practice – not merely the absence of reported concerns. Medical appraisal and revalidation aim to strengthen patient confidence, and support the provision of high quality medical care.

This report is the Trust's sixth end of year report on Medical Appraisal and Revalidation since the government's revalidation plans were signed off by the Health Secretary in December 2012.

# 8. Governance Arrangements

Appraisal and revalidation for 2017/18 has been monitored using a system which gives appraisers, appraisees and system administrator a live update of the progress on their appraisal.

Outline of Responsibilities:

**Responsible Officer (RO)**

i. Ensuring that an effective Trust-wide appraisal system is in place for all Consultant and career grade medical staff.

ii. Ensuring that training is in place for appraisers to provide information to the GMC as appropriate to support revalidation processes.

iii. Providing an appraisal and revalidation report to the Board on an annual basis.

iv. Making recommendations about revalidation to the GMC based on feedback from appraisers and other Trust performance management information

v. Appointing a medical appraiser coordinator (management rep or lead medical appraiser) to lead and coordinate the activities of the medical appraisers.

**Medical Appraisal Co-ordinator**

A. To co-ordinate and monitor the annual medical appraisal process, in conjunction with the RO, ensuring that all doctors with whom the Trust has a 'prescribed connection' have an annual appraisal (i.e. those doctors employed wholly or mainly by the Trust) or that the reasons for non-completion of the appraisal process are documented.

B. To facilitate an annual review of the medical appraisal and revalidation process along with the RO and medical appraisers.

C. To identify areas of potential concern to the Responsible Officer.

**Medical Appraisers**

1. To undertake appraisals within each appraisal period – generally appraisers are expected to undertake a minimum of 2 and a maximum of 5 medical appraisals annually.
2. To participate in appraisal training and maintenance of their appraisal skills and current knowledge of the medical appraisal process and discuss their performance and skills as an appraiser in their own medical appraisal. This includes seeking and reflecting on feedback from appraisees.
3. To participate in medical appraisal review meetings as required by the RO.

# 9. Medical Appraisal

## a. Appraisal and Revalidation Performance Data

Number of doctors: **39**

Number of completed appraisals: **38**

Number of doctors in remediation and disciplinary processes: **0**

## b. Appraisers :

There are 10 appraisers in the Trust. The Trust maintains appropriately trained appraisers based on a minimum ratio of 1:5 appraisers to appraisees.

Medical appraisers commit to undertake the core requirements of this role, and are expected to demonstrate the core competencies, as set out in the Trust's Medical Appraisal Policy.

Appraisers undertake initial appraisal training to the standard set out by the Revalidation Support Team (RST), and take part in an annual review of their performance as an appraiser within their own medical appraisal. Update appraiser training is provided as appropriate. The RO and medical appraisal coordinator provide support to medical appraisers on request. Medical appraisers are encouraged to seek peer support from fellow appraisers and to engage in regular discussion about their performance in the role.

The need for both initial appraisal training (for new medical appraisers), and update and/or refresher training (for established medical appraisers), is reviewed on an annual basis by the medical appraisal lead and the medical appraisal coordinator.

The need for training or support for medical appraisees is also reviewed on an annual basis.

## c. Quality Assurance

The Allocate Software system ensures that the Trust are following previous audit recommendations on the quality of medical appraisals.

The first annual internal spot-check took place in September 2017 to review the appraisal process and that documentation was been recorded correctly. The aim of the spot check is to ensure: The quality of appraisals and revalidation is assured in relation to both assurance of the process and assurance of the appraiser work:

- Appraisees are asked by the appraiser for feedback on their experience of medical appraisal by their medical appraiser as part of the appraisal process.

- Appraisees are invited periodically (ideally annually) to participate in a short anonymous survey of medical appraisal experience within the Trust. Appraiser performance will be reviewed by analysis of feedback from these questionnaires.

- Appraisers are asked to take part in a self-assessment for their role as an appraiser on an annual basis and to discuss this in their own appraisal and annual RO- appraiser review meeting.

All three appraisals in the spot check were found to meet the above criteria.

### d. Access, Security and Confidentiality

Appraisal folders are accessible only by the appraisee and, once submitted, the appraiser. Folders are stored on a secure system by password protection. No one else, other than a restricted number of system administrators, can access this information.

## 6. Revalidation Recommendations

All eligible doctors in the Trust received a positive recommendation. There were no delays, deferrals or non-engagement notifications.

## 7. Recruitment and engagement background checks

All permanent and temporary (including agency) medical staff are subject to the NHS pre-employment check standards.

## 8. Monitoring Performance

The annual job plan review and appraisal process ensures that performance standards are maintained and reviewed annually.

## 9. Responding to Concerns and Remediation

In the event of a complaint about the conduct or performance of a doctor in their role as medical appraiser, every effort should be made to address and resolve these informally between the parties to the appraisal. Where difficulties cannot be resolved informally, the doctor should pursue their complaint under the Trust's Grievance Procedure.

Any complaints about the Trust's appraisal process itself should be referred to the responsible officer (RO) or medical appraisal coordinator.

No complaints have been made in the current reporting period.

## 10. Risks and Issues

One Specialty Doctor failed to engage in their appraisal process by 31st March 2018 deadline, citing reason of difficulty in arranging an appointment with their appraiser.

There have been no risks or other issues reported around the appraisal and revalidation process or systems.

## 11. Board Reflections

The Trust Board is asked to note the contents of this end-of-year review.

## 12. Corrective Actions, Improvement Plan and Next Steps

The capacity within Medical Staffing ensures that the administration management of Appraisals and Revalidation will be improved in 2018-19 and will help to prevent future deferrals of appraisals.

With effect from May 2018, the Appraisal and Revalidation Administrator will provide:

- a monthly update report to the Medical Director and Trust Lead Appraiser
- a quarterly update report to SLT
- an end of year report to PCD

## 13. Recommendations

We recommend that the board accept this report (please note that it will be shared, along with the annual audit, with the higher level responsible officer).

The Trust's Statement of Compliance will also be supplied to the higher level responsible offer.

# REPORT TO TRUST BOARD

Enclosure No:14

| | | | |
|---|---|---|---|
| Date of Meeting: | 26th September 2018 | | |
| Title of Report: | Smoke Free Progress Report | | |
| Presented by: | Dr Darren Carr, Clinical Director, NOAP | | |
| Author: | Amanda Miskell – Consultant Nurse, Physical health (PH) | | |
| Executive Lead Name: | Dr Adeyemo – Medical Director | Approved by Exec | ☒ |

| Executive Summary: | | Purpose of report | |
|---|---|---|---|
| To provide the Board with assurance in relation to the "Smoke Free" arrangements within the Trust. | | Approval | ☐ |
| | | Information | ☒ |
| | | Discussion | ☐ |
| | | Assurance | ☒ |
| Seen at: | SLT ☒ | Date: 11th September 2018 | |
| | Execs ☐ | Date: | |
| Committee Approval / Review | • Quality Committee ☐<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☐<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Digital by Choice Board ☐ | | |
| Strategic Objectives (please indicate) | 1. To enhance service user and carer involvement. ☐<br>2. To provide the highest quality services. ☒<br>3. Create a learning culture to continually improve. ☒<br>4. Encourage, inspire and implement research & innovation at all levels. ☐<br>5. Maximise and use our resources intelligently and efficiently. ☒<br>6. Attract and inspire the best people to work here. ☐<br>7. Continually improve our partnership working. ☒ | | |
| Risk / legal implications: Risk Register Ref | | | |
| Resource Implications:<br><br>Funding Source: | Purchase of E cigs as a pilot arrangement and ongoing Nicotine Replacement (NRT) costs. | | |
| Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups) | There is no direct impact on protected characteristics in relation to the completion of this report. | | |
| STP Alignment / Implications | None | | |
| Recommendations: | For assurance | | |

| Version | Name/group | Date issued |
|---|---|---|
| V1 | CEG | 31/08/2018 |
| V2 | | 04/09/2018 |
| V3 | | 05/09/2018 |
| V4 | Board | 18/09/2018 |
| V1 | SLT | 31/08/2018 |
| V2 | | 04/09/2018 |

| | | |
|---|---|---|
| V3<br>V4 | <br>Board | 05/09/2018<br>18/09/2018 |

## 1. Purpose of the report

This report will update and provide assurances for quarter one (Q1) and the majority of quarter 2 (Q2) on Smoke Free including the use of E-cigs, and the prevalence of issues, including regional, national and those within the organisation.

## 2. Update on position

All inpatient areas are now smoke free, with Edward Myers Unit (EMU) becoming smoke free on 1st July 2018. This has been an accumulation of all the actions since February 2017 when Combined commenced its "Towards Smoke Free" Journey. This journey included the formation of a Task & Finish Group (T&FG) chaired by the Executive lead Dr Adeyemo. The final action plan and progress may be viewed as appendix 1.

## 3. Smoke Free Task & Finish (T&F) Group

The T&F Group continues. This group is chaired by Dr Adeyemo, the Executive lead for Smoke Free at the Trust.

## 4. Acute meetings

In addition to the above, meetings have been arranged and conducted with the Acute inpatient services. These have concluded with actions for operational staff led by the Head of Directorate and Ward Managers.

## 5. Policy

The smoke free policy has been developed and following governance approval and ratification is now available on SID (intranet). This has been updated following feedback from staff to provide more clarity. There is also an accompanying Standard Operating Procedure (SOP) which describes the use of Nicotine Replacement Therapy (NRT), administration, and the review timelines in relation to contra indications with medications. As part of the discussions, the T&F Group developed and approved an administration form for registered nurses who could give several products to patients within 30 minutes of arriving at hospital. This mitigates the risk of withdrawal by waiting for a doctor or Non-Medical Prescriber (NMP) to prescribe and is seen as best practice.

## 6. Frequently Asked Questions

In addition to the policy and SOP a Frequently Asked Question (FAQ) document has also been developed to support staff.

## 7. Brief advice leaflets

Leaflets on smoking offering brief advice and interventions have been developed and are available in every welcome pack. This is supported by the Smoke Free posters which were also developed.

## 8. Training

Face to face training in smoking cessation, Nicotine Replacement Treatment (NRT), referral and sustaining commenced in October 2017. This was provided jointly between the Infection

Prevention & Control/Physical Health (IPC/PH) team and QUIT 51. This is supported by Public Health colleagues. In addition, we have e learning sessions which have also been advertised and monitored along with training. We have also utilised and devised a training programme which formed part of the Physical Health training day up to April 2018 based on The National Centre for Smoking Cessation and Training (NCSCT) which is a social enterprise committed to support the delivery of effective evidence-based tobacco control programmes and smoking cessation interventions which is based on the national smoking guidelines. In addition we have delivered "Search" training.

| Compliance Type | Total Users | Compliant | Non Compliant | Percentage Compliance |
|---|---|---|---|---|
| Very Brief Advice on Smoking | 883 | 664 | 219 | 75.2 |
| Smoking Cessation | 48 | 35 | 13 | 72.92 |

## 9. LESTER tool

Training continues in line with the LESTER tool which includes smoking and the interventions. Lorenzo has been updated so all PH assessments include a question around smoking habits, offer of brief interventions, referral and NRT.

## 10. Commissioning for Quality & Innovation (CQUIN)

CQUINs continue to include smoking and this is likely to continue. Compliance with assessment and offer on intervention increased to over 90% in line with going smoke free in April 2018. This is a huge achievement by staff and reflects the training and preparedness in going smoke free. However the CQUIN requirement is a dual approach, to include not only assessment and intervention but referral too smoking cessation services. This has proved difficult and lengthy conversations have taken place with commissioners.

One of the key concerns is patients must consent to referral and this is outside of the Trusts control despite advice and recommendation. Secondly not all patients have access to a smoking cessation service which is hugely difficult for staff in terms of equity etc.

## 11. Dear Caroline's (DCs)

Several DCs have been responded to since the Trust became Smoke Free in April 2018. This was expected given it is a significant change in the organisation. The T&FG has worked hard to consider all the elements and trends associated with DCs and complaints. The two trends that are significant are smoking in the garden on Ward 3 and at the reception foyer at Harplands. These have been responded to by the actions which are included within this report and future actions.

## 12. Incidents

The reporting of incidents increased in April and into May 2018 as the Trust commenced smoke free. These included aggression, smoking covertly, at reception area and absconding. There are now 3 categories associated with smoking on Ulysses. This enables good governance around reporting and its separation.

All smoking incidents are discussed either at that time or at the incident review group, and at CEG. This enables support to the staff and patients involved and to address and issues in a

timely manner. Responding to these issues and providing an alternative to NRT and smoking has prompted the agreement to purchase and provide E.cigs in the interim period.

The incidents are now decreasing (till Q1) as can be seen in table 1 below.

| Court of Incident Column labels | | | | | | |
|---|---|---|---|---|---|---|
| Row labels | Jan 18 | Mar 18 | Apr 18 | May 18 | Jun18 | Grand total |
| Edward Myers Unit | 1 | | | | | 1 |
| Harplands Ward 1 | | | 5 | | 1 | 6 |
| Harplands Ward 2 | | 3 | 1 | 4 | 1 | 9 |
| Harplands Ward 3 | 1 | | 12 | 20 | 14 | 47 |
| Grand total | 2 | 3 | 18 | 24 | 16 | 63 |

**13. Signage**

New signage for garden areas and externally areas has been devised and erected. We continue to monitor the impact of these and consider additional/change in signage where indicated.

**14. Local involvement**

The IPC/PH team continue to represent Combined at the local council meetings and have received acknowledgement from Councillor Conteh recognising the work carried out at Combined regarding smoke free. The summary of the letter includes the following, “As a result of the excellent work you and other partnership organisations are undertaking both the number of young people smoking and adult smoking rates are falling. There is still more work to be done to close the gap on the England adult smoking prevalence average of 15.5% but we are confident this can be achieved with the excellent progress your team and other key partners are making”.

**15. National initiatives**

The team continue to respond to and consider national guidance and initiatives from NHSE, PHE and significant others.

**16. House of Commons**

We received a letter from Duncan Selbie commending the work to date by the Trust in relation to the smoke free environment and work in reducing smoking across the Trust. Statement included, “commending us as an exemplary Trust regarding work on smoke free, and has said he will highlight the Trust as a national good practice case study”.

**17. Pledge**

Early in 2018, a representative from Combined attended the national launch of the NHS Smoke Free pledge. The pledge was signed by the CEO and Chair of the Trust and distributed across the organisation by the trusts communications team.

**18. Progress internally**

Becoming Smoke Free has been a challenging time for the staff and patients at Combined. The organisation has spent significant time and resources on preparedness and benchmarking ourselves against copious amounts of literature and information, and attending a national event.

There has and continues to be challenges, however we have been acknowledged by significant others, PHE, local council and commissioners included on our progress and continue towards making our Trust a smoke free safe environment for all.

Learning from others has included our choices in NRT administration and the remit around E.cigs which we allow in our outside spaces.

**19. Multi-Disciplinary Team and leave**

Recognising the challenges we have faced and the continuing issue around smoking outside the reception, we have worked with colleagues around leave, detained patients and activities. As a Trust we offer support in discouraging smoking and supporting patients, and staff to become non-smokers. The implementation has presented challenges to staff. There continues to be meetings with ward managers, matrons and Head of Directorates to ensure consistency across all wards in implementation of the policy.

**20. Search policy & Training**

Search training sessions were increased late 2017 in terms of preparedness for the increase in contraband items, including ignition sources. On 3rd April 2018 all the permanent ignition sources in the garden areas were removed. This has led to an increase in patients secreting lighters about themselves and sharing with others. This has been particularly apparent on ward 3.

**21. PLACE and positive feedback**

Despite the issues the trust has experienced there have been numerous positive messages and suggestion going forward.

- Our PLACE team including external verifier noted the more pleasant garden areas and neutral smelling corridors
- Staff have noticed a cleaner environment in which to work
- Non-smoking patients can freely use a tobacco free garden and bedrooms do not now smell of stale tobacco
- The uptake of NRT has increased significantly since April 2018
- Some patients who do smoke have cut down dramatically. Patients have described, " only now having a ciggie after a meal", "down from 50 to 10 cigs a day", "trying NRT for the first time", "giving up by vaping"
- Staff would like access to try NRT, or E.cigs whilst on shift so they don't have to go for cigarette break

**22. Nicotine Replacement Therapy (NRT)**

Patients have access to a wide selection of NRT products in different strengths. These are a combination of slow and fast acting. All patients are offered NRT and support on admission. All patients are asked if they consent to being referred to smoking cessation on discharge.

**23. E-cigs and vending machine**

Following lengthy consideration and a review of the evidence and guidance, the Trust has made the decision to purchase 1500 E.cigs from a manufacturer that prison and other secure/MH services use.

These are stored in a safe, secure area and are distributed to wards when required. Initial distribution included all 3 flavours, and all have the same content of nicotine. These are given to patients as an alternative and documented in the same way as NRT. Each E.cig consists of 400 “puffs” and is single patient use. Each is labelled with the patients name once given to the patient who must sign that they have received.

This is a “one off” purchase to pilot prior to the instillation of an E.cig vending machine in a locked room opposite reception at Harplands. Staff will support patients to purchase the same E.cig at a cost of £3.00. It must be noted that one other Trust using these E.cigs do not charge patients for them, and one also has a vending machine that staff and visitors may use.

From discussions with staff it is likely that staff will also purchase as the cost is significantly lower than purchase from elsewhere. The E.cigs are recyclable, and the Trust is supporting this by placing recyclable boxes in appropriate areas which will be collected by the company once full at no cost to the Trust.

**24. Action on Smoking & Health (ASH) interviews**

Some of the T&F group were interviewed as part of a research project around Mental Health Trusts going Smoke Free on behalf of Cancer Research UK. This was discussed with Dr Link and 5 members of staff were interviewed both clinical and non-clinical to give a wide perspective. We will have an opportunity to see the draft before publication.

**25. Referrals**

We continue to be in discussion with our local Health & Wellbeing partners and Commissioners regarding referrals and the logistics in achieving the CQUIN for referral. There has been challenges in referrals and this has been discussed and encouraged throughout the organisation since summer 2017. There are gaps in provision and agreement over the consent to pass details to smoking cessation services, whether they exist or not. There is no consistency between North Staffordshire & Stoke on Trent, and the conversations continue.

**27. Recommendations**

The Board is asked to note and comment on the Smoke Free Quarter 1/2 Report for 2018/19.

## 28. Appendix 1

The Clinical, Policy and Training & Implementation Workstream has progressed as below:

| | |
|---|---|
| • E learning for brief interventions is now available to all community staff and this has commenced. | |
| • Smoking as part of the Lester Intervene tool is included in the Physical Health training, which commenced in June 2017 and competency document for all MH/LD staff and relevant Allied Health Professional colleagues. This stands at 63%. | |
| • Face to face training started January 2018 which includes the national standards and bespoke Nicotine Replacement Therapy (NRT) information for all nursing and AHP staff for Combined. This continues alongside workplace training with new administration charts for Nicotine Replacement Therapy. | |
| • Living well Hub now (smoking cessation service) accepting and collating referrals from NSCHT both via phone and email for both Stoke and Staffordshire. | |
| • Fast acting spray now available in pharmacy and forms part of all inpatient areas stock.<br>• Bulk purcase of Lozenges, patches and inhalators distributed to all inpatient areas prior to the phased approach. | |
| • Policy reviewed, considered and consulted, and now on SID, with supporting documents for NRT and rationale for medical review. | |
| • 5K budget costed and agreed mostly spent. The removal of ashtrays and ignition sources unfortunately has been costed for year 18/19 as this activity took place on 3rd March 2018. | |
| • Remedial works and clean up for estates and facilities confirmed and costed. Additional cleans agreed for reception, and other frequent tobacco use areas with facilities department | |
| • All ignition devices to be removed from garden areas 3rd April 2018 | |
| • Collaborative working with PHE and Stoke on Trent (SoT) council, NSCHT members of those meetings and acknowledged for innovative processes, including allowing vaping | |
| • Vaping discussed and agreed for inpatient outside space (garden) and maintain shelters for same by estates department | |
| • All letterheads and communications need to reflect the strapline that NSCHT is working “Towards Smoke Free” commencing in January 2018 | |
| • All community and inpatient staff must discuss Smoking and offer advice and brief interventions, now included on Lorenzo as part of Lester tool/assessment | |

| | |
|---|---|
| • Attendance at Government and NHS smokefree launch communicated to staff 12.01.18. Pledges signed and distributed. | |
| • Two complaints received, one from a member of the public re staff smoking area, and one from a member of staff regarding patients smoking close to reception area at Harplands, both responded too. | |
| • All incidents are discussed with Consultant Nurse on a weekly basis and at T&F group. None have resulted in harm. | |
| • Agreed at last T&F group to write up expectations for staff, patients and visitors. These will include:<br>• Removal of towards smoke free posters and distribution of Smoke Free ones to include a named individual for inpatients/community teams, or who to speak to and where to get advice.<br>• Agree better signage with Estates around smoking "hotspots" including reception area at Harplands.<br>• Patients will be asked to move away from entrances<br>• Patients will be expected to be appropriately dressed on leaving the ward to smoke, with footwear<br>• Staff should not be visibly smoking from site<br>• Ward managers will ensure NRT stock levels are adequate to administer within 20 minutes of patient arriving on the ward | |
| • Leaflets x 2000 have been distributed across all inpatient and community settings and included in every welcome pack | |
| • National Stop Smoking Day was highlighted and celebrated at Harplands and well attended for resources and advice. | |

The Pharmacological Workstream has progressed as below:

| | |
|---|---|
| • NRT formulary and product information has been circulated to the group and approval by Clinical Effectiveness Group (CEG) in January | |
| • Guidance on Effects of Smoking on Medicines has been circulated to the group and approval by CEG in January | |
| • NRT guideline, including a prescription sheet for initial 72 hours of NRT supply has been agreed and distributed to all inpatient areas | |

The Communications Workstream has progressed as below:

| | |
|---|---|
| • Logo and leaflets approved by group, printed and distributed started 10.01.18. | |
| • Generic email address for any questions created and will be triaged by administration from N&Q team - towardssmokefree@combined.nhs.uk | |
| • FAQ section to be added to TSF web page | |

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# REPORT TO OPEN TRUST BOARD

Enclosure No:15

| | | | |
|---|---|---|---|
| Date of Meeting: | 26 September 2018 | | |
| Title of Report: | Performance & Quality Management Framework: Month 4 | | |
| Presented by: | Suzanne Robinson, Executive Director of Finance, Performance & Digital | | |
| Author: | Vicky Boswell, Associate Director of Performance | | |
| Executive Lead Name: | Suzanne Robinson, Executive Director of Finance, Performance & Digital | Approved by Exec | ☒ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| The report provides an overview of performance for July 2018 covering Contracted Key Performance Indicators (KPIs) and Reporting Requirements.<br><br>In Month 4 there is 1 target related metric rated as Red and 1 target related metric as Amber; all other indicators are within expected tolerances.<br><br>In addition to the performance dashboards a full database (Divisional Drill-Down) has been made available to Directorate Heads of Service and Clinical Directors to enable them to interrogate the supporting data and drive directorate improvement. This is summarised in the supporting PQMF dashboard. | Approval | ☐ |
| | Information | ☒ |
| | Discussion | ☐ |
| | Assurance | ☐ |

| | | | |
|---|---|---|---|
| Seen at: | SLT ☒ Execs ☐<br>Date: 28.08.18: Performance Review meeting | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☒<br>• Finance & Performance Committee ☒<br>• Audit Committee ☐<br>• People & Culture Development Committee ☒<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Digital by Choice Board ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement.☐<br>2. To provide the highest quality services ☒<br>3. Create a learning culture to continually improve.☐<br>4. Encourage, inspire and implement research & innovation at all levels.☐<br>5. Maximise and use our resources intelligently and efficiently.☒<br>6. Attract and inspire the best people to work here.☒<br>7. Continually improve our partnership working. ☐ | | |
| Risk / legal implications:<br>Risk Register Ref | All areas of underperformance are separately risk assessed and a rectification plan is developed, overseen by the relevant sub-committee of the Trust Board. | | |
| Resource Implications:<br><br>Funding Source: | There are potential contractual penalties if the Trust is not able to meet reporting requirements or performance standards. There have been significant improvements in data completeness and data quality following Lorenzo implementation. There are plans to address remaining issues and to support further developments in the Data Quality Improvement Plan agreed with commissioners. | | |

| | |
|---|---|
| Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups) | The PQMF includes monitoring of ethnicity as a key national requirement. The Trust is seeking to ensure that all Directorates are recording in a timely way the protected characteristics of all service users to enable monitoring of service access and utilisation by all groups in relation to the local population. |
| STP Alignment / Implications | None |
| Recommendations: | The Trust Board is asked to<br>• Receive the Trust reported performance, management action and committee oversight on the Month 4 position. |

# PERFORMANCE & QUALITY MANAGEMENT FRAMEWORK
# REPORT TO PUBLIC TRUST BOARD

| | |
|---|---|
| **Date of meeting:** | 26 September 2018 |
| **Report title:** | **Performance & Quality Management Framework<br>Performance Report – Month 4 2018/19** |
| **Executive Lead:** | Suzanne Robinson, Executive Director of Finance, Performance & Digital |
| **Prepared by:** | Vicky Boswell, Associate Director of Performance |
| **Presented by:** | Suzanne Robinson, Executive Director of Finance, Performance & Digital |

## 1 Introduction to Performance Management Report

The report provides an overview of performance for July 2018 covering Contracted Key Performance Indicators (KPIs) and Reporting Requirements.

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

## 2 Executive Summary – Exception Reporting

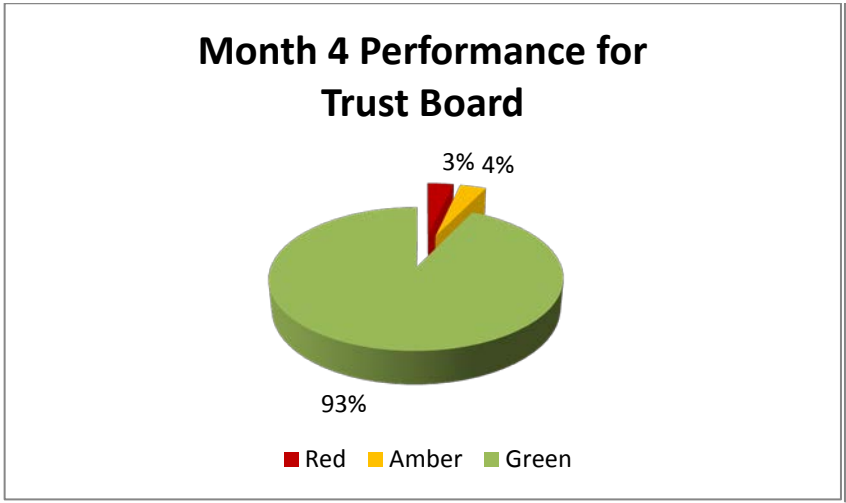
The following performance highlights should be noted:

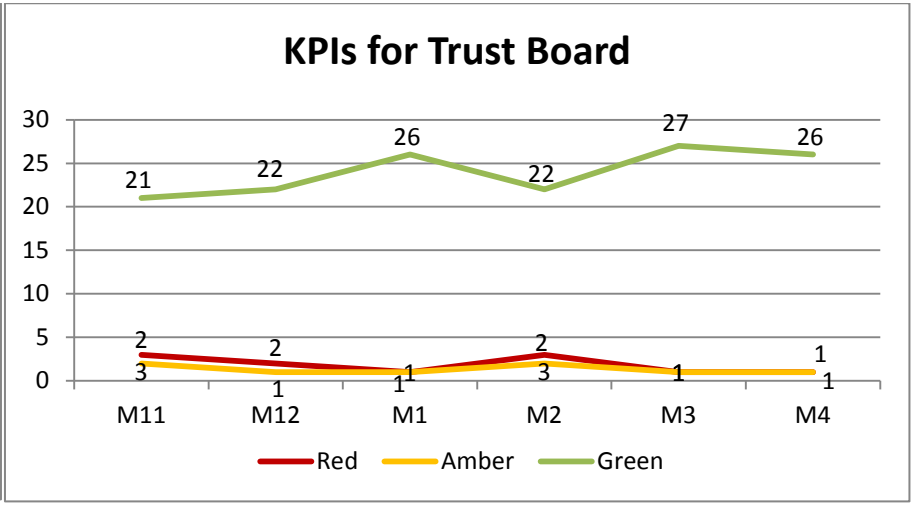
**Access and waiting times:**

- 93.9% of patients have received treatment or intervention within 18 weeks of referral (target 92%)
- 75.0% of early intervention in psychosis patients have received treatment within 2 weeks (target 53%)
- 100% of service users referred to an IAPT programme were treated within 6 weeks of referral (target 100.0%)
- All MH Liaison target response times have been met

**CPA compliance:**

- 97% of those on Care Programme Approach (CPA) for at least 12 months received a formal review within 12 months (target 95%)
- 96.3% of those on Care Programme Approach (CPA) received a follow-up contact within 7 days of discharge (target 95%)



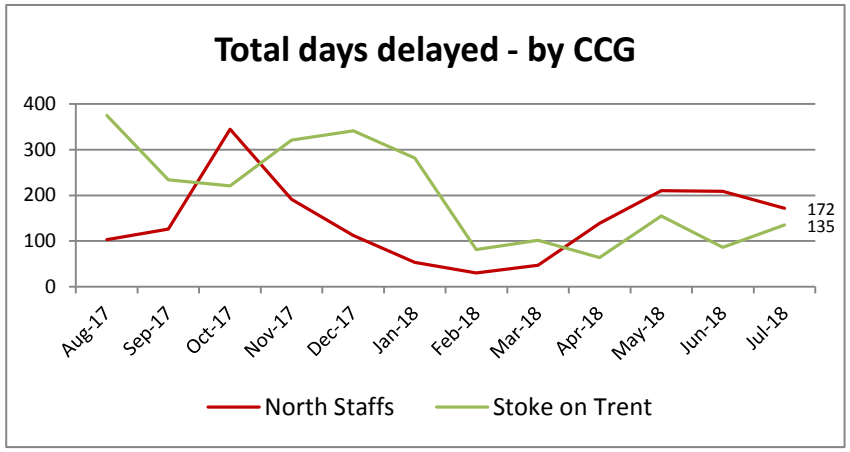

## 3 Updated metrics and targets

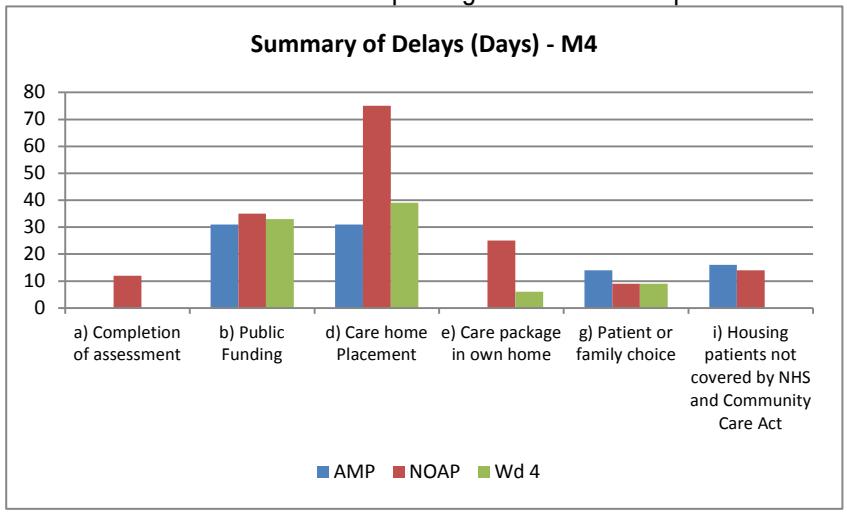
The following measures and targets have been updated for Month 4:

- M3 data now available for MH Liaison team
- IAPT: various targets adjusted in response to contract variation
- New metric: IAPT: Patients wait no longer than 90 days between 1st and 2nd appointment
- Sickness absence percentage figures for April confirmed, provisional data received for May, June and July 2018
- 7 day follow up (all patients) now RAG rated
- Bed Occupancy is no longer RAG rated

## 4 Exceptions - Month 4

In Month 4 there is 1 target related metric rated as **Red** and 1 as **Amber**, all other indicators are within expected tolerances.

| KPI Classification | Metric | Exec/Op Lead | Target | M3 | M4 | Trend | Commentary |
|---|---|---|---|---|---|---|---|
| National | Delayed Transfers of Care:<br><br>Mental health delayed transfers of care | Exec Dir of Ops | 7.5% | AMBER<br>7.6% | AMBER<br>7.8% | ↗ | 7.8% at M4 from 7.6% at M3<br><br>AMHIP – 6.5% at M4 from 4.4% at M3<br>LD – 0.0% at M4 the same as at M3<br>NOAP – 6.7% at M4 from 11.3% at M3<br>Ward 4 – 19.6% at M4 from 13.5% at M3<br><br>56.1% of all DTOCS were attributable to patients from North Staffordshire CCG and 44% were located with Stoke-on-Trent CCG<br><br>  <br><br><br>Stoke CCG (95.5% NHS, 4.4% Social Care)<br>Total days delayed = 135<br>• 129 days attributed to NHS delays (106 days AMHIP, 23 days NOAP) |

| KPI Classification | Metric | Exec/Op Lead | Target | M3 | M4 | Trend | Commentary |
|---|---|---|---|---|---|---|---|
| | | | | | | | • 6 days attributed to Social Care delays (NOAP)<br><br>The NHS delays in AMHIP are a consequence of delays in securing CCG funding through panel and a lack of availability of residential and nursing home places. This has been escalated to commissioners.<br><br>North Staffordshire CCG (59.8% NHS, 40.1% Social Care)<br>Total days delayed 172<br>• 103 days attributed to NHS delays (31 days Adult MH, 72 days NOAP)<br>• 69 days attributed to Social Care delays (69 days NOAP)<br><br>There is a particular issue with the approval process in Staffordshire County Council (SCC), which is adding to delays. The Trust continues to liaise with SCC to expedite the assessment and placement of individuals in need of social care packages or care home placements.<br>  |

| KPI Classification | Metric | Exec/Op Lead | Target | M3 | M4 | Trend | Commentary |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| CCG | 7 Day Follow Up:<br><br>The proportion of service users receiving follow up within 7 days of discharge (all service users CPA and non-CPA) | Exec Dir of Ops | 90.0% | GREEN<br>91.0% | RED<br>80.2% | ↘ | 80.2% at M4 from 91.0% at M3<br><br>The national standard requires follow up within 7 days for all inpatients on CPA. The Trust has consistently exceeded the 95% target year to date, with current performance at 96.3% in M4.<br><br>This is a contractual requirement to ensure that all patients discharged from an inpatient admission receive a 7 day follow up, both CPA and non CPA.<br><br>81 of the 116 patients discharged in M4 were followed up within 7 days, 35 patients were not followed up within the timescale.<br><br>• AMHIP - 69 of the 103 patients had recorded follow ups, 34 patients were not followed up within the timescale<br>• NOAP - 12 of the 13 patients had recorded follow ups, 1 patient was not followed up within the timescale<br><br>A recitation plan is in development to include the strengthening of weekly monitoring. Both inpatient and community staff has been reminded of the requirements of the SOP in respect of discharge planning and follow up. Further training is planned in this respect. |

## 5 Recommendations

The Trust Board is asked to:

- Receive the Trust reported performance, management action and committee oversight on the Month 4 position

**Month:** **July**
**4**
**Key:-**

# PQMF Report

North Staffordshire Combined Healthcare NHS Trust

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

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

| | Metric | Frequency | Standard | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NHSI | Early Intervention in Psychosis - A maximum of 2 week waits for referral to treatment (Target 17/18-50%, 18/19-53%) | Monthly | 53% | 75.0% | 75.0% | 100.0% | 75.0% | | | | | | | | |
| | Early Intervention in Psychosis - A maximum of 2 week waits for referral to treatment (North Staffordshire CCG) (Target 17/18-50%, 18/19-53%) | Monthly | 53% | 100.0% | 100.0% | 100.0% | 100.0% | | | | | | | | |
| | 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%) | Monthly | 53% | 50.0% | 66.6% | 100.0% | 66.6% | | | | | | | | |
| 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% | | | | | | | | | |
| | 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% | | | | | | | | | |
| | 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% | | | | | | | | | |
| 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% | | | | | | | | | |
| | 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% | | | | | | | | | |
| | 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% | | | | | | | | | |
| CCG | Compliance with 18 week waits (Referral to Treatment or Intervention) | Monthly | 92% | 90.5% | 86.8% | 93.5% | 93.9% | | | | | | | | |
| CCG | AMH Community | Monthly | 92% | 90.1% | 87.3% | 92.7% | 92.6% | | | | | | | | |
| CCG | LD | Monthly | 92% | 92.3% | 87.5% | 90.9% | 100.0% | | | | | | | | |
| CCG | NOAP | Monthly | 92% | 92.5% | 93.2% | 95.0% | 95.3% | | | | | | | | |
| CCG | C&YP | Monthly | 92% | 82.4% | 65.2% | 90.6% | 91.9% | | | | | | | | |
| CCG | Zero tolerance RTT waits over 52 weeks for incomplete pathways | Monthly | 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% | | | | | | | | |
| 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% | | | | | | | | |
| CCG | Number of people seen for crisis assessment within 4 hours of referral | Monthly | 95% | 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% | | | | | | | | |
| National/CCG | Overall safe staffing fill rate | Monthly | No Target | 93.7% | 93.4% | 94.1% | 93.7% | | | | | | | | |
| National | Mental health delayed transfers of care (target NHSI) | Monthly | 7.5% | 5.5% | 9.1% | 7.6% | 7.8% | | | | | | | | |
| 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% | | | | | | | | |
| NHSI | Total bed days patients have been Out of Area | Monthly | No target | 4.0 | 0.0 | 22.0 | 2.0 | | | | | | | | |
| Trust Measure | Adult | Monthly | No target | 4.0 | 0.0 | 22.0 | 2.0 | | | | | | | | |
| Trust Measure | Older Adult | Monthly | No target | 0.0 | 0.0 | 0.0 | 0.0 | | | | | | | | |
| NHSI | Ratio of days Out of Area to baseline (Baseline set at M9 2017/18 figure of 150 bed days, as per SOF guidance, shown as 100%. The ratio of days each month to this baseline figure is then expressed as a percentage.) | Monthly | <100% | 2.7% | 0.0% | 14.7% | 1.3% | | | | | | | | |
| Trust Measure | Total patients Out of Area | Monthly | No target | 2.0 | 0.0 | 6.0 | 2.0 | | | | | | | | |
| Trust Measure | Adult | Monthly | No target | 2.0 | 0.0 | 6.0 | 2.0 | | | | | | | | |
| Trust Measure | Older Adult | Monthly | No target | 0.0 | 0.0 | 0.0 | 0.0 | | | | | | | | |
| Trust Measure | Total bed days - PICU | Monthly | No target | 252.0 | 441.0 | 715.0 | 547.0 | | | | | | | | |

| | Metric | Frequency | Standard | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust Measure | Total patients - PICU | Monthly | No target | 5.0 | 4.0 | 4.0 | 12.0 | | | | | | | | |
| **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 | | | | | | | | |
| NHSI | Admission to adult facilities of U16s | Monthly | 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% | | | | | | | | |
| CCG | Bed Occupancy (incl home leave) - AMHIP | Monthly | 90% | 89.7% | 77.8% | 89.5% | 91.1% | | | | | | | | |
| CCG | Bed Occupancy (Including Home Leave)-Trust excluding AMHIP | Monthly | 85% | 90.6% | 94.9% | 85.9% | 79.6% | | | | | | | | |
| CCG | LD | Monthly | 85% | 79.7% | 83.6% | 90.6% | 81.7% | | | | | | | | |
| CCG | Neuro | Monthly | 85% | 88.2% | 102.0% | 91.8% | 93.1% | | | | | | | | |
| CCG | Old Age Psychiatry | Monthly | 85% | 91.5% | 95.9% | 83.4% | 78.4% | | | | | | | | |
| CCG | C&YP | Monthly | 85% | 98.7% | 95.1% | 85.1% | 68.3% | | | | | | | | |
| 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) | | | 4.84% | | | | | | | | | |
| 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% | | | | | | | | |
| 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% | | | | | | | | |
| 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% | | | | | | | | |
| CCG | IAPT: Patients wait no longer than 90 days between 1st and 2nd treatment | Monthly | <10% | 26.1% | 17.9% | 17.8% | 15.1% | | | | | | | | |
| CCG | S136 (Place of Safety) Assessments | Monthly | No Target | 22 | 24 | 22 | 25 | | | | | | | | |
| 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% | | | | | | | | |
| 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% | | | | | | | | |
| Trust Measure/CCG | (ALL PATIENTS) The proportion of those receiving follow up within 7 days of discharge | Monthly | CCG -90% | 91.2% | 85.2% | 91.0% | 80.2% | | | | | | | | |
| NHSI/CCG | Never Events | Monthly | 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 | | | | | | | | |
| CCG | Mixed Sex Accommodation Breach | Monthly | 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% | | | | | | | | |
| National | Staff Friends and Family Test - % recommended - care | Quarterly | No Target | | | No data | | | | | | | | | |
| National | Percentage of complaints responded to in line with timescale agreed with complainant | Monthly | 95% | 100.0% | 100.0% | 100.0% | 100.0% | | | | | | | | |
| National | Written complaints rate | Quarterly | No Target | | | 9.4% | | | | | | | | | |
| 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 | | | | | | | | |
| **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% | | | | | | | | |
| National | Sickness Absence Percentage: Days lost | Monthly | 4.95% | 2.8% | 2.64% | 2.63% | 2.34% | | | | | | | | |
| National | Staff Turnover (% FTE) | Monthly | >10% | 0.6% | 0.8% | 0.5% | 0.9% | | | | | | | | |

NHS
North Staffordshire
Combined Healthcare
NHS Trust

# REPORT TO OPEN TRUST BOARD

Enclosure No:16

| | | | |
|---|---|---|---|
| Date of Meeting: | 26th September 2018 | | |
| Title of Report: | Being Open Report: An Evaluation and Analysis of Dear Caroline, Freedom to Speak up Guardian, Raising Concerns and Workforce Grievance activity (July 2017 – June 2018 and quarterly update April 2018 – June 2018) | | |
| Presented by: | Caroline Donovan, Chief Executive | | |
| Author: | Kerry Smith, Associate Director of Workforce | | |
| Executive Lead Name: | Alex Brett, Director of Workforce, OD and Communications | Approved by Exec | ☒ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| The Being Open report provides a combined report of Dear Caroline, FSUG, 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 July 2017 – June 2018 and a detailed quarterly review for the period of April 2018 – June 2018.<br><br>Combined Being Open Key themes – July 2017 – June 2018<br>Top three themes:<br>- Policies, Procedures and Processes<br>- Other<br>- Staffing levels and workload<br><br>Combined Being key themes – Apr 18 – June 18<br>Top themes:<br>- Policies, Procedure and Processes<br>- Other<br>- Manager Behaviour<br>- Patients<br><br><u>Next Steps</u><br><br>It is proposed that the Trust will:<br>• Continue to utilise all four mechanisms to support staff to raise concerns and issues<br>• Support the ongoing development of an open and transparent culture through development and embedding of the Trust Values and supporting Behaviours Framework<br>• Continuation of the Freedom to Speak Up Guardian role including further strengthening of approach/ development of a range of Freedom to Speak Up Champions to further support the FSUG role.<br>• Continue and strengthen communication to the wider Trust to help promote speaking to managers, professional leads, trade union representatives as well as the more formal routes that are available. | Approval | ☐ |
| | Information | ☒ |
| | Discussion | ☐ |
| | Assurance | ☒ |

| | | | |
|---|---|---|---|
| Seen at: | SLT ☒ Execs ☒<br>Date: | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☐<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☒<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐ | | |

| | |
|---|---|
| | • Digital by Choice Board ☐ |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement.☐<br>2. To provide the highest quality services ☒<br>3. Create a learning culture to continually improve.☒<br>4. Encourage, inspire and implement research & innovation at all levels.☐<br>5. Maximise and use our resources intelligently and efficiently.☐<br>6. Attract and inspire the best people to work here.☒<br>7. Continually improve our partnership working. ☐ |
| Risk / legal implications:<br>Risk Register Reference | n/a |
| Resource Implications:<br><br>Funding Source: | Management Time<br><br>N/A |
| Diversity & Inclusion Implications:<br>(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: | None |
| Recommendations: | • Receive the report for assurance<br>• Support the proposed next steps<br>• Receive an update report quarterly |

# Being Open Report:
# An Evaluation and Analysis of Dear Caroline, Freedom to Speak up And Raising Concerns activity (July 2017 to June 2018)

## 1. Introduction

As a Trust we are committed to supporting staff to raise issues or concerns they 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 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 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 July 2017 – June 2018 and a detailed quarterly review for the period of April 2018 – June 2018. Furthermore, to allow greater comparison and review the high level themes developed by the National Freedom to Speak Up Guardian have been adopted and allocated to all submissions across each of the abovementioned mechanisms. Further detailed drill downs are available.

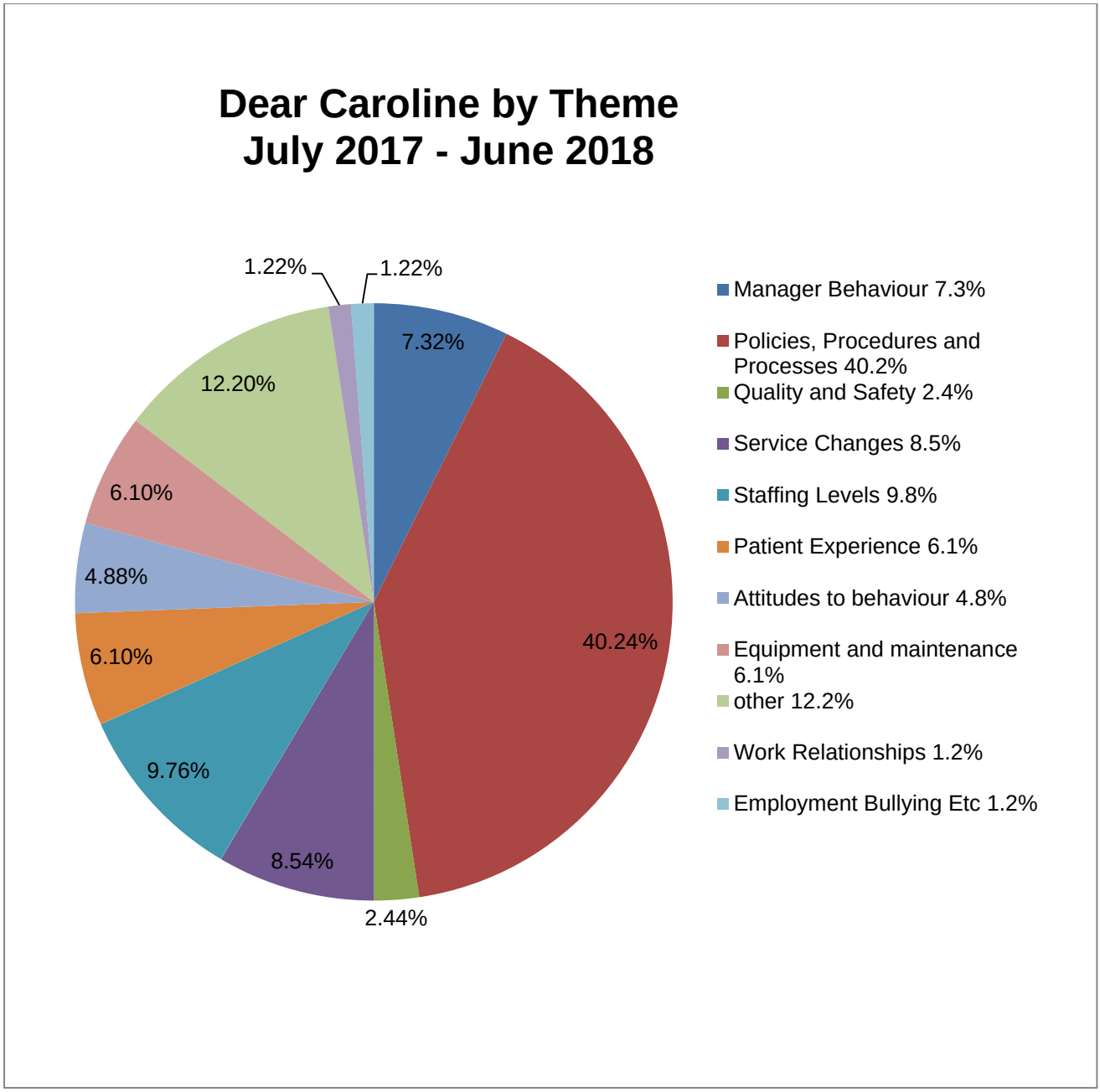
The high level themes recommended by the FSUG include:

- 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 – July 2017 – June 2018 )

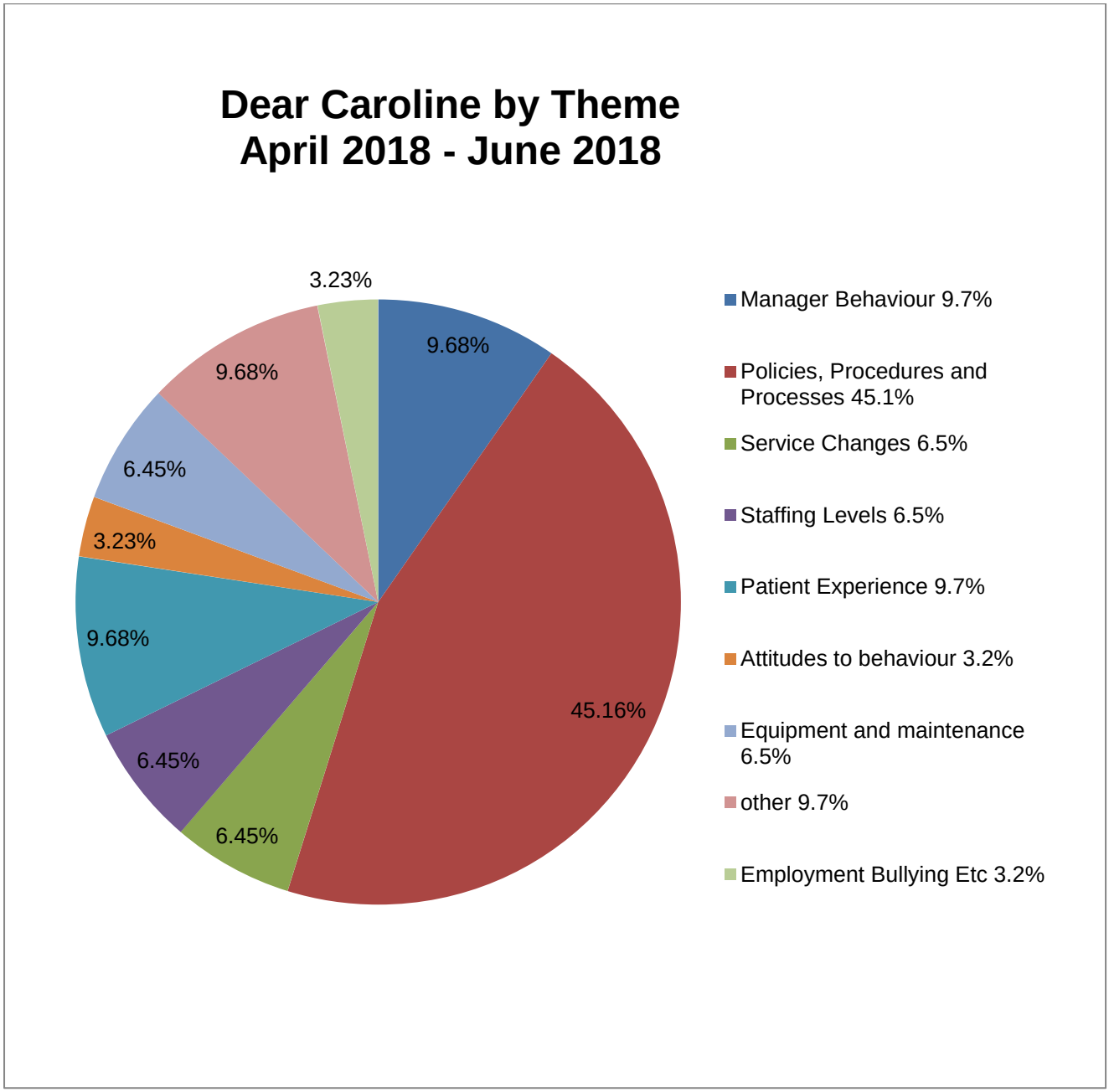
### 2.1 Dear Caroline (DC) Activity

Between July 2017 to June 2018, a total of 75 DC submissions have been received and 31 submissions between April 2018 – June 2018. The pie chart below details themes by percentage over the 12 month period.




Over the 12 month period submissions relating to Policies, procedures and processes (40.24%) other (12.2%) and Staffing Levels (9.8%) have been raised most frequently. Repeat themes include concerns with regards to staffing shortages within Adult Inpatient and Community Services, car parking fines, E-rostering implementation concerns, Lorenzo implementation concerns, a variety of workforce reward and recognition suggestions, concerns relating to culture and manager leadership behaviours and concerns/suggestions regarding no smoking Trust policy.

The pie chart below details themes by percentage between April – June 2018.




Between April and June 2018, themes are fairly disparate. The most common concerns raised are with regards to policies, procedures, and processes (45%) which cover a wide variety of matters the most common being E-rostering, Lorenzo, Trac (online recruitment system), Learning Management System (LMS) and No Smoking Policy.

Additional repeat themes include 'other' which includes a variety of submissions including recruitment and retention suggestions, CEO Blog, request for an extension to the Harplands Café Opening times. Patient experience which incorporates submissions relating to future plans for ward areas, the RAID service and access to water dispensers within clinical settings. Finally, Manager Behaviour relates to submissions concerning perceived Line Manager Role Modelling/Behaviours within the Executive Director Team and two separate teams within the AMH Community Directorate.

It is important to note that compliments, positive feedback, and helpful suggestions regarding improving our services have also been received via Dear Caroline; examples include compliments about staff members/teams, positive feedback regarding CEO Blog and suggestions to improve service user and staff facilities, Dear Caroline and the Lorenzo IT system.

### 2.2 Freedom to Speak Up Guardian Activity

From July 2017 – June 2018, 2 submissions have been received by the Freedom to Speak Up Guardian within the last 12 months and both within the quarter from April – June 2018. The submissions relate to the AMH Inpatients which is connected to Patient/Safety concerns and AMH Community with regards to training for Bank staff.

### 2.3 Raising Concerns Activity

From July 2017 to June 2018, five submissions have been received and 2 submission for the period April 2018 – June 2018. Previous submissions relate to building work on Ward One, a complaint concerning Darwin and a concern regarding the use of the Meridian Tool within the AMH Community Directorate.

With regards to the two quarter one submissions one relates to the culture and leadership style of a Senior Manager who is no longer employed by the Trust and the second relates to the perceived leadership style, morale and staff engagement within a team in the AMH Inpatient Directorate.

### 2.4 Grievance and Dispute Activity

From July 2017 to June 2018, a total of five grievances have been raised and two submissions raised during the period April 2018 – June 2018.

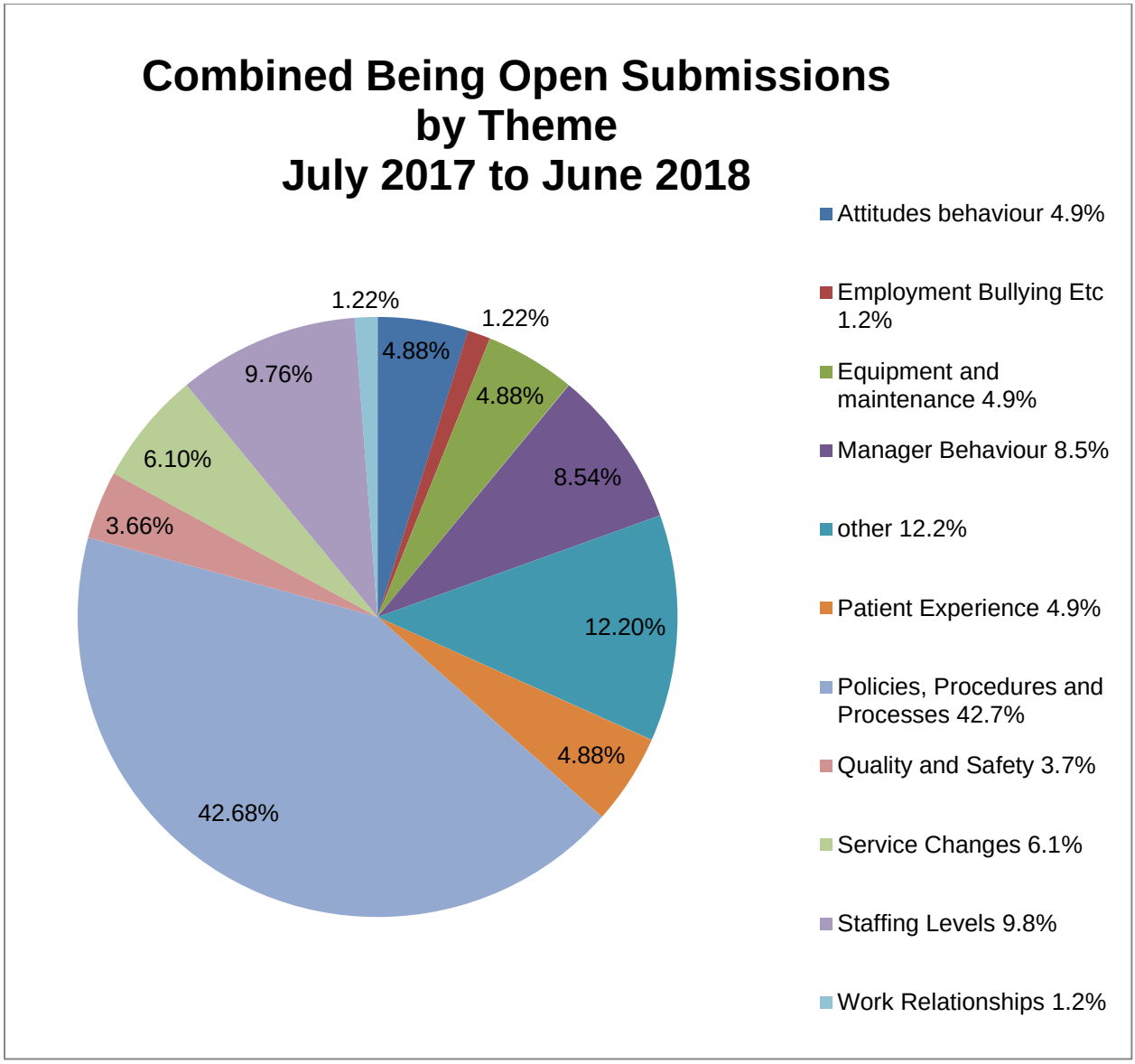
Overall, grievances raised relate in the main to the Corporate function (Estates Team with 3 submissions) and have an overarching classification of Manager Behaviour theme pertaining to concerns relating to a management of change and TUPE process, request to take on additional duties and manager behavior. Additionally one collective grievance was received which concerned historical break patterns within the LD Directorate and a further grievance within the Substance misuse Directorate concerning a Management of Change and Job Banding challenge. All matters continue to be managed in accordance with the Trusts Grievance policy and procedure.

## 1. Combined Being Open Key Themes

### 1.1. High level: 12 month theme analysis

In order to assess the themes that emerge from Dear Caroline, FSUG, 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 FSUG national themes.

It is important to note, however, that 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 (39%), Staff Levels (16.7%) and Service Changes (10.6%).




### 1.1.1. Policies, Procedures and Processes (42.7%%)

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.

Submissions have been made regarding Trust Policies, suggestions regarding service improvement, Lorenzo, E-rostering, LMS, Trac recruitment, dress code and No Smoking Policy.

### 1.1.2. Other (12.2%)

This category combines a variety of submissions including Cycle to work suggestions, CEO Blog, Christmas incentives, Recruitment and Retention incentives and café opening times.

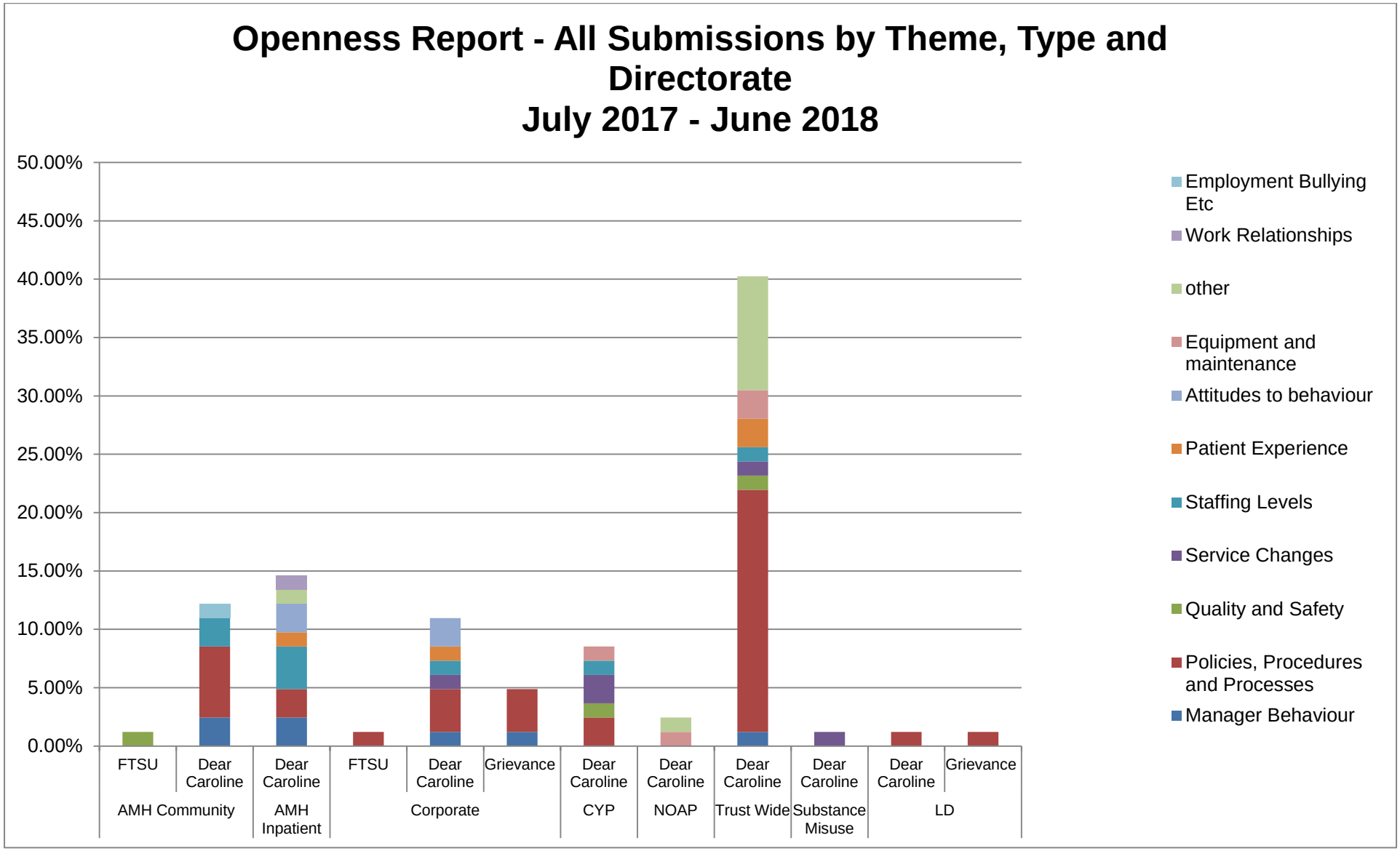
### 1.1.3. Staffing Levels & Workload (9.8%)

A number of submissions have been received concerning staff levels within the AMH Community, AMH Inpatients and Corporate Directorate. Concerns raised are similar across the areas and indicate a negative impact upon staff wellbeing and patient safety/care. Concerns include volume

and appropriateness of referrals/admissions, high caseloads, quality of care, competing demands, low staffing levels and over reliance on agency/bank staff.

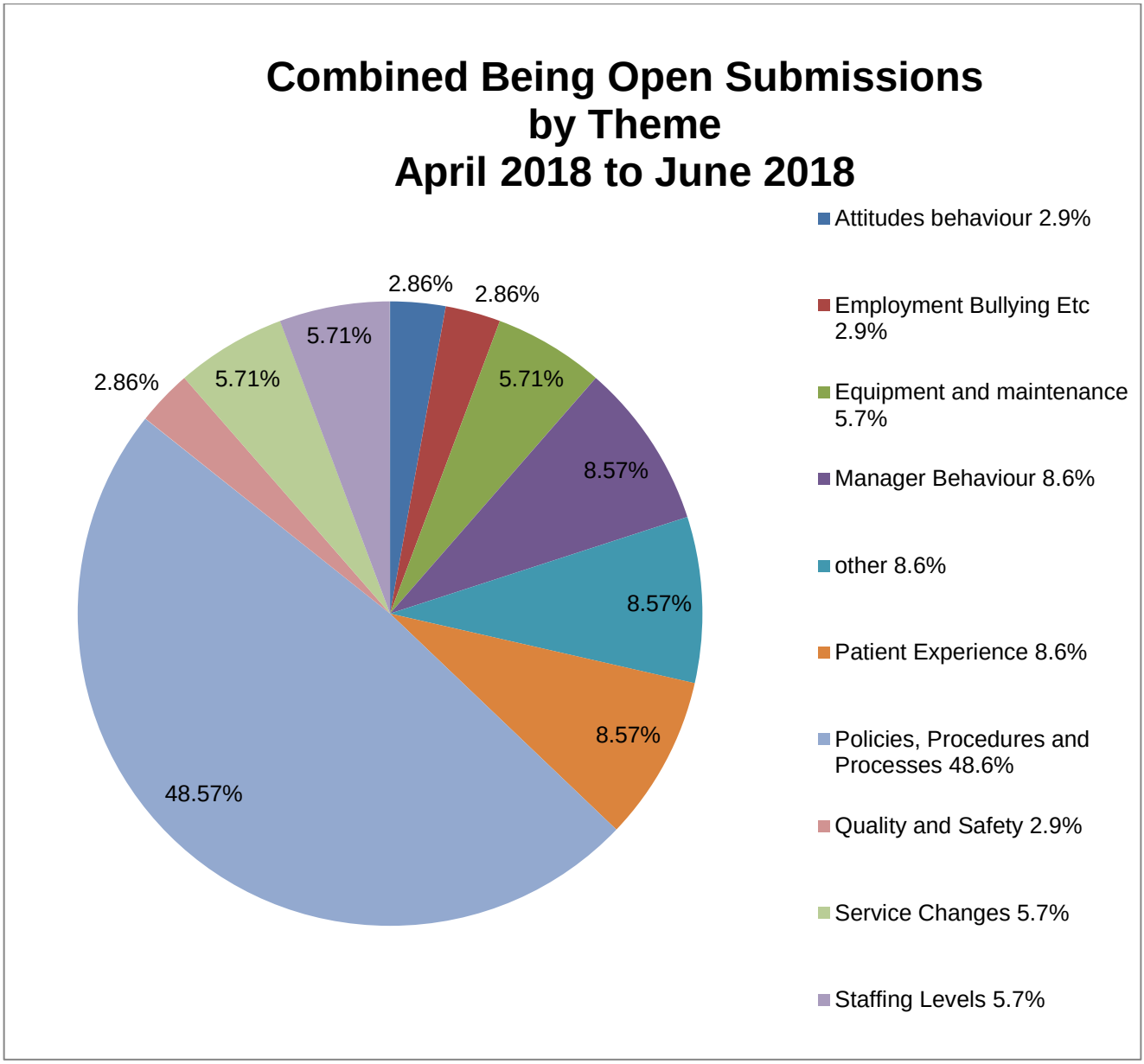
### 1.2. High Level: Quarterly Directorate Themes and activity (January – April 2018)

For all Directorates/areas, the graph below details themes including Dear Caroline (DC), FSUG, Raising Concerns (RC) and Grievance (Gri) themes. Broadly, themes within AMH Inpatients, AMH Community and CYP are aligned to overall Trust wide themes.


Openness Report - All Submissions by Theme, Type and Directorate
July 2017 - June 2018
50.00%
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
FTSU
Dear Caroline
Dear Caroline
FTSU
Dear Caroline
Grievance
Dear Caroline
Dear Caroline
Dear Caroline
Dear Caroline
Dear Caroline
Grievance
AMH Community
AMH Inpatient
Corporate
CYP
NOAP
Trust Wide
Substance Misuse
LD
Employment Bullying Etc
Work Relationships
other
Equipment and maintenance
Attitudes to behaviour
Patient Experience
Staffing Levels
Service Changes
Quality and Safety
Policies, Procedures and Processes
Manager Behaviour

### 1.2.1. Being Open Combined High level Quarterly Theme Update (1 April 2018 – June 2018)

Following the last Being Open report submissions for DC's have significantly increased whilst Grievance, FSUG and Raising Concerns have reduced when compared to the same time frame in 2017/18. Themes continue to be varied as previously highlighted.




### 1.2.2. Policies, Procedures and Processes (49%)

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 matters.

Submissions have been made regarding Trust Policies and process relate to topics including the new inpatient e-rostering system, Lorenzo, Trac, Dear Caroline, Recruitment, the Dress Code Policy and the No-Smoking Policy.

### 1.2.3. Other (8.6%)

Submissions relate to service changes connected to the introduction of the Meridian tool in the AMH Community Directorate, concerns regarding the lack of Eating Disorder Service and the incorporation of the CAMHs service into the RAID/MHLT service.

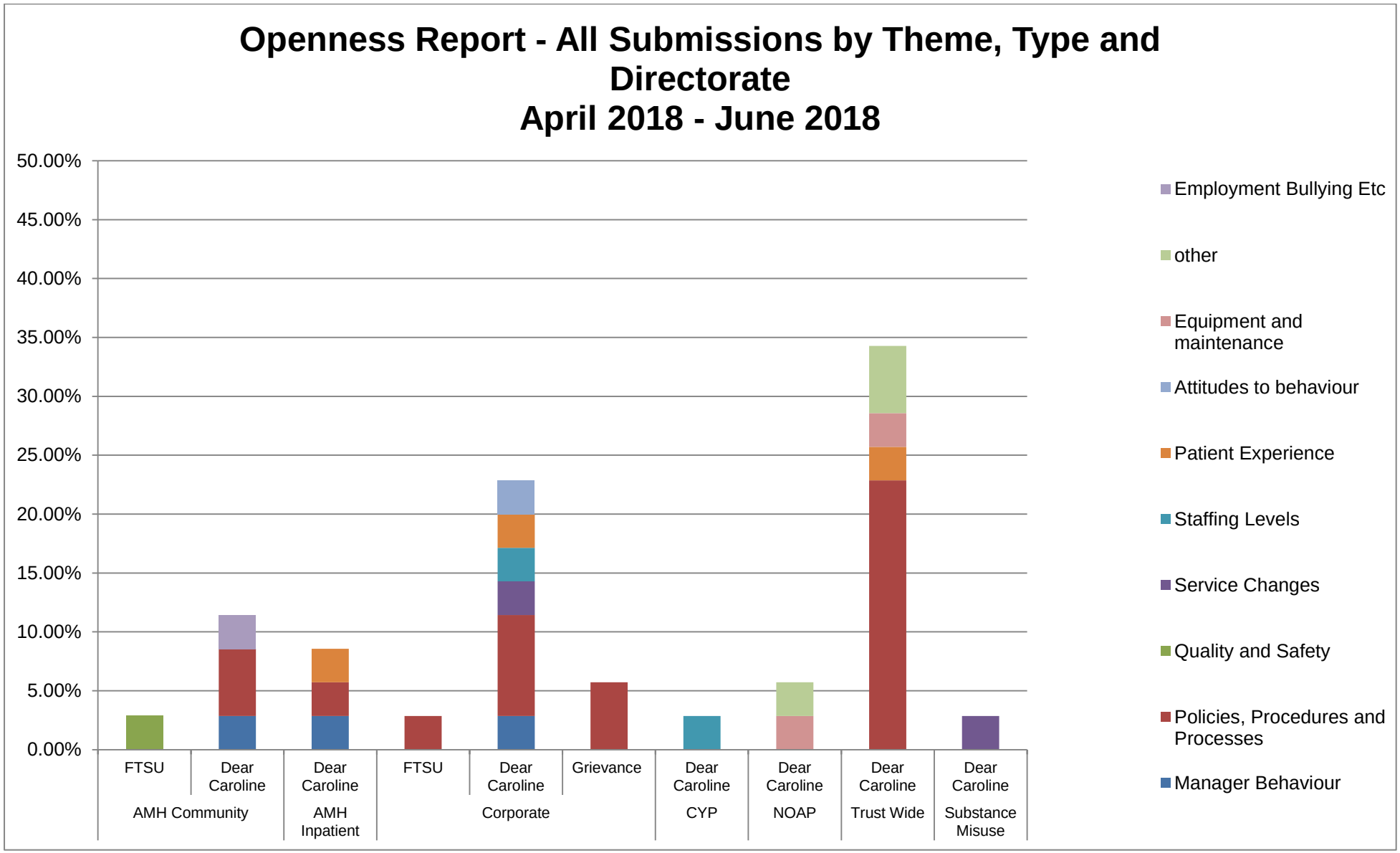
### 1.2.4. Manager Behaviour (8.6%)

Submissions relate to submissions relate to perceived unfairness concerning management action and behavior concerns raised concerning Substance Misuse Directorate, Ward 1 and AMHC Wellbeing Service.

### 1.2.5. Patient Experience (8.6%)

Submissions relate to submissions relate to perceived unfairness concerning management action and behavior concerns raised concerning Substance Misuse Directorate, Ward 1 and AMHC Wellbeing Service.

For all Directorates/areas in receipt of submissions, graphs below demonstrate themes including Dear Caroline, FSUG, Raising Concerns and Grievance submissions. Due to the low submission and varied nature of submissions it is not possible to draw any significant themes.


Openness Report - All Submissions by Theme, Type and Directorate
April 2018 - June 2018
50.00%
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
FTSU
Dear Caroline
Dear Caroline
FTSU
Dear Caroline
Grievance
Dear Caroline
Dear Caroline
Dear Caroline
Dear Caroline
AMH Community
AMH Inpatient
Corporate
CYP
NOAP
Trust Wide
Substance Misuse
Employment Bullying Etc
other
Equipment and maintenance
Attitudes to behaviour
Patient Experience
Staffing Levels
Service Changes
Quality and Safety
Policies, Procedures and Processes
Manager Behaviour

## 2. Being Open Mechanisms – Impact review

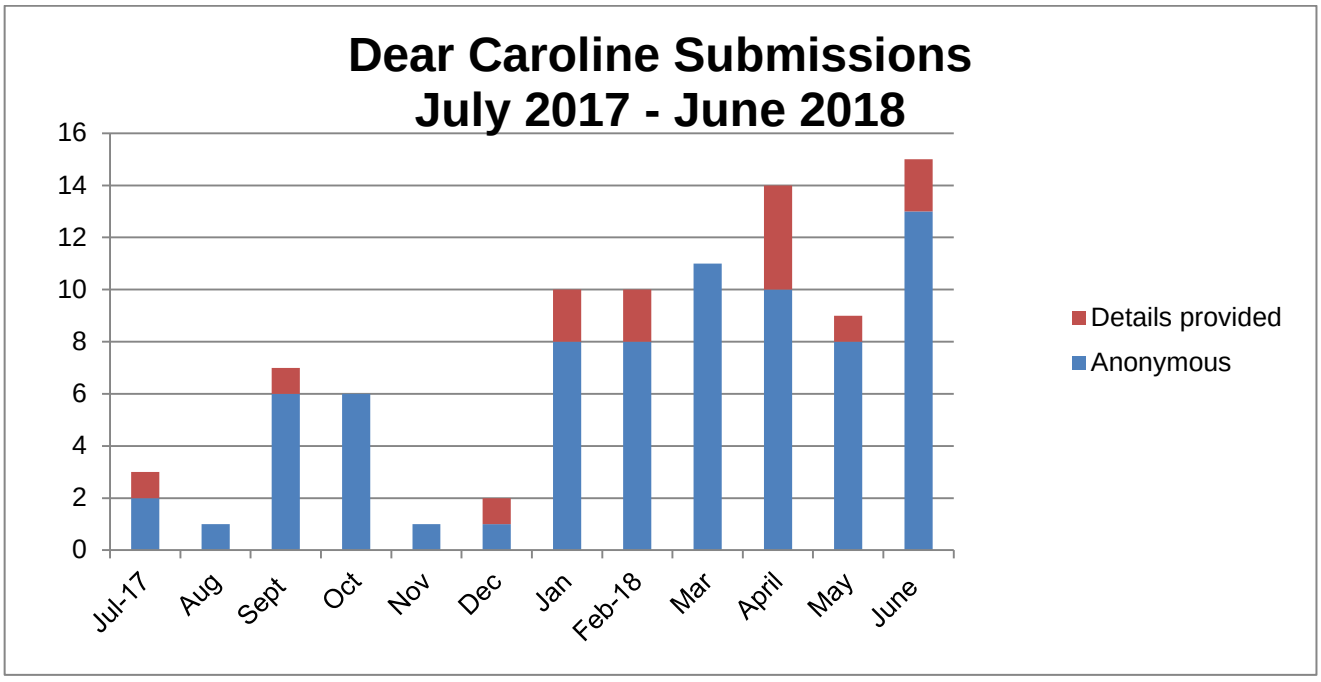
### 2.1. Dear Caroline Impact

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:

May-August 2017 - http://sid/news/DC/Pages/May-to-August-2017.aspx
Sept – Dec 2017 - http://sid/news/DC/Pages/September-to-December-2017.aspx
Jan – June 2018 http://sid/news/DC/Pages/January-to-June-20180228-1636.aspx

The Dear Caroline website provides staff with an anonymous channel to raise concerns. Between July 2017–June 2018, 75 submissions have been received against a position of 117 submissions for the same period in the previous 12 months (July 2016 – June 2017).

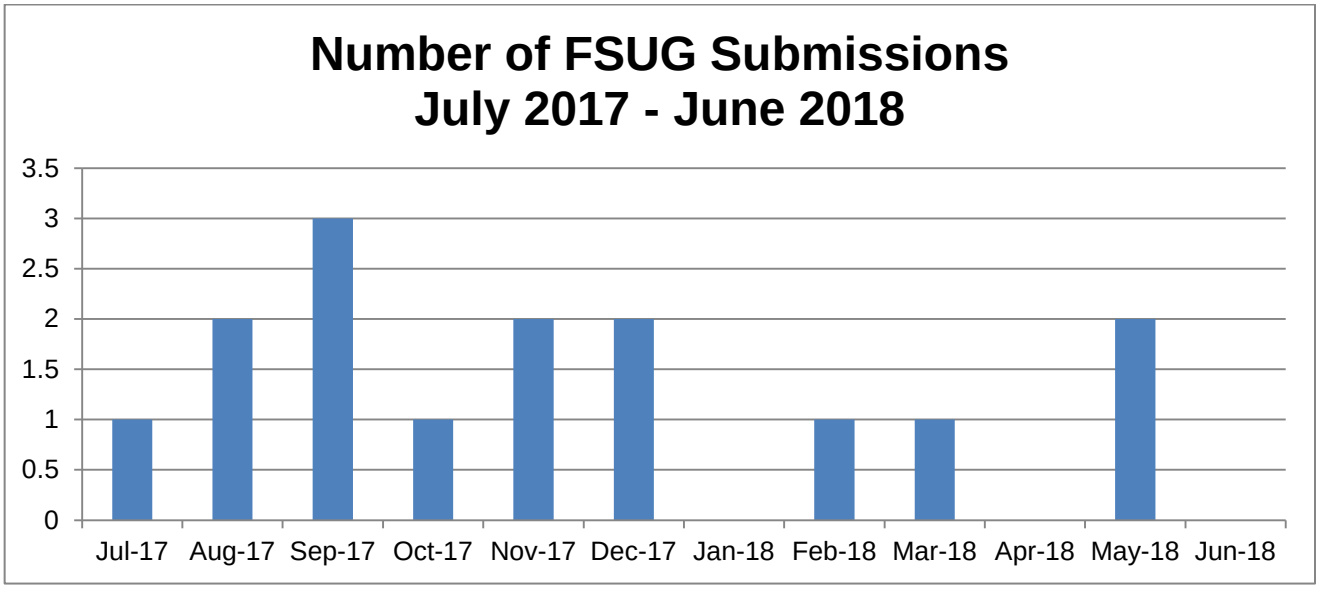
Feedback has been received from a range of areas and regular submissions are being made. The bar chart below shows the number of submissions made by month over a rolling 12 month period. The most recent quarter (April – June 2018) has seen a continued increase in submissions to 32 in comparison from the previous two quarters (Oct – Dec and Jan – March) from 8 to 26 submissions respectively. Moreover, this is significantly higher when also compared to the same time frame in 2017 (quarter Apr – June) during which 10 submissions were received.




The majority of submissions (81%) continue to be submitted anonymously; however some submissions have raised concerns with regards to whether the mechanism is entirely anonymous as sighted during a number of submissions. That said it should be noted that 19% 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.

### 2.2. Freedom to Speak Up Guardian Impact

15 concerns have been raised during July 2017 – June 2018 which is 50% more than for the same period in 2016/17 and two new concerns in the last quarter.




It should be noted that a new Freedom to Speak Up Guardian has recently been appointed which may have led to an increase in submissions.

### 2.3. Raising Concerns Impact

Two concerns have been raised via this method in the last quarter, one submission relates to the culture and leadership style of a Senior Manager and the second relates to the perceived leadership style, morale and staff engagement within the AMH I team.

Previous submissions raised via this method include an allegation of bullying and harassment, service changes and the introduction of the Meridian Tool.

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 concerns were being raised via this method. However it is important for the Trust not to be complacent with regards to this matter.

### 2.4. Grievances Impact

Five concerns have been raised via this method between July 2017 and June 2018, one in April concerning a TUPE transfer and one in May concerning a Management of Change outcome and job banding. This is a reduction against six concerns which were raised between in the previous 12 months.

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 concerns 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.

### 2.5. Summary of combined mechanisms impact

In summary, from July 2017 to June 2018 there has been a decrease in FSUG, Dear Caroline, Raising Concerns and Grievance submissions when compared to the same period in 2016/17. All mechanisms will continue to be publicised internally using a variety of media.

### 2.6. 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, FSUG 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
- Amending 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
- Developments to the REACH Awards ceremony and process
- Development of policies such as the Dress Code Policy.

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 Towards Outstanding Engagement Programme and commissioning of further cohorts of the People Management Programme.

Detailed Staff Survey analysis based on the 2017 survey has been undertaken and a separate full report given and action plan developed which will continue to be monitored and reviewed at the Trust's People Culture and Development Committee along with the quarterly Towards Outstanding Engagement survey results.

## 3. 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 75 submissions received from July 2017 to June 2018. It is noted that submissions are less when compared to the same period in 2016/17 where 112 submissions were received. It continues to provide a mechanism for staff to raise concerns anonymously if they prefer. Whilst the majority of submissions, 81% (down from 84% in previous quarter), 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 investigation and/or action. The Dear Caroline process will therefore continue as a means of raising concerns. High level summary of each continues to be published on SID, along with each of the Dear Caroline submissions – published in a 'you said, we did' approach.

Although the FSUG role and initiative is relatively new, it is encouraging that staff are accessing the Guardian to raise issues or concerns. Further developments are expected with regards to this role as directed by the National FSUG office, the CQC advancements and the newly appointed FSUG.

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.

Moving forward 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.

## 4. 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 development and embedding of the Trust Values and supporting Behaviours Framework
- Continuation of the Freedom to Speak Up Guardian role including further strengthening of approach/ development of a range of Freedom to Speak Up Champions to further support the FSUG role.
- Continue and strengthen communication to the wider Trust to help promote speaking to managers, professional leads, trade union representatives as well as the more formal routes that are available.

## 5. 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 (FSUG)**
  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 Dan Platt. 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 (previously the Whistleblowing Policy) is used when someone who works in or for an organisation 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 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 the Trust's HR department 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 TRUST BOARD

Enclosure No:17

| | | | |
|---|---|---|---|
| Date of Meeting: | 26/09/2018 | | |
| Title of Report: | Finance Overview as at 31st July 2018 | | |
| Presented by: | Suzanne Robinson Executive Director of Finance, Performance and Digital | | |
| Author: | L Dodds - Assistant Director of Finance | | |
| Executive Lead Name: | Suzanne Robinson – Executive Director of Finance, Performance and Digital | Approved by Exec | ☒ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| The report summarises the finance position at month 4 (July 2018) | Approval | ☒ |
| | Information | ☒ |
| | Discussion | ☐ |
| | Assurance | ☒ |
| Seen at: SLT ☒ Execs ☒ Date: | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☐<br>• Finance & Performance Committee ☒<br>• Audit Committee ☐<br>• People & Culture Development Committee ☐<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Digital by Choice Board ☐ | |
| Strategic Objectives (please indicate) | 1. To enhance service user and carer involvement.☐<br>2. To provide the highest quality services ☐<br>3. Create a learning culture to continually improve.☐<br>4. Encourage, inspire and implement research & innovation at all levels.☐<br>5. Maximise and use our resources intelligently and efficiently.☒<br>6. Attract and inspire the best people to work here.☐<br>7. Continually improve our partnership working. ☐ | |
| Risk / legal implications: Risk Register Reference | Ref 1035: Trust top 3 risks around delivery of cost improvement target. | |
| Resource Implications: Funding Source: | None applicable | |
| 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: | Trust Board are asked to;<br><br>• The reported YTD surplus of £229k against a planned surplus of £156k. This is a favourable variance to plan of £73k. | |

| | |
|---|---|
| | • The M4 CIP achievement:<br><br>• YTD achievement of £349k (51%); an adverse variance of £335k;<br>• 2018/19 forecast CIP delivery of £1,458k (52%) based on schemes identified; an adverse variance of £1,337k to plan;<br>• The recurrent value of schemes transacted at £1,043k, 37% of target.<br><br>• The cash position of the Trust as at 31st July 2018 with a balance of £10,159k; £852k better than plan<br><br>• Month 4 capital expenditure at £122k compared to planned capital expenditure of £167k;<br><br>• Use of resource rating of 2 against a plan of 2.<br><br>Approve:<br>• The month 4 position reported to NHSI. |

NHS
North Staffordshire Combined Healthcare NHS Trust

# Financial Overview as at 31st July 2018

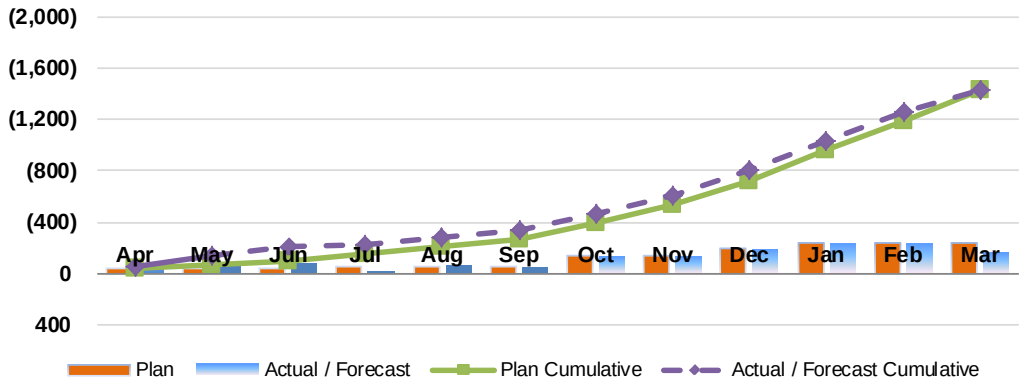
## Income & Expenditure - Control Total (Surplus) / Deficit

| £000 | Plan | Actual | Var | % | RAG |
|---|---|---|---|---|---|
| YTD | (156) | (229) | (73) | (47) | G |
| FOT | (1,423) | (1,423) | 0 | 0 | G |

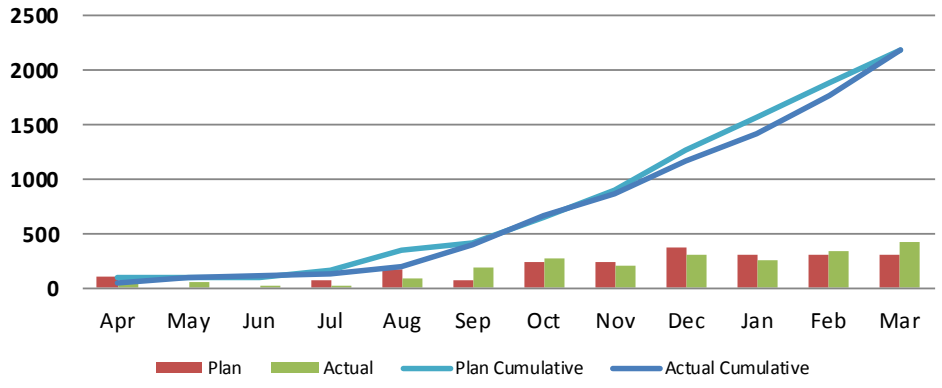
## Charge to CRL

| £000 | Plan | Actual | Var | % | RAG |
|---|---|---|---|---|---|
| YTD | 167 | 122 | (45) | (27) | A |
| FOT | 2,185 | 2,185 | 0 | 0 | G |

## Retained (Surplus) / Deficit Run Rate 2018/19



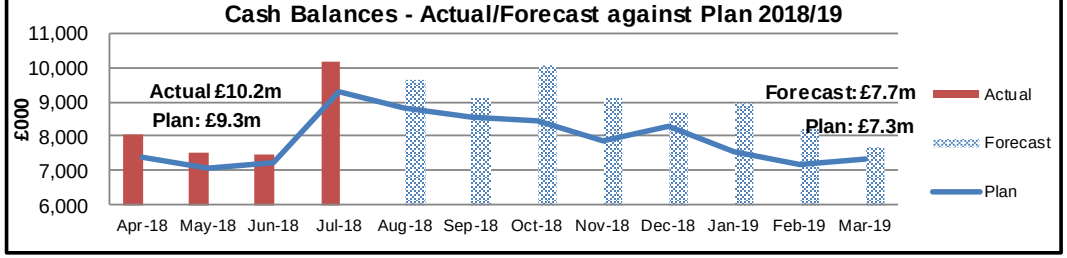

## Net Capital Expenditure - Plan / Forecast 2018/19




## Cash Balances

| £000 | Plan | Actual | Var | % | RAG |
|---|---|---|---|---|---|
| YTD | 9,307 | 10,159 | 852 | 9 | G |
| FOT | 7,339 | 7,676 | 337 | 5 | G |

## Cash Balances - Actual/Forecast against Plan 2018/19




## Cost Improvement

| £000 | Plan | Actual | Var | % | Rec Var | RAG |
|---|---|---|---|---|---|---|
| Clinical | 460 | 236 | (224) | (49) | (1,142) | R |
| Corporate | 224 | 113 | (111) | (50) | (83) | R |
| Total | 684 | 349 | (335) | (49) | (1,225) | R |

| Use of Resource | Plan | Actual |
|---|---|---|
| **Overall Risk Rating** | 2 | 2 |
| Liquidity Ratio | 1 | 1 |
| Capital Servicing Capacity | 3 | 3 |
| I& E Margin | 2 | 2 |
| I&E Margin Variance to Plan | 1 | 1 |
| Agency Spend | 1 | 1 |

## 1. Introduction:

The Trust's 2018/19 financial plan is to deliver a trading position of £0.720m surplus. The Trust has accepted the Control Total from NHS Improvement (NHSI) of £1.423m surplus which includes £0.703m from the Sustainability & Transformation Fund.

## 2. Income & Expenditure (I&E) Performance

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

- During month 4, the trust had an in month trading position of £28k deficit against a plan of £7k surplus; **an adverse variance of £35k**. Sustainability and Transformation funding has been assumed at £47k for month 4, bringing the overall trust control to a £19k surplus against plan of £54k; **an adverse variance of £35k**.

- Year to date the trust has a trading position of £77k surplus against a plan of £4k surplus, **giving a favourable variance of £73k**. Sustainability and Transformation funding is assumed at £152k, bringing the overall year to date trust control total to £229k surplus, **a favourable variance of £73k.**

| | | Month 4 | | | Year to Date | | | Forecast | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Table 1: Summary Performance** | **Annual Budget £'000** | **Budget £'000** | **Actual £'000** | **Variance £'000** | **Budget £'000** | **Actual £'000** | **Variance £'000** | **Budget £'000** | **Actual £'000** | **Variance £'000** |
| Income | (83,985) | (7,045) | (7,011) | 34 | (27,815) | (27,799) | 16 | (84,468) | (84,469) | (0) |
| Pay | 62,062 | 5,461 | 4,995 | (466) | 20,939 | 19,893 | (1,047) | 62,240 | 60,932 | (1,309) |
| Non Pay | 18,470 | 1,350 | 1,818 | 468 | 5,961 | 6,913 | 952 | 18,775 | 20,078 | 1,304 |
| **EBITDA** | **(3,453)** | **(235)** | **(199)** | **36** | **(915)** | **(994)** | **(79)** | **(3,453)** | **(3,458)** | **(5)** |
| Other Non-Op Costs | 2,733 | 228 | 227 | (1) | 911 | 917 | 6 | 2,733 | 2,739 | 6 |
| **Trading Surplus** | **(720)** | **(7)** | **28** | **35** | **(4)** | **(77)** | **(73)** | **(720)** | **(720)** | **0** |
| Sustainability & Transformational Funding | (703) | (47) | (47) | 0 | (152) | (152) | 0 | (703) | (703) | 0 |
| **(Surplus)/Deficit for the year** | **(1,423)** | **(54)** | **(19)** | **35** | **(156)** | **(229)** | **(73)** | **(1,423)** | **(1,423)** | **0** |

## 3. Income

Table 2 below shows the Trust income position by contract:

- The NHS Stoke-on-Trent CCG and NHS North Staffordshire CCG contracts are set on a block basis. £23k variance year to date relates to 2017/18 quarter 4 under performance of CQUIN, which was not confirmed until June 2018 and further CQUIN under performance in quarter 1 of 2018/19.
- Specialised Services are under performing year to date by £40k due to a reduction in activity at the Darwin Centre.
- Stoke on Trent Public Health is underperforming against the contract due to a reduction in activity.
- Out of Area income is over performing year to date by £102k due to additional patients in A&T recharged to Stafford & Surrounds CCG.

| | | Month 4 | | | Year to Date | | | Forecast | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Table 2: Income** | **Annual Budget £'000** | **Budget £'000** | **Actual £'000** | **Variance £'000** | **Budget £'000** | **Actual £'000** | **Variance £'000** | **Budget £'000** | **Actual £'000** | **Variance £'000** |
| NHS Stoke-on-Trent CCG | (37,411) | (3,004) | (3,001) | 4 | (12,244) | (12,230) | 14 | (37,205) | (37,174) | 32 |
| NHS North Staffordshire CCG | (25,529) | (2,027) | (2,024) | 3 | (8,274) | (8,265) | 9 | (25,392) | (25,371) | 21 |
| Specialised Services | (3,189) | (266) | (212) | 54 | (1,063) | (1,023) | 40 | (3,189) | (3,070) | 119 |
| Stoke-on-Trent CC s75 | (3,999) | (346) | (346) | (0) | (1,333) | (1,333) | (0) | (3,999) | (4,031) | (32) |
| Staffordshire CC s75 | (1,054) | (88) | (88) | (0) | (351) | (352) | (1) | (1,054) | (1,056) | (2) |
| Stoke-on-Trent Public Health | (1,190) | (89) | (75) | 14 | (493) | (443) | 50 | (1,479) | (1,367) | 112 |
| Staffordshire Public Health | (613) | (51) | (51) | 0 | (204) | (204) | 0 | (613) | (613) | 0 |
| ADS/One Recovery | (1,467) | (122) | (122) | 0 | (489) | (489) | 0 | (1,467) | (1,467) | 0 |
| Associates | (1,538) | (331) | (333) | (2) | (513) | (513) | (0) | (1,538) | (1,539) | (1) |
| OATS | (771) | (64) | (120) | (56) | (257) | (359) | (102) | (771) | (1,051) | (280) |
| Private Patients | 0 | 0 | (3) | (3) | 0 | (3) | (3) | 0 | (3) | (3) |
| **Total Clinical Income** | **(76,762)** | **(6,388)** | **(6,375)** | **13** | **(25,222)** | **(25,215)** | **7** | **(76,708)** | **(76,741)** | **(32)** |
| Other Income | (7,223) | (657) | (636) | 21 | (2,593) | (2,584) | 9 | (7,760) | (7,728) | 32 |
| **Total Income** | **(83,985)** | **(7,045)** | **(7,011)** | **34** | **(27,815)** | **(27,799)** | **16** | **(84,468)** | **(84,469)** | **0** |
| Sustainability Transformation Funding | (703) | (47) | (47) | 0 | (152) | (152) | 0 | (703) | (703) | 0 |
| **Total Income Incl. STF** | **(84,688)** | **(7,092)** | **(7,058)** | **34** | **(27,967)** | **(27,951)** | **16** | **(85,171)** | **(85,172)** | **0** |

## 4. Expenditure

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

- Underspend of £1,047k at month 4 on pay is due to vacancies across the trust, partially covered by temporary staffing.
- Agency costs at month 4 are £592k, **£89k below the M4 agency ceiling of £681k.**
- Non-Pay is overspent year to date at £952k mainly due to residential payments and unachieved Cost Improvement.

| Table 3: Expenditure | Annual Budget £'000 | Month 4 Budget £'000 | Month 4 Actual £'000 | Month 4 Variance £'000 | Year to Date Budget £'000 | Year to Date Actual £'000 | Year to Date Variance £'000 | Forecast Budget £'000 | Forecast Actual £'000 | Forecast Variance £'000 |
|---|---|---|---|---|---|---|---|---|---|---|
| Medical | 7,412 | 616 | 318 | (298) | 2,494 | 1,989 | (505) | 7,404 | 6,651 | (753) |
| Nursing | 29,249 | 2,616 | 2,386 | (231) | 9,934 | 9,514 | (420) | 29,389 | 28,820 | (570) |
| Other Clinical | 14,927 | 1,284 | 1,182 | (102) | 5,028 | 4,368 | (660) | 14,978 | 13,051 | (1,926) |
| Non-Clinical | 10,251 | 926 | 898 | (28) | 3,409 | 3,357 | (52) | 10,247 | 10,297 | 50 |
| Apprenticeship Levy | 214 | 18 | 18 | 0 | 71 | 72 | 0 | 214 | 218 | 4 |
| Agency | 8 | 0 | 193 | 193 | 3 | 592 | 590 | 8 | 1,894 | 1,886 |
| **Total Pay** | **62,062** | **5,461** | **4,995** | **(466)** | **20,939** | **19,893** | **(1,047)** | **62,240** | **60,932** | **(1,309)** |
| Drugs & Clinical Supplies | 2,169 | 138 | 194 | 56 | 726 | 824 | 98 | 2,194 | 2,390 | 196 |
| Establishment Costs | 1,645 | 138 | 97 | (41) | 555 | 455 | (99) | 1,963 | 1,329 | (634) |
| Information Technology | 622 | 50 | 54 | 4 | 207 | 236 | 29 | 622 | 721 | 99 |
| Premises Costs | 2,148 | 180 | 207 | 28 | 728 | 796 | 67 | 2,175 | 2,376 | 200 |
| Private Finance Initiative | 4,372 | 364 | 359 | (5) | 1,457 | 1,456 | (1) | 4,372 | 4,380 | 8 |
| Services Received | 3,337 | 323 | 337 | 14 | 1,115 | 1,191 | 77 | 3,341 | 3,618 | 276 |
| Residential Payments | 1,760 | 160 | 171 | 11 | 587 | 857 | 270 | 1,760 | 2,471 | 711 |
| Consultancy & Prof Fees | 143 | 36 | 37 | 1 | 66 | 96 | 30 | 143 | 239 | 96 |
| External Audit Fees | 65 | 5 | 5 | (0) | 22 | 21 | (1) | 65 | 62 | (3) |
| Legal Fees | 65 | 5 | 4 | (1) | 22 | 14 | (7) | 65 | 46 | (18) |
| Unacheived CIP | (1,753) | (29) | 0 | 29 | (333) | 0 | 333 | (1,218) | (56) | 1,162 |
| Other | 3,898 | (22) | 352 | 374 | 809 | 966 | 157 | 3,293 | 2,502 | (790) |
| **Total Non-Pay** | **18,470** | **1,350** | **1,818** | **468** | **5,961** | **6,913** | **952** | **18,775** | **20,078** | **1,304** |
| Finance Costs | 1,293 | 108 | 103 | (5) | 431 | 422 | (9) | 1,293 | 1,254 | (39) |
| Local Government Pension Scheme | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Unwinding of Discounts | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Dividends Payable on PDC | 561 | 47 | 47 | 0 | 187 | 187 | 0 | 561 | 561 | 0 |
| Investment Revenue | (14) | (1) | (3) | (2) | (5) | (11) | (6) | (14) | (34) | (20) |
| Fixed Asset Impairment | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Depreciation (excludes IFRIC 12) | 893 | 74 | 80 | 5 | 298 | 319 | 21 | 893 | 957 | 64 |
| **Total Non-op. Costs** | **2,733** | **228** | **227** | **(1)** | **911** | **917** | **6** | **2,733** | **2,739** | **6** |
| **Total Expenditure** | **83,265** | **7,038** | **7,039** | **1** | **27,811** | **27,722** | **(89)** | **83,748** | **83,749** | **0** |

**Agency Breakdown**

| Agency Type | YTD (£'000) | % |
|---|---|---|
| Medical | 371 | 63% |
| Nursing | 166 | 28% |
| Other Clinical | 1 | 0% |
| Non Clinical | 55 | 9% |
| **Total** | **592** | **100%** |

## 5. Directorate Summary

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

| Table 4: YTD Expenditure | Pay | | | Non Pay | | | Income | | | Total | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Budget £'000 | Actual £'000 | Variance £'000 | Budget £'000 | Actual £'000 | Variance £'000 | Budget £'000 | Actual £'000 | Variance £'000 | Budget £'000 | Actual £'000 | Variance £'000 |
| AMH Community | 5,985 | 5,659 | (325) | 1,464 | 1,764 | 300 | (750) | (789) | (40) | 6,699 | 6,634 | (65) |
| AMH Inpatients | 2,101 | 2,091 | (9) | 111 | 118 | 7 | (1) | (1) | (0) | 2,211 | 2,208 | (2) |
| Children's Services | 2,068 | 1,966 | (102) | 212 | 266 | 54 | (200) | (218) | (18) | 2,080 | 2,014 | (66) |
| Substance Misuse | 1,036 | 975 | (61) | 301 | 333 | 32 | (165) | (115) | 50 | 1,173 | 1,194 | 21 |
| Learning Disabilities | 1,792 | 1,637 | (155) | 76 | 99 | 23 | (149) | (146) | 3 | 1,718 | 1,590 | (128) |
| Neuro & Old Age Psychiatry | 4,212 | 3,966 | (246) | 174 | 270 | 96 | (405) | (400) | 4 | 3,982 | 3,836 | (146) |
| Corporate | 3,746 | 3,598 | (148) | 4,534 | 4,979 | 445 | (26,298) | (26,282) | 16 | (18,018) | (17,705) | 313 |
| **Total** | **20,939** | **19,893** | **(1,047)** | **6,872** | **7,829** | **958** | **(27,967)** | **(27,951)** | **16** | **(156)** | **(229)** | **(73)** |

- AMH Community is underspent on pay due to vacancies partially offset with bank and agency. The adverse variance on non-pay is due to an under delivery of cost improvement against target and overspends on residential payments.

- Other Directorates are underspent on pay mainly due to vacancies, partially offset with under delivery of cost improvement.

## 6. Cost Improvement Programme

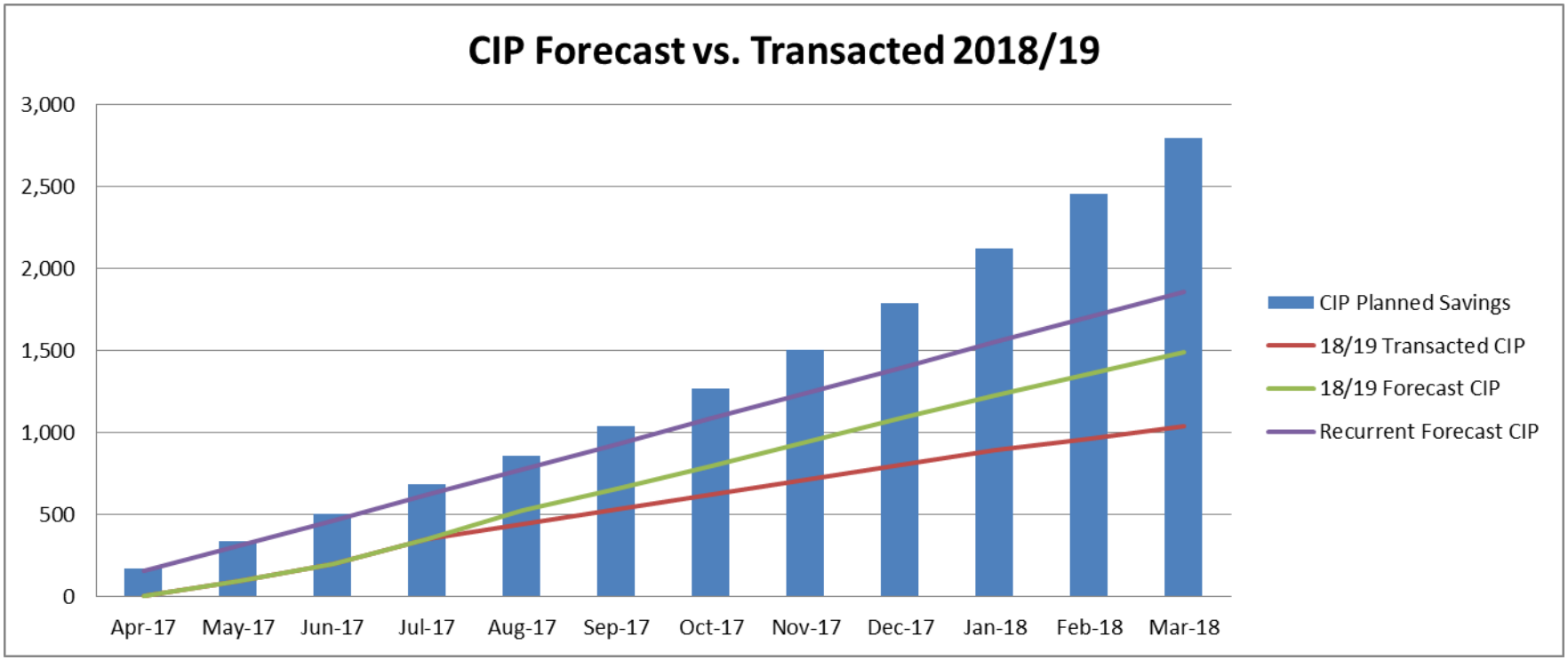
The Trust target for the year is £2,795k, as reported to NHSI. This takes into account the requirement to deliver a £1,423k control surplus for 2018/19. The table below shows the achievement by Directorate towards individual targets at M4. The Trust wide cost improvement achievement year to date is 51% at M4 compared to plan.

| | | YTD M4 | | | Forecast | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| CIP Delivery | Annual CIP Target 2018/19 | Plan | Transacted | (Under)/Over Achievement | Plan | Total Schemes | (Under)/Over Achievement | RAG | Recurrent Transacted | Recurrent Position |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | | £'000 | £'000 |
| **Clinical** | | | | | | | | | | |
| AMH Community | 973 | 152 | 31 | (121) | 973 | 157 | (816) | 16% | 140 | 238 |
| AMH Inpatients | 160 | 27 | 20 | (7) | 160 | 106 | (53) | 66% | 129 | 129 |
| Children's Services | 296 | 69 | 64 | (5) | 296 | 257 | (39) | 87% | 236 | 297 |
| Learning Disabilities | 234 | 96 | 69 | (27) | 234 | 223 | (11) | 95% | 64 | 167 |
| NOAP | 551 | 115 | 52 | (64) | 551 | 239 | (312) | 43% | 161 | 242 |
| **Total Clinical** | **2,214** | **460** | **236** | **(223)** | **2,214** | **982** | **(1,232)** | **44%** | **730** | **1,072** |
| **Corporate** | | | | | | | | | | |
| CEO | 15 | 5 | 5 | 0 | 15 | 15 | 0 | 100% | 15 | 15 |
| Finance, Performance & Digital | 43 | 14 | 20 | 6 | 43 | 60 | 17 | 140% | 60 | 60 |
| MACE | 9 | 3 | 5 | 1 | 9 | 14 | 4 | 144% | 14 | 14 |
| Operations | 6 | 2 | 2 | (0) | 6 | 6 | 0 | 100% | 6 | 6 |
| Quality & Nursing | 41 | 14 | 7 | (6) | 41 | 42 | 2 | 104% | 22 | 42 |
| Strategy | 11 | 4 | 4 | (0) | 11 | 11 | 0 | 100% | 11 | 11 |
| Trustwide | 384 | 159 | 53 | (106) | 384 | 216 | (168) | 56% | 133 | 298 |
| Workforce & OD | 72 | 24 | 18 | (7) | 72 | 53 | (20) | 73% | 53 | 53 |
| **Total Corporate** | **581** | **224** | **113** | **(111)** | **581** | **416** | **(165)** | **72%** | **313** | **498** |
| **Total** | **2,795** | **684** | **349** | **(335)** | **2,795** | **1,398** | **(1,397)** | **50%** | **1,043** | **1,571** |

| | | | |
|---|---|---|---|
| Below 75% | | Target | 2,795 |
| Below 90% | | Variance | (1,224) |

- The forecast position at M4 for 2018/19 is £1,398k (50%), which represents an in year shortfall against the annual target of £1,397k.
- The recurrent position stands at **£1,571k** which is **56%** of the total requirement.

### 6.1 Cost Improvement Programme Forecast & Transacted 2018/19



## 7. Statement of Financial Position

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

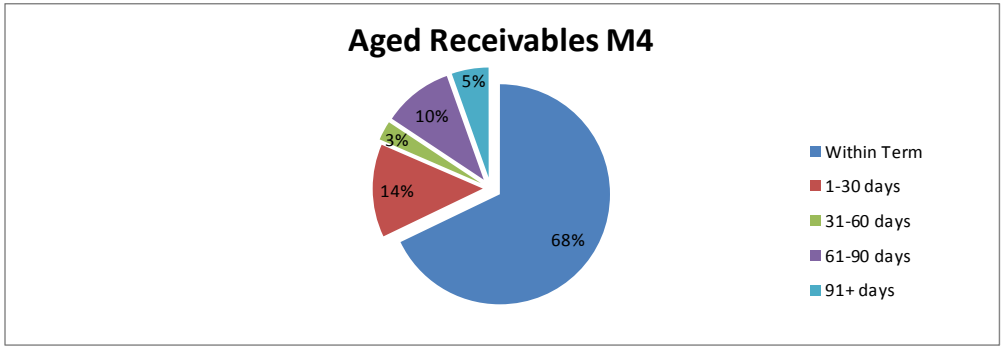
| *Table 6: SOFP* | 31/03/2018 £'000 | 31/05/2018 £'000 | 30/06/2018 £'000 | 31/07/2018 £'000 |
|---|---|---|---|---|
| **Non-Current Assets** | | | | |
| Property, Plant and Equipment - PFI | 16,185 | 16,208 | 16,190 | 16,175 |
| Property, Plant and Equipment | 14,841 | 14,775 | 14,731 | 14,681 |
| Intangible Assets | 277 | 264 | 258 | 252 |
| NCA Trade and Other Receivables | 608 | 0 | 0 | 0 |
| Other Financial Assets | 1,089 | 1,089 | 1,089 | 1,089 |
| **Total Non-Current Assets** | **33,000** | **32,337** | **32,269** | **32,197** |
| **Current Assets** | | | | |
| Inventories | 79 | 76 | 78 | 80 |
| Trade and Other Receivables | 7,347 | 6,920 | 7,568 | 5,722 |
| Cash and Cash Equivalents | 6,633 | 7,510 | 7,457 | 10,159 |
| Non-Current Assets Held For Sale | 0 | 0 | 0 | 0 |
| **Total Current Assets** | **14,058** | **14,506** | **15,103** | **15,961** |
| **Current Liabilities** | | | | |
| Trade and Other Payables | (7,166) | (6,961) | (7,476) | (8,298) |
| Provisions | (621) | (545) | (543) | (540) |
| Borrowings | (633) | (635) | (635) | (635) |
| **Total Current Liabilities** | **(8,420)** | **(8,142)** | **(8,653)** | **(9,473)** |
| **Net Current Assets / (Liabilities)** | **5,639** | **6,364** | **6,450** | **6,487** |
| **Total Assets less Current Liabilities** | **38,639** | **38,701** | **38,718** | **38,684** |
| **Non Current Liabilities** | | | | |
| Provisions | (458) | (458) | (458) | (458) |
| Borrowings | (11,557) | (11,479) | (11,426) | (11,373) |
| **Total Non-Current Liabilities** | **(12,015)** | **(11,937)** | **(11,884)** | **(11,831)** |
| **Total Assets Employed** | **26,624** | **26,764** | **26,834** | **26,853** |
| **Financed by Taxpayers' Equity** | | | | |
| Public Dividend Capital | 7,648 | 7,648 | 7,648 | 7,648 |
| Retained Earnings reserve | 7,943 | 8,084 | 8,154 | 8,172 |
| Other Reserves (LGPS) | 1,089 | 1,089 | 1,089 | 1,089 |
| Revaluation Reserve | 9,944 | 9,944 | 9,944 | 9,944 |
| **Total Taxpayers' Equity** | **26,624** | **26,764** | **26,834** | **26,853** |

Current receivables are £5,722k, of which:

- £2,965k is based on accruals (not yet invoiced) and relates mainly to income accruals for services invoiced retrospectively at the end of every quarter.
- £2,757k is awaiting payment of invoice. (£1,871k within terms)

£510k is overdue by 31 days or more and therefore subject to routine credit control processes.

| | | Days Overdue | | | | |
|---|---|---|---|---|---|---|
| *Table 6.1 Aged Receivables/Payables* | Within Term £'000 | 1-30 Days £'000 | 31-60 Days £'000 | 61-90 Days £'000 | 91+ Days £'000 | Total £'000 |
| Receivables Non NHS | 1,306 | 99 | 5 | 266 | 491 | 2,167 |
| Receivables NHS | 565 | 277 | 73 | 16 | (341) | 590 |
| Payables Non NHS | 741 | 41 | (19) | 5 | 11 | 779 |
| Payables NHS | 615 | 24 | 113 | 28 | 14 | 794 |



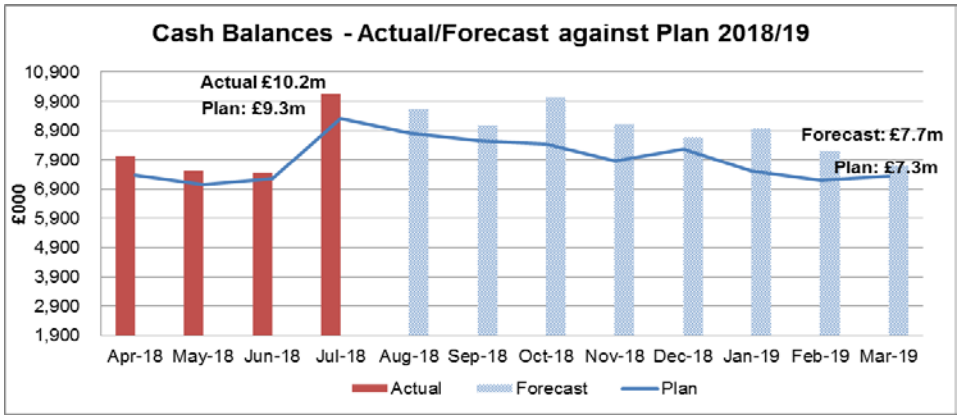
## 8. Cash Flow Statement

The cash balance at 31st July 2018 has increased by **£2.701m** to **£10.159m**. The increase in the cash balance is due to receipt of the final 2017/18 STF funding payment relating to the bonus element of STF at £1.871m and the quarter 4 core STF payment at £0.175m.

The Trust cash position at 31st July 2018 is **£852k higher than planned,** mainly due to lower payroll payments compared to plan as well as the timing of pay award arrears which will be paid in August. The Trust anticipates being slightly above plan by March 2019.

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

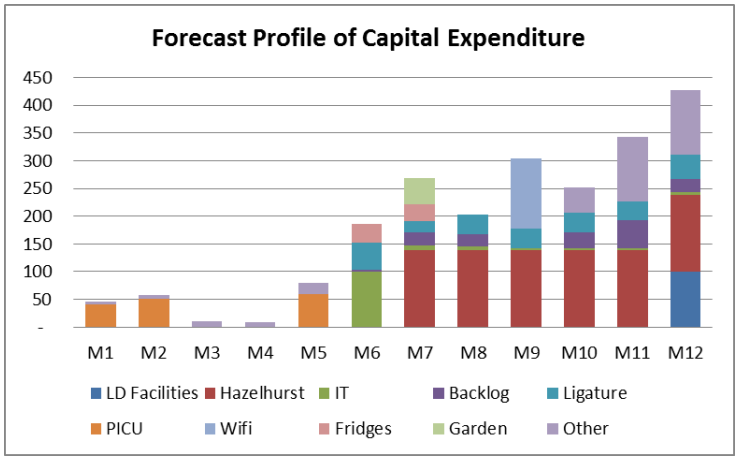
| *Table 7: Statement of Cash Flows* | Apr-18 £'000 | May-18 £'000 | Jun-18 £'000 | Jul-18 £'000 | Aug-18 £'000 | Sep-18 £'000 | Oct-18 £'000 | Nov-18 £'000 | Dec-18 £'000 | Jan-19 £'000 | Feb-19 £'000 | Mar-19 £'000 | Annual £'000 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Net Inflows/(Outflow) from Operating Activities | 927 | (281) | 159 | 2,908 | (140) | (275) | 1,379 | (478) | 14 | 806 | (232) | (17) | **4,770** |
| Net Inflows/(Outflow) from Investing Activities | 676 | (60) | (8) | (6) | (174) | (65) | (240) | (240) | (240) | (306) | (307) | (309) | **(1,279)** |
| Net Inflows/(Outflow) from Financing Activities | (193) | (193) | (202) | (202) | (207) | (207) | (207) | (208) | (207) | (207) | (207) | (208) | **(2,448)** |
| **Net Increase/(Decrease)** | **1,410** | **(534)** | **(51)** | **2,701** | **(521)** | **(547)** | **932** | **(926)** | **(433)** | **293** | **(746)** | **(534)** | **1,044** |
| | | | | | | | | | | | | | |
| **Opening Cash & Cash Equivalents** | **6,633** | **8,043** | **7,509** | **7,458** | **10,159** | **9,638** | **9,091** | **10,023** | **9,097** | **8,663** | **8,956** | **8,210** | |
| **Closing Cash & Cash Equivalents** | **8,043** | **7,509** | **7,458** | **10,159** | **9,638** | **9,091** | **10,023** | **9,097** | **8,663** | **8,956** | **8,210** | **7,677** | |
| | | | | | | | | | | | | | |
| Plan | 7,366 | 7,055 | 7,255 | 9,307 | 8,825 | 8,568 | 8,445 | 7,873 | 8,263 | 7,523 | 7,204 | 7,339 | 7,339 |
| **Variance** | **(677)** | **(454)** | **(203)** | **(852)** | **(813)** | **(523)** | **(1,578)** | **(1,224)** | **(400)** | **(1,433)** | **(1,006)** | **(338)** | |



## 9. Capital Expenditure

The Trust's permitted capital expenditure agreed within the 2017/18 plan is £2,058k. Table 7 below shows the planned capital expenditure for 2018/19 as submitted to NHSI.

| | | Year to Date | | | Forecast | | |
|---|---|---|---|---|---|---|---|
| *Table 8: Capital Expenditure* | Annual Plan £'000 | Plan £'000 | Actual £'000 | Variance £'000 | Plan £'000 | Actual £'000 | Variance £'000 |
| Learning Disability Facilities | 400 | 0 | 0 | 0 | 100 | 100 | 0 |
| Hazelhurst incl Second Place of Safety | 1,000 | 0 | 0 | 0 | 827 | 827 | 0 |
| Information Technology Replacement Programme | 108 | 0 | 0 | 0 | 108 | 137 | 29 |
| Backlog Maintenance | 150 | 25 | 0 | (25) | 150 | 150 | 0 |
| Reduced Ligature Risks | 250 | 42 | 0 | (42) | 250 | 250 | 0 |
| Equipment Replacement Programme | 50 | 0 | 0 | 0 | 50 | 50 | 0 |
| Psychiatric Intensive Care Unit | 0 | 100 | 93 | (7) | 100 | 150 | 50 |
| Darwin | 0 | 0 | 0 | 0 | 0 | 17 | 17 |
| Generator | 0 | 0 | 33 | 33 | 0 | 34 | 34 |
| Garden Redesign CYP Short Breaks | 0 | 0 | 0 | 0 | 0 | 48 | 48 |
| IP Telephony Replacement | 0 | 0 | 1 | 1 | 0 | 0 | 0 |
| Pharmacy Temperature Monitoring System | 0 | 0 | 0 | 0 | 0 | 65 | 65 |
| Contingency | 100 | 0 | (5) | (5) | 473 | 230 | (243) |
| **Sub Total Gross Capital Expenditure** | **2,058** | **167** | **122** | **(45)** | **2,058** | **2,058** | **0** |
| Wifi | 127 | 0 | 0 | 0 | 127 | 127 | 0 |
| **Total Gross Capital Expenditure** | **127** | **167** | **122** | **(45)** | **2,185** | **2,185** | **0** |




- Actual Capital cumulative expenditure as at month 4 is £122k mainly relating to PICU and the purchase of the Estates generator.
- The Capital Investment Group made recommendations to Business Development Committee to account for the profile of spend for Learning Disability's facilities which are still subject to approval of a business case. This has resulted in a shift of £300k to capital contingency
- Any commitment against contingency funds will follow the usual business case process.

## 10. Use of Resource Metrics

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

| *Table 9: Use of Resource* | Year to Date Plan | Year to Date Actual | RAG Rating |
|---|---|---|---|
| **Liquidity Ratio (days)** | | | |
| Working Capital Balance (£000) | | 6,407 | |
| Annual Operating Expenses (£000) | | 26,805 | |
| Liquidity Ratio days | | 29 | |
| **Liquidity Ratio Metric** | **1** | **1** | |
| **Capital Servicing Capacity (times)** | | | |
| Revenue Available for Debt Service (£000) | | 1,157 | |
| Annual Debt Service (£000) | | 791 | |
| Capital Servicing Capacity (times) | | 1.5 | |
| **Capital Servicing Capacity Metric** | **3** | **3** | |
| **I&E Margin** | | | |
| Normalised Surplus/(Deficit) (£000) | | 229 | |
| Total Income (£000) | | 27,951 | |
| I&E Margin | | 0.8% | |
| **I&E Margin Rating** | **2** | **2** | |
| **I&E Margin Variance from Plan** | | | |
| I&E Margin Variance | | 0.3% | |
| **I&E Margin Variance From Plan** | **1** | **1** | |
| **Agency Spend** | | | |
| Providers Cap (£000) | | 681 | |
| Agency Spend (£000) | | 592 | |
| Agency % | | (13%) | |
| **Agency Spend Metric** | **1** | **1** | |
| **Use of Resource** | **2** | **2** | |

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

## 11. Better Payment Practice Code

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

At month 4, the Trust has achieved above the 95% target in terms of the value of invoices paid, but has under-performed against this target for the number of invoices, having paid 91% of the total number within target. Table 10 below shows the Trust's BPPC performance split between NHS and non-NHS suppliers.

| | 2017/18 | | | 2018/19 Month 4 | | | 2018/19 YTD | | |
|---|---|---|---|---|---|---|---|---|---|
| ***Table 10: Better Payment Practice Code*** | **NHS** | **Non-NHS** | **Total** | **NHS** | **Non-NHS** | **Total** | **NHS** | **Non-NHS** | **Total** |
| **Number of Invoices** | | | | | | | | | |
| Total Paid | 659 | 10,933 | 11,592 | 58 | 747 | 805 | 234 | 3,642 | 3,876 |
| Total Paid within Target | 575 | 9,527 | 10,102 | 57 | 675 | 732 | 222 | 3,224 | 3,446 |
| % Number of Invoices Paid | 87% | 87% | 87% | 98% | 90% | 91% | 95% | 89% | 89% |
| % Target | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |
| **RAG Rating (Variance to Target)** | **-8%** | **-8%** | **-8%** | **3%** | **-5%** | **-4%** | **0%** | **-6%** | **-6%** |
| **Value of Invoices** | | | | | | | | | |
| Total Value Paid (£000s) | 7,164 | 33,211 | 40,375 | 490 | 2,692 | 3,182 | 2,032 | 11,087 | 13,119 |
| Total Value Paid within Target (£000s) | 6,258 | 31,653 | 37,911 | 450 | 2,634 | 3,084 | 1,881 | 10,628 | 12,509 |
| % Value of Invoices Paid | 87% | 95% | 94% | 92% | 98% | 97% | 93% | 96% | 95% |
| % Target | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |
| **RAG Rating (Variance to Target)** | **-8%** | **0%** | **-1%** | **-3%** | **3%** | **2%** | **-2%** | **1%** | **0%** |

- The majority of breaches in number of invoices relates to the retrospective raising of purchase orders, or late authorisation, 41 invoices in total (45 in month 3). The finance team will continue to monitor the retrospective raising of Purchase Orders and also to review the reasons for late authorisation.

- The underperformance on the value of invoices paid within target on NHS invoices relates materially to CQC fees invoice which was delayed awaiting a purchase order (c.£60k) and Aqua Membership (£40k) which was delayed awaiting a waiver request.

## 12. Recommendations

The Trust Board are asked to:

**Note:**

- The reported YTD surplus of £229k against a planned surplus of £156k. **This is a favourable variance to plan of £73k.**
- The M4 CIP achievement:
  - YTD achievement of £349k (51%); **an adverse variance of £335k**;
  - 2018/19 forecast CIP delivery of £1,398k (50%) based on schemes identified; **an adverse variance of £1,397k to plan**;
  - The recurrent value of schemes transacted at £1,043k, **37% of target**.
- The cash position of the Trust as at 31st July 2018 with a **balance of £10,159k**; £852k better than plan
- Month 4 capital expenditure at £122k compared to planned capital expenditure of £167k;
- Use of resource rating of **2** against a plan of 2.

**Approve:**

- The month 4 position reported to NHSI.

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# REPORT TO OPEN TRUST BOARD

Enclosure No:18

| | | | |
|---|---|---|---|
| Date of Meeting: | 26 September 2018 | | |
| Title of Report: | Finance, Performance and Digital Committee Assurance Report | | |
| Presented by: | Tony Gadsby<br>Chair/Non-Executive Director | | |
| Author: | Mike Newton - Deputy Director of Finance | | |
| Executive Lead Name: | Suzanne Robinson – Executive Director of Finance, Performance and Digital | Approved by Exec | ☒ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| This paper details the issues discussed at the Finance, Performance and Digital Committee meeting on the 5 July 2018 and 3 August 2018. The meeting was quorate with minutes approved from the previous meetings. Progress was reviewed and actions confirmed from previous meetings. | Approval | ☐ |
| | Information | ☒ |
| | Discussion | ☐ |
| | Assurance | ☒ |

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

# Assurance Report to the Trust Board
# August 2018

## Finance, Performance and Digital Committee Report to the Trust Board – August 2018.

This paper details the issues discussed at the Finance, Performance and Digital Committee meeting on the 3rd August 2018. The meeting was quorate with minutes approved from the previous meeting on the 6th July 2018. Progress was reviewed and actions confirmed from previous meetings.

## Executive Director of Finance, Performance and Digital Update

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

- **Q1 Deep Dive –** A presentation providing a deep dive analysis into the 2018/19 financial position, which outlined the current forecast and sensitivity analysis to consider best and worst case forecast scenarios. Key risks to the financial position were presented, as well as mitigations, with a particular focus around the shortfall in identified schemes for Cost Improvement.

  The committee are assured around the delivery of control in 2018/19, but were concerned with the financial risk surrounding Section 75 Residential Placements and delivery of Cost Improvement.

- **NHS Pay Award** – An update on the NHS Pay award which has been agreed for 2018/19. Some initial analysis has been undertaken which suggests the pay award is within the budgeted envelope.

- **STP System Diagnostic –** An update on the STP system diagnostic designed to support improvement to health and care systems. A delivery unit has been set up nationally, which will bring together work from model hospital, GIRFT and Right Care.

  The diagnostic commenced for a 12 week programme for Staffordshire and Stoke on Trent STP. Updates will be fed into the trust board.

## Finance

- **Monthly Finance Report – Q1**

The Finance position was presented, showing £108k favourable variance to plan. Agency utilisation in Q1 was £399k a ceiling of £552k, giving a £123k favourable variance.

Use of resource rating is 1 against a plan of 2.

- **Cost Improvement Programme (CIP)**

The Committee received an update for Cost Improvement for Q1 and were concerned that the total identified was significantly short of the target. CIP achievement in Q1 was £201k, giving an adverse variance of £306k. A high level forecast at Q1 shows CIP delivery of £1,415k, giving an adverse variance to plan of £1,380k. The recurrent shortfall is forecast to be £1,046k

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, particularly given the level of unidentified schemes.

## Performance:

- **PQMF and Dashboard**

The committee received an update on the Trust performance against Local and National KPIs.

Use of Locums has increased in month due to low than usual locum fill rates in M1 and M2. The financial value for locums utilised is close to the monthly use for the last quarter of 2017/18.

Delayed Transfers of Care has improved to 7.6% for M3 from 9.1% in M2. The trust is liaising with Stoke on Trent City Council and Staffordshire County Council to expedite assessments and placements of service users.

- **PBR Care Cluster Activity Report: M3 2018/19 Care Cluster Compliance**

Post ROSE implementation and particularly the Q4 2017/18, the committee noted concern that the percentage of unassigned clusters (cluster 99) rose to over 55% and performance was not improving, despite focus.

The Associate Director of Performance presented a much improved position for 2018/19 Q1, following the implementation of the PBR action plan and work with Directorates. The committee noted that there was still some work to do but commended the performance team for the work to date, particularly noting the positive impact Miss Boswell has made since joining the trust. A further update will be presented in Q2.

- **CAMHs Waits**

Following concerns raised by the committee around performance against waiting time targets in CYP, a report was presented outlining the performance against each target for Q1. The committee were assured that significant progress has been made against the 18 week referral to treatment targets, however noted that the 4 week referral to assessment target still fell short of the required performance. The 4 week wait target is an internal stretch target over and above national requirements.

The committee requested a trajectory for improvement against the 4 week referral to

assessment target from the directorate, with realistic expectations for achievement.

## Other Reports and Updates

The Committee received additional assurance reports as follows:

- Estates Financial Recovery Plan (Verbal)
- Cost Improvement Programme (CIP) – Month 3
- Agency Utilisation Month 3
- Quarterly report on Digital Priorities.
- Finance, Performance and Digital Risk Register 2017/18
- Cycle of Business 2018/19 *(for information)*
- Capital Report and Capital Affordability Q1 *(for information)*
- Partnerships and Contracts Q1 *(for information)*
- Cash and Treasury Report Q1 *(for information)*
- FPD Monitoring Schedule (*for information*)
- Cycle of Business 2017/18 and 2018/19 (*for information*)

## Recommendation

The Board is asked to receive the contents of this report and take assurance from the review and challenge evidenced in the Committee.

On Behalf of Tony Gadsby
Chair of Finance, Performance and Digital Committee

# Assurance Report to the Trust Board
# 26th September 2018

## Finance, Performance and Digital Committee Report to the Trust Board – 26th September 2018.

This paper details the issues discussed at the Finance, Performance and Digital Committee meeting on the 6th September 2018. The meeting was quorate with minutes approved from the previous meeting on the 3rd August 2018. Progress was reviewed and actions confirmed from previous meetings.

## Executive Director of Finance, Performance and Digital Update

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

- **Pay Award Update –** An update around the pay award, originally presented in August 2018. The overall annual cost pressure is estimated to be £99k, which includes £103k unrealised pressure for vacant posts not currently filled.
- **KPMG Q1 Benchmarking** – A report from KPMG which benchmarked the Q1 Key financial performance against other Midlands NHS Trusts and Foundation Trusts.
- **10 Year Plan –** An update on the Prime Ministers "sustainable long term plan" which sees particular focus on Mental Health parity of esteem, improved outcomes for Cancer and better integration of health and social care.

## Finance

- **Monthly Finance Report – M4**

The Finance position was presented, showing £73k favourable variance to plan. Agency utilisation in M4 was £592k a ceiling of £681k, giving a £89k favourable variance.

Use of resource rating is 2 against a plan of 2.

- **Cost Improvement Programme (CIP)**

The Committee received an update for Cost Improvement for M4 and were concerned that the total identified was significantly short of the target. CIP achievement in M4 was £349k, giving an adverse variance of £335k. A high level forecast at M4 shows CIP delivery of £1,398k, giving an adverse variance to plan of £1,397k. The recurrent shortfall is forecast to be £1,224k

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, particularly given the level of unidentified schemes.

Committee members also noted the potential for a reduced management focus on CIP during the significant Divisional restructuring about to take place and sought assurance that the Executive Team would maintain clear Divisional oversight during this period.

The committee also requested the Cost Improvement Report to be updated to reflect the performance by "theme" as outlined in the original 2018/19 plan, which includes accountability by names leads.

## Digital:

- **September Digital Update**

The committee received an update around Key Digital Developments. An updated business case has been submitted to NHS Digital, since the business case approved at board due to changes in the funding envelope.

The programme costs have reduced from £3.65m to £3.1m, which includes a £10k reduction the North Staffordshire Combined contribution. The committee were given assurance that there would be no reduction in specification as a result of the funding reduction.

## Other:

- **Finance, Performance and Digital Risk Register**

The committee received an update on current risks which have an impact on Finance, Performance or Digital.

S.75 was highlighted as a key risk; with a forecast overspend of nearly £800k. The committee received an update on an independent review of the placements which gave assurance around their appropriateness, as well as a deep dive into the financial position. This fully bridging the movements in overspend between 2016/17 and 2018/19 and highlighted the daily cost of care homes being a driving factor in the increase.

Whilst the committee understood the position and were concerned with the level of overspend, which was significant financial risk to control.

The Committee received additional assurance reports as follows:

- 10 Year Plan
- PQMF and Dashboard
- 2017/18 Reference Costs
- Capital Funding Request – NHSI
- Terms of Reference FPD
- Review of Committee Effectiveness
- Board Assurance Framework
- Finance, Performance and Digital Risk Register 2017/18
- Cycle of Business 2018/19 *(for information)*
- Capital Report and Capital Affordability Q1 *(for information)*

## Recommendation

The Board is asked to receive the contents of this report and take assurance from the review and challenge evidenced in the Committee.

On Behalf of Tony Gadsby
Chair of Finance, Performance and Digital Committee

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# REPORT TO OPEN TRUST BOARD

Enclosure No:19

| | | | |
|---|---|---|---|
| Date of Meeting: | 26th September 2018 | | |
| Title of Report: | Register of Board Members – Declarations of Interest | | |
| Presented by: | Laurie Wrench, Associate Director of Governance | | |
| Author: | Lisa Wilkinson, Corporate Governance Manager | | |
| Executive Lead Name: | Caroline Donovan, CEO | Approved by Exec | ☐ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| The report provides an update as at the 31st August 2018 of current Board members interests. 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. | Approval | ☐ |
| | Information | ☒ |
| | Discussion | ☐ |
| | Assurance | ☒ |

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

# NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST

## REGISTER OF DIRECTORS' DECLARED PRIVATE INTERESTS

**As at 31st August 2018**

| NAME OF DIRECTOR | INTEREST DECLARED |
|---|---|
| **D Rogers**<br>Chairman | **Crystal Care Solutions Ltd**<br>Chairman<br><br>**Staffordshire Wildlife Trading Limited**<br>Director<br><br>**CQC**<br>Executive Reviewer<br><br>**GGI (Good Governance Institution)**<br>Non-Executive Director |
| **T Gadsby**<br>Non-Executive Director | **MedicAlert Foundation, British Isles and Ireland**<br>Chairman of Trustee Board<br><br>**MedicAlert Trading, British Isles and Ireland**<br>Director<br><br>**CQC**<br>Executive Reviewer |
| **P Sullivan**<br>Non-Executive Director | **Care Quality Commission**<br>Mental Health Act Reviewer<br><br>**Health, Education and Social Care Chamber (Mental Health)**<br>Fee-paid Specialist Lay Member of the First-tier Tribunal<br><br>**HMP/YOI Drake Hall**<br>Member of Independent Monitoring Board |
| **J Walley**<br>Non-Executive Director<br>Commenced 01/12/16 | **City Learning Trust**<br>Trustee<br><br>**Burslem Regeneration Trust**<br>Chairperson<br><br>**Carrick Court Freehold Company**<br>Director |
| **L Barber**<br>Non-Executive Director | **Macmillan Cancer Support with Investment Portfolio in Local Providers**<br>Employee |
| **G Mahadea**<br>Non-Executive Director | **General and Medical Accountants Ltd**<br>Owner and Director |
| **K Tattum**<br>GP Associate Director | **Baddeley Green Surgery Medical Limited**<br>Owner |

| | |
|---|---|
| | **North Staffordshire GP Federation**<br>Member<br><br>**Baddley Green Surgery**<br>Senior Partner |
| **C Donovan**<br>Chief Executive | **CQC**<br>Executive Reviewer |
| **Dr B Adeyemo**<br>Executive Medical Director | **Staffordshire University**<br>Honorary Lecturer<br><br>**WRES Strategic Advisory Group**<br>Membership<br><br>**University of Wolverhampton**<br>Board of Governors<br><br>**CQC**<br>Executive Reviewer |
| **A Brett**<br>Director of Leadership & Workforce (*non-voting*) | **STP System Leadership and OD Workstream**<br>Programme Director |
| **M Nelligan**<br>Director of Nursing & Quality | **Hospice of the Good Shepherd**<br>Company Director<br><br>**University of Chester**<br>Honorary Senior Lecturer<br><br>**CQC**<br>Executive Reviewer<br><br>**National Mental Health Nurse Directors Forum**<br>Member |
| **S Robinson**<br>Director of Finance and Performance | **STP Staffordshire and Stoke-on-Trent**<br>Finance Director<br><br>**CQC**<br>Executive Reviewer |
| **L Wrench**<br>Associate Director of Governance | **Wrench Fine Jewellery (t/a Timecraft)**<br>Family Business |
| **A Hughes**<br>Joint Director of Strategy & Development | **Joint Director of Strategy & Development**<br>Joint post with North Staffordshire GP Federation<br><br>**Partners in Paediatrics**<br>Chair<br><br>**Teenage Cancer Trust**<br>Safeguarding Trustee (Non-Executive Director) |

| | |
|---|---|
| | **Meant Ltd**<br>Owner and Director<br><br>**Meant Consortium Ltd**<br>Owner and Director<br><br>**The Village Rainbow Ltd**<br>Owner and Director<br><br>**Ashbourne Retailers Association**<br>Member<br><br>**School of the Built Environment, Oxford Brookes University**<br>Specialist Lecturer |
| **Jonathan O'Brien**<br>Director of Operations | **No interests declared** |
| **J McCrea**<br>Associate Director of Communications | **J B McCrea Ltd (Business Partner of Mood International Ltd)**<br>Managing Director<br><br>**East Leicestershire and Rutland GP Federation**<br>Member of the Board |
| **J Harvey**<br>Staff Side Representative | **No interests declared** |

Guidance issued by NHS England in February 2017 regarding NHS Conflicts of Interest outline the definition for a 'conflict of interest' and this may be *Actual* or *Potential*. Interests can arise in a number of different contexts and fall into the following 4 categories :

| Financial interest | Non financial professional interests | Non financial personal interests | Indirect interests |
|---|---|---|---|
| Direct financial benefit from the consequences of a decision | Non financial professional benefit | Personal benefit | Close association with someone who has an interest |

### 7.1.2 Interests which are relevant and material (Standing Orders Policy 4.4)

(i) Interests which should be regarded as "relevant and material" are:

a) any directorship of a company;

b) any interest held by a director in any firm or company or business which, in connection with the matter, is trading with the Trust, or is likely to be considered as a potential trading partner with the Trust;

c) any interest in an organisation providing health and social care services to the health service;

d) a position of authority in a charity or voluntary organisation in the field of health and social care

# REGISTER OF ACCEPTANCE OF THE CODE OF CONDUCT AND CODE OF ACCOUNTABILITY IN THE NHS

In November 2007, the Trust Board requested that a formal register of acceptance of the Code of Conduct and Code of Accountability in the NHS is established.

All Directors have provided a signed declaration of their acceptance of the Code of Conduct and Code of Accountability in the NHS to the Trust Secretary

The Code of Conduct and Code of Accountability in the NHS can be viewed on the Department of Health website at:

**http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4116281**

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# REPORT TO OPEN TRUST BOARD

Enclosure No: 20

| | | | |
|---|---|---|---|
| Date of Meeting: | 26 September 2018 | | |
| Title of Report: | Assurance Report from the People and Culture Development Committee | | |
| Presented by: | Lorien Barber, Non-Executive Director | | |
| Author: | Alex Brett, Executive Director of Workforce, OD and Communications | | |
| Executive Lead Name: | Alex Brett | Approved by Exec | ☒ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| A summary of the People & Culture Development Committee meeting held on 10 September 2018 and chaired by Mrs Lorien Barber. It received a number of reports for assurance and approval including:<br>• Director of Workforce, OD & Communications Update<br>• Locality Working<br>• Board Assurance Framework<br>• Workforce & OD Risks<br>• Performance Report<br>• Workforce Metrics<br>• Staff Survey Results Action Plan (2017-18)<br>• Being Open Report<br>• WRES<br>• Staff Assaults Report<br>• Recruitment and Retention (Medical Aspect) Action Plan<br>• BMA response to the Sir Williams Review (Gross Negligence)<br>• Policies for extension | Approval | ☒ |
| | Information | ☒ |
| | Discussion | ☐ |
| | Assurance | ☒ |

| | | | |
|---|---|---|---|
| Seen at: | SLT ☐ Execs ☐<br>Date: N/A | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☐<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☒<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Digital by Choice Board ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement. ☒<br>2. To provide the highest quality services ☒<br>3. Create a learning culture to continually improve. ☒<br>4. Encourage, inspire and implement research & innovation at all levels. ☐<br>5. Maximise and use our resources intelligently and efficiently ☒<br>6. Attract and inspire the best people to work here ☒<br>7. Continually improve our partnership working. ☐ | | |
| Risk / legal implications:<br>Risk Register Ref | N/A | | |
| Resource Implications:<br><br>Funding Source: | N/A<br><br>N/A | | |

| | |
|---|---|
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups) | 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<br>• Eliminate unlawful discrimination<br>• Advance equality of opportunity<br>• Foster good relations |
| STP Alignment / Implications | None |
| Recommendations: | The Board are asked to approve the policy extension for ratification and receive the summary for assurance purposes. |

**Summary to Trust Board**
**People & Culture Development Committee**
**Monday, 10 September 2018, 9.30 – 12.40am**

The meeting was chaired by Mrs Lorien Barber.

## 1. Director of Workforce, OD and Communications Update

The Committee was updated on the following issues:

- Pay Review Body
- STP
- STP OD and System Leadership Programme Board
- LWAB
- Section 75
- Symphony of Hidden Voices Conference

The Committee also noted that that NHSI have asked the Trust to hold off pay awards around VSM. The Chairman, David Rogers has been notified in respect of REMCO.

## 2. Locality Working

The Committee was informed that the Locality Working Phase 3 Management of Change consisting of middle management, Matrons, Governance Leads, has now been closed off and we are currently working through the feedback. There has been engagement with staff and where applicable the structure has been revised to take on staff feedback. The 'Go live' date has been delayed until 1 October 2018.

## 3. Board Assurance Framework

This report was deferred to the next meeting in November 2018.

## 4. Workforce & OD Risks

A number of risks are monitored and reviewed through the Committee. The Committee drew attention to the following risk and the mitigations;

***Risk 330 – The Trust fails to reduce sickness levels due to anxiety/stress/depression and other psychiatric illness, therefore potentially impacting on quality of service delivery and costs.*** The residual risk has decreased down to a score of 9 and the Trust is continuing to maintain a good position. However, this will remain on the register and be monitored going forward during this period of change

## 5. Performance Report

The Committee was updated on the highlights from M4 data:

- Sickness absence continues to reduce to 2.34% (target 4.95%)
- Staff Turnover is at 0.9% (target 10%)
- 92% of staff have completed statutory/mandatory training during M4 (target 85%)

**Use of Locums** – 21.2% from 18.4%. There has been an increase associated with medics with individuals off sick and this relates to covering posts. It remains challenging with Consultant appointments, although it is pleasing to note the Trust has appointed a substantive post to the Sutherland Centre recently.

**Personal Development** – 76.8% from 72%. All directorates have plans in place and compliance anticipated to be back up by end of September.

**Clinical Supervision** – 84.0% from 82.0%. 1% below target, all directorates working hard with the cultural journey. This is regularly discussed at the monthly performance meetings.

## 6. Workforce Metrics

The Committee was updated by exception.

Sickness absence rate is exceptionally low at 3.57% The highest recorded reason for sickness is anxiety/stress/depression.

The turnover and vacancy position noted. Currently recorded at 13%, but with the mitigations reduces to 6%. It was further highlighted that the Trust has more starters than leavers. In terms of DBS compliance, the Trust is reporting at 98%.

## 7. Staff Survey Results Action Plan (2017/18)

The Committee received the action plan and noted the progress made.

- Towards Outstanding Engagement – Cohort 2 start date has been postponed due to the locality restructure
- Values and Behaviours Framework – this is ongoing and will be further progressed with the new structure in place
- Quality Improvement Approach defined by the Board – AQUA and Toward outstanding engagement continuing
- Recruitment and Retention – there is an action plan in place for both nursing and medical staff
- Define our approach to Talent and Leadership development – the People and OD Strategy has been drafted. A Talent Management Strategy to be completed and submitted to the PCD in January 2019.
- Refresh our approach to further strengthen Being Open and Raising Concerns - Zoe Grant has recently been appointed as the Freedom to Speak up guardian with an engagement session at the October Leadership session to raise further awareness
- WRES – further work is ongoing to improve our WRES scores and the experiences of our BAME staff through LIA including workshop on 20 September 2018.

It was further noted that the Staff Survey for this year is due to 'Go live' on 24 September 2018 and close on 30 November 2019. A monetary initiative will also be implemented for teams who complete the most returns.

## 8. Being Open Report

The Committee received the Being Open report which provides a combined report of Dear Caroline, FSUG, 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 July 2017 – June 2018 and a detailed quarterly review for the period of April 2018 – June 2018.

All Dear Caroline responses are uploaded onto SID. The majority of submissions continue to be submitted anonymously. This report will be submitted to the Trust Board on 26 September 2018.

## 9. Workforce Race Equality Standard (WRES) full report and Equality and Diversity Update

The Committee received the Workforce Race Equality Standard (WRES) which is based on the principle NHS employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

In addition to the main report, a revised Submission Template for Workforce RACE Equality Standards 2017/18 was tabled for information purposes which has been submitted to NHS England.

Committee members noted the progress with actions from WRES 2017 and approved the 2018 WRES report, including the outline action plan for 2018-19.

**10. Freedom to Speak Up Guardian Role**

Zoe Grant, Freedom to Speak up Guardian, delivered a presentation in respect of her role.

**11. Staff Assaults Report**

The Committee received this report to the Committee regarding assaults on Trust staff by service users. It demonstrates a 10% reduction in the number of incidents from 2016 – 17 and discusses initiatives to reduce incidents within the Trust.

This report will be submitted to the next Quality Committee on 27 September 2018. Going forward the PCD committee requested a quarterly update on staff assaults by directorate.

**12. Recruitment and Retention (Medical Aspect) Action Plan**

The Committee received this action plan which outlines some of the underlying reasons for the recruitment and retention difficulties of Consultants, the impact of these vacancies and what the Trust has done to try and improve recruitment.

There are approx. 6 Agency locums in the Trust being paid approx. £46k more than substantive consultants. The current vacancies in the Trust were noted as well as the length of time they have been vacant, which have all been advertised without success.

The common themes were also noted and the proactive initiatives the Trust is undertaking to address recruitment and retention to-date and going forward. This will continue to be progressed.

**13. BMA Response to the Sir Williams Review**

The Committee received this report. The Gross Negligence Manslaughter in Healthcare Review was set up to consider the wider patient safety impact which resulted from concerns among healthcare professionals regarding the potential for prosecution for Gross Negligence manslaughter, particularly in cases where the errors occur in the context of broad organisational failings and system-wide errors such as the case of Dr Bawa-Garba who was charged with manslaughter and removed from the GMC register following the death of a child in her care. Following this case, concerns were that fear of prosecution had a negative impact on clinical behaviours leading to more defensive clinical practice, a poorer standard of openness and honesty in instances of untoward events as well as impacting on reflective practice.

**14 Policies**

***Approval was requested for the following policies:***

- 3.30 Learning & Development Policy (previously extended until the July PCD meeting)
- 7.2 Subject Access Request Policy
- 7.1 Draft Confidentiality of Patient & Employee Information

***Approved***

**Extensions until the end of December 2018 were requested for the following policies:**

- 3.01 Disciplinary Policy – expires 30.09.2018
- 3.09 Freedom to Speak Up Policy (expired 30.09.2017)
- 3.12 Equality of Opportunity – expired 30.07.2018
- 3.19 Retirement Procedure – expires 30.09.2018
- 3.36 Supporting Staff Policy – expires 30.09.2018
- 3.39 Medical Appraisal Policy – expires 30.09.2018
- 3.40 Local Government Pension Scheme – expires 30.09.2018
- 3.41 Management Supervision Guidance – expired 02.03.2018

3.42 Medical & Dental Starting Salary Procedure – expires 31.10.2018

***Approved***

**15 Date & Time of Next Meeting**

Monday 12 November 2018, at 9.30 am, Boardroom, Trust HQ, Lawton House, Trentham

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# REPORT TO OPEN TRUST BOARD

Enclosure No:21

| | | | |
|---|---|---|---|
| Date of Meeting: | 26TH September 2018 | | |
| Title of Report: | Summary of the Audit Committee held on 25th May 2018 | | |
| Presented by: | Gan Mahadea, Chair / Non Executive | | |
| Author: | Laurie Wrench, Associate Director of Governance | | |
| Executive Lead Name: | Suzanne Robinson | Approved by Exec | ☒ |

| Executive Summary: | | Purpose of report | |
|---|---|---|---|
| This report provides a summary of the key headlines from the Audit Committee held on the 6th September 2018. The full papers are available as required to members. | | Approval | ☒ |
| | | Information | ☐ |
| | | Discussion | ☐ |
| | | Assurance | ☒ |
| Seen at: | SLT ☐ Execs ☐<br>Date: | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☐<br>• Finance & Performance Committee ☐<br>• Audit Committee ☒<br>• People & Culture Development Committee ☐<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Digital by Choice Board ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement.☒<br>2. To provide the highest quality services ☒<br>3. Create a learning culture to continually improve.☒<br>4. Encourage, inspire and implement research & innovation at all levels.☒<br>5. Maximise and use our resources intelligently and efficiently.☒<br>6. Attract and inspire the best people to work here.☒<br>7. Continually improve our partnership working. ☒ | | |
| Risk / legal implications:<br>Risk Register Ref | To ensure that the committee meets its terms of reference by receiving reports of the work of its sub groups | | |
| Resource Implications:<br><br>Funding Source: | n/a<br><br>n/a | | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups) | n/a | | |
| STP Alignment / Implications | None | | |
| Recommendations: | Receive the report for assurance and note the approval of the Annual Governance Statement, Annual Accounts and Annual Report | | |

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# Assurance Report of the Audit Committee

# 6th September 2018

**Board Assurance Framework Q1 2018/19**

The Chair requested further assurance in terms of concerns with CIP and opening of PICU. It was noted that key leadership appointments for PICU have now been made and it is anticipated that further appointments will be made with the new intake of students in October 2018. The Committee approved the Board Assurance Framework Q1 2018/19 subject to final Board approval. This will be submitted to the Trust Board on 26th September 2018.

**Risk Assurance Mapping Exercise**

The Committee received the report which maps out the strategic, trust wide and directorate highest scoring risks at 12+ for information and assurance purposes. The report was split by Committee and members noted the risks. Assurance was provided that this information is scrutinised by the Senior Leadership Team and mitigations are challenged.

The Committee agreed that a risk mapping exercise report will be submitted on a quarterly basis going forward.

**Audit Recommendations – Tracking Report**

The Committee received an update on Internal Audit actions and their progress in terms of implementation as of 6th September 2018. One action was overdue for which an extension was approved. It was also noted that 9 actions had been implemented and 6 further actions were in progress.

**Healthcare Quality Standards Assurance Report**

The Committee received the report which is intended to provide members with the necessary assurance as to the ongoing monitoring of healthcare quality standards within the organisation and the systems and processes to support this. This particular paper focusses on one of our main initiatives being the Trust's unannounced quality assurance programme.

The Trust has now implemented the process for community teams as well as inpatient teams with each visit comprising an Executive Director, Non-Executive Director, Service User / Carer representative, Peer Reviewer and a member of Governance Team. The visits involve the teams being reviewed in line with the CQC's Key Lines of Enquiry (KLOES) and the Institute for Innovation and Improvement 15 Steps challenge methodology. The visits are reported to the Quality Committee and Performance Meetings. A quarterly report will be overseen by the Committee going forward.

**Information Governance Disclosures**

The Committee received the report which is a summary of information governance disclosures that have occurred from 1 April 2018 to 31 August 2018. It was noted that all incidents have been assessed at Level 1; there are some themes and potential areas that could be high risk to note.

Contents were noted, the next report will include a summary format detailing trends over the last 12 months.

**Register of Declared Interests**

The Committee received the report for information purposes which provides an update as of 31 August 2018 of current Board members interests. 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.

**KPMG**

The Committee received three reports from KPMG as detailed below:

Internal Audit Progress Report – The report summarises the work delivered against 2018-19 Internal Audit Plan for the period April to August 2018. There have been some frustrations with progress regarding IT General Controls with the Trust's IT provider (third party). This was anticipated to be complete but will now be completed by the end of September 2018.

LCFS Progress Report - The report summarises the work delivered against the 2018-19 Counter Fraud plan for the period April to August 2018. LCFS continue to support the Trust's Induction sessions to provide new starters with guidance on prevention of fraud and bribery. LCFS have also reviewed the Trust's Anti-Fraud and Bribery policies.

HR Governance Report - Internal Audit have provided partial assurance with improvement required as a result of their review.

**Ernst and Young – Annual Audit Letter**

Ernst and Young presented the Annual Audit Letter following their completion of their audit procedures for the year end 31 March 2018. External Audit have concluded that the financial statements give a true and fair view of the financial position of the Trust as of 31 March 2018 and of its expenditure and income for the year and therefore issued an unqualified opinion.

**Waivers over £20k Report – Q1 1st April 2018 – 31st July 2018**

The Scheme of Delegation requires the Audit Committee to review all waivers over £20,000 and noted that during Q1 there were 6 waivers over £20k issued in 1st April 2018 – 31st July 2018 totalling £269k.

**Finance Policies**

The Committee approved renewal of the following policies for 3 years and request formal ratification at September 2018 Trust Board.

1. Standing Financial Instructions Policy

2. Scheme of Delegation Policy
3. Standing Orders
4. Local Counter Fraud Policy
5. Bribery Policy

**Additional Reports Received:**

- Summary of the Quality Committee –7 June 2018
- Summary of the Finance, Performance and Digital Committee – 7 June, 6 July and 3 August 2018
- 
- Summary of the People and Culture Development Committee - 14 May 2018
- Summary of the Business Development Committee – 5 July 2018
- Minutes of the Information Governance Steering Group – 18 May and 25 June 2018
- Minutes of the Data Quality Forum 25 May and 25 June 2018

Laurie Wrench, Associate Director of Governance
On behalf of
Gan Mahadea, Chair
19th September 2018

North Staffordshire Combined Healthcare NHS Trust

# REPORT TO: OPEN TRUST BOARD

Enclosure No:22

| | | | |
|---|---|---|---|
| Date of Meeting: | 26 September 2018 | | |
| Title of Report: | Assurance Report from the Quality Committee | | |
| Presented by: | Patrick Sullivan<br>Non-Executive Director and Chair of Quality Committee | | |
| Author: | Sandra Storey, Associate Director of MACE | | |
| Executive Lead Name: | Dr Buki Adeyemo, Executive Medical Director | Approved by Exec | ☒ |

| Executive Summary: | | Purpose of report | |
|---|---|---|---|
| This report provides a high level summary of the work of the committee from the meeting held on 9 August 2018 and request for the Trust Board to ratify policies and endorse recommendations in the report. | | Approval | ☐ |
| | | Information | ☒ |
| | | Discussion | ☐ |
| | | Assurance | ☒ |
| Seen at: | Approved by Chair of Quality Committee and Executive Lead | Document Version No. | |
| Committee Approval / Review | | | |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement. X<br>2. To provide the highest quality services X<br>3. Create a learning culture to continually improve.<br>4. Encourage, inspire and implement research & innovation at all levels.<br>5. Maximise and use our resources intelligently and efficiently. X<br>6. Attract and inspire the best people to work here. X<br>7. Continually improve our partnership working. X<br><br>The business of the Quality Committee is applicable to all strategic objectives. | | |
| Risk / legal implications:<br>Risk Register Ref | None identified | | |
| Resource Implications:<br><br>Funding Source: | N/A<br><br>N/A | | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups) | None identified | | |
| STP Alignment / Implications | None | | |
| Recommendations: | To note policy approval | | |

North Staffordshire Combined Healthcare NHS
NHS Trust

**Key points from the Quality Committee meeting held on 9 August 2018 for the Trust Board meeting on 20 September 2018**

## 1. Introduction

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

## 2. Patient Story – presentation and discussion

The committee watched a video story from a gentleman who has been accessing the Trust's community learning disability service. Of note was the gentleman's comments about his positive experience of the service, how staff had helped him over time to improve his confidence and motivation enabling him to live a much more fulfilled life with his hobbies and interests. Committee members welcomed the story and future presentations will also include staff representation in order to receive direct feedback which will also help to further discussions about individual teams or services.

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

### 3a Reports:

- ✓ ***Learning from Experience Report May - June 18*** (summary of all patient related incidents / events for May & June 2018 and learning outcomes. Of note falls prevention work, learning from medicine related incidents, improved reporting relating to smoking incidents).

- ✓ ***Trust Unannounced Assurance Visit April - June 18*** (summary of key themes from the Trust's unannounced assurance visits, with visits focusing on community services and learning and action discussed at Senior Operational Team Meetings. Of note focused piece of work in respect to case load management, introduction of standing operating procedure, with alignment of caseloads to new structure).

- ✓ ***Performance & Quality Management Framework Month 3 2018/19 (***Report on performance by exception and the rectification plans in place. Month 3 was noted to have 7 target related metrics rated as red and 2 target related metrics as amber, with all other indicators within expected tolerances).

- ✓ ***Clinical Effectiveness Report*** (noting outputs of the work of Mental Health Law Governance Group, Medicines Optimisation, Clinical Records and System Design Group, Research and Development Group and the Clinical Effectiveness Group. Of note electronic fridge monitoring system due to be deployed mid- October 2018 to further assist safe and effective medicines management).

- ✓ ***Environmental Ligature Risk Assessment and Investment Proposals*** (further progress on the programme following discussion at the last meeting of the committee. Priority areas discussed and agreed).

- ✓ ***OFSTED Action Plan*** (the plan outlined the areas of improvement required following an unannounced OFSTED inspection and update on progress made).

- ✓ ***Infection Prevention & Control (IPC) Annual Report 2017/18*** (overview of the IPC activities from April 17 – March 18, highlighting achievements and progress against annual work programme priorities).

- ✓ ***Safeguarding Annual Report 2017/18*** (assurance on safeguarding activity throughout the Trust, including referral rates, training, audit and case reviews. Includes safeguarding children, adults, prevent and domestic abuse).

- ✓ ***Interim Report into the Independent Review of the Mental Health Act (MHA)*** (In October 2017 the Government arranged for a review of the MHA, they are half way through their work and the interim report provides a summary of their initial findings. Key topics are the rising number of detentions, renewals, interface with Mental Capacity Act, and Police role).

- ✓ ***Data Quality Forum update*** (minutes of the meeting held on 25 June 2018).

- ✓ ***Research and Development Annual Report 2017/18*** (summary of research journey from April 17 – March 18, sharing successes, performance and stories).

- ✓ **Safer Staffing monthly report – May 2018** (Reporting of Registered Nurse (R/N) and non-registered nurse staffing levels is a key requirement to ensure the Trust complies with National Quality Board requirements. During May 2018 there was a fill rate of 77% for R/N staff and 103% for care staff on day shifts, with 85% and 108% respectively on night shifts. An overall 93% fill rate was achieved).

- ✓ ***Quality Committee Cycle of Business*** *(reviewed and approved).* The committee will review its terms of reference at its November 18 meeting and align the cycle of business with the new directorate structure.

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

| | |
|---|---|
| ✓ 1.62 | Physical Health Policy |
| ✓ Medical Gases | New Policy |
| ✓ 4.25 | Consent Policy |
| ✓ MHA01 | Supervised CTO – Extend to 31.12.18 |
| ✓ MHA03 | Nurses Holding Power |
| ✓ MHA04 | Doctors Holding Power |
| ✓ MHA09 | S117 Aftercare – Extend to 31.12.18 |
| ✓ MHA12 | Section 17 Leave |
| ✓ MHA16 | Mental Capacity Act Policy |
| ✓ MHA18 | Deprivation of Liberty Safeguards |
| ✓ 4.34 | Intellectual Property – Extend to 31.12.18 |

**4. Summary brief of Article 2 Jury Inquest – July 18**

The committee received a summary report outlining the details of an inquest and the conclusion and findings. It was noted that there was no Regulation 28 report (prevention of future deaths) or letter of concern issued to address any residual matters.

The Jury found no circumstances or failures which they felt had probably contributed to this person's sad death. The Coroner noted that a considerable amount of work had been done by the Trust and continued work in progress. The Coroner also welcomed the independent review, hearing about the action plan alongside more general developments in respect to the continued enhancement to acute mental health services.

Staff were thanked by family for the care and compassionate shown to their relative. A debrief took place immediately post the inquest with a further session planned for further support and reflection.

## 5. Directorate Performance Reports

Each Directorate presented in detail their performance, capturing information from performance reviews thereby enabling a more focussed discussion around cross cutting issues. The focus of the discussion centred on good practice and achievements, new developments and innovations, current and potential challenges. Of note:

***AMH Community***

Achievement: CQC visit highlighted Ashcombe Community MHT Anxiety and Depression Pathway as being positive practice,
Challenge: S75 and review of impact.

***AMH Inpatients***

Achievement: Acute Care Pathways Development,
Challenge: RN recruitment.

***Children and Young People***

Achievement: Cost Improvement Programme,
Challenge: Darwin Service Specification requirements.

***Learning Disabilities***

Achievement: Significant improvements to Care co-ordinator allocation,
Challenge: Assessment & Treatment environmental upgrade.

***Neuro and Old Age Psychiatry***

Achievement: Positive response to restructure engagement sessions,
Challenge: All age Mental Health Liaison.

***Substance Misuse***

Achievement: New Beginnings recognised again for their outstanding work,
Challenge: Restructuring of Directorate.

## 6. Trust Risks to Quality Committee

There are currently 9 Trust risks for Quality Committee. Committee members considered these risks and how they interrelate to Directorate risks. Risk treatment plans and actions being taken were noted**.**

**7. Next meeting:**
**Thursday 27 September 2018 2pm**

On behalf of the Committee Chair, Mr Patrick Sullivan, Non-Executive Director
Sandra Storey Associate Director Medical and Clinical Effectiveness

10 August 2018

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# REPORT TO OPEN TRUST BOARD

Enclosure No:23

| | | | |
|---|---|---|---|
| Date of Meeting: | 26th September 2018 | | |
| Title of Report: | Trust WRES Update and Action Plan 2018 | | |
| Presented by: | Caroline Donovan, Chief Executive | | |
| Author: | Lesley Faux, Diversity and Inclusion Lead | | |
| Executive Lead Name: | Caroline Donovan, Chief Executive | Approved by Exec | ☐ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| The Workforce Race Equality Standard (WRES) is based on the principle NHS employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.<br><br>This is the Trust's third WRES report. Since April 2015, all NHS organisations were required to demonstrate through the nine point WRES metric how they are addressing race equality issues in a range of staffing areas through the NHS Standard Contract.<br><br>The WRES requires NHS organisations to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address national problems such as poor BME representation on NHS Trust Boards and a range of indicators suggesting poorer experiences by BME staff in the NHS compared to their white counterparts (including less access to development, more likely to experience bullying, harassment, discrimination, disciplinary action etc).<br><br>*Findings and Recommendations for NSCHT*<br>The Trust has made great strides in raising the profile of workforce (and service user) race inclusion, increasing visibility and beginning to identify and address the associated issues. This is at every level, from Board to service/team and individual staff levels. It is acknowledged, however, that some areas are more actively involved and engaged than others.<br><br>Some progress has been made in terms of developing the workforce profile to be more representative of our local population for BAME ethnicity across the organisation and at board level. However, there remain service areas, staff groups and pay bandings where BAME ethnicities are significantly absent or under-represented. We are still some way short of achieving our goal of being representative of the local community for BAME by 2020 (after medical staff excluded from the data).<br><br>It remains that there is both an immediate and a long-term challenge around addressing a range of societal, historical, cultural and organisational factors which culminate in our BAME workforce experiencing poorer employment prospects and experiences than their white counterparts in the NHS on a range of measures. | Approval | ☐ |
| | Information | ☒ |
| | Discussion | ☐ |
| | Assurance | ☒ |

| | | | |
|---|---|---|---|
| Seen at: | SLT ☐ Execs ☐<br>Date: | Document Version No. | |

| | |
|---|---|
| Committee Approval / Review | • Quality Committee ☐<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☒<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Digital by Choice Board ☐ |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement.☐<br>2. To provide the highest quality services ☒<br>3. Create a learning culture to continually improve.☐<br>4. Encourage, inspire and implement research & innovation at all levels.☐<br>5. Maximise and use our resources intelligently and efficiently.☐<br>6. Attract and inspire the best people to work here.☒<br>7. Continually improve our partnership working. ☐ |
| Risk / legal implications:<br>Risk Register Reference | • NHS England and commissioner–required imperative.<br>• Links with the Equality Act (2010) and our associated Public Sector Equality Duty (PSED) |
| Resource Implications:<br><br>Funding Source: | n/a |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | The WRES is specifically intended to highlight race inequalities in NHS organisations and to prompt effective and impactful action to address these inequities. |
| STP Alignment / Implications: | All NHS Trusts are required to participate in WRES. The STP is making a clear commitment to race inclusion through the Staffordshire and Stoke-on-Trent Stepping Up BAME Leadership Programme and the Symphony for Hidden Voices Inclusion Conference (7 September 2018) |
| Recommendations: | Committee members are asked to:-<br><br>1. Note the progress with actions from WRES 2017<br><br>2. Approve the 2018 WRES report, including the outline action plan for 2018-19<br><br>3. Commit to taking personal action to deliver tangible progress on this critical agenda throughout your own area of responsibility |

North Staffordshire Combined Healthcare NHS Trust

# 2018 Trust Workforce Race Equality Standard (WRES) Report and Action Plan


**Date:** August 2018

**Author:** Lesley Faux, Diversity & Inclusion Lead

**Lead Director:** Alex Brett, Director of Workforce, OD & Communications

# Trust Workforce Race Equality Standard (WRES) Report 2018

## 1. Introduction

The Workforce Race Equality Standard (WRES) was introduced in April 2015 and mandated as part of the NHS Standard Contract. Implementation of the WRES is a requirement on both NHS commissioners and NHS provider organisations.

The Trust also sees this as a vital component as we strive to improve and deliver our obligations under the Public Sector Equality Duty to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The WRES ultimately supports the Trust to increase its diversity and inclusivity enabling us to deliver services for all people within our communities. It is not possible to deliver safe, personalised, accessible and recovery-focussed services if we are not diverse and inclusive.

This report contains the Trust's fourth WRES report which will be published on our website and shared with NHS England and our local commissioners, as well as being reviewed as part of CQC inspection processes.

The key purpose of the WRES was to address persistent workforce race inequity evident across the NHS in England. The WRES is designed to prompt inquiry and assist healthcare organisations to develop and implement evidence-based responses to the challenges their data reveal. It assists organisations to meet the aims of the NHS Five Year Forward View and complements other NHS policy frameworks such as Developing People – Improving Care, as well as the principles and values set out in The NHS Constitution.

Background

NHS Trusts produced and published their first WRES baseline data in July 2015. Since then, NHS England have published 3 national reports on the WRES, the most recent (based on data submitted in 2017) is available HERE.

Trusts are required to submit 2 documents to Commissioners and NHS England to satisfy the WRES:

- NSCHT spreadsheet data set - ***attachment 1*** (submitted 10/08/18)
- A WRES progress report and Action Plan - ***attachment 2***

Additionally, in response to the detail sought in relation to WRES indicator 1, a further spreadsheet is attached containing workforce breakdowns for 2018 including breakdowns by clinical and non-clinical workforce, staff group and pay band - ***attachment 3***

The above information will be published on our Trust website and shared with our lead commissioners.

The 2017 national WRES report stated:

> *This 2017 report will show that the low baseline we started off from in 2015 has improved, albeit with room to improve further. The change we to continue to seek in workforce race equality is not change for political correctness; there is a moral, legal, financial and, most importantly, a quality of patient care case for change.*

Key national WRES findings were in 2017 were as set out in Box 1 below:

| | |
|---|---|
| White shortlisted job applicants are 1.60 times more likely to be appointed from shortlisting than BME shortlisted applicants, who continue to remain absent from senior grades within Agenda for Change (AfC) pay bands. | BME staff remain significantly more likely to experience discrimination at work from colleagues and their managers compared to white staff, at 14% and 6% respectively. |
| An increase in numbers of BME nurses and midwives at AfC Bands 6 to 9 is observed once again in 2017; this pattern has persisted since 2014. | Similar proportions of white (28%) and BME (29%) are likely to experience harassment, bullying or abuse from patients, relatives and members of the public in the last 12 months. |
| The number of very senior managers (VSMs) from BME backgrounds increased by 18% from 2016 to 2017 – from 212 to 250 in England. This is 7% of all VSMs, which remains significantly lower than BME representation in the overall NHS workforce (18%) and in the local communities served (12%). | The overall percentage of BME staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months dropped from 27% to 26%. BME staff remain more likely than white staff to experience harassment, bullying or abuse from other colleagues in the last 12 months. |
| BME staff are 1.37 times more likely to enter the formal disciplinary process in comparison to white staff. This is an improvement on the 2016 figure of 1.56. | There is a steady increase in the number of NHS trusts that have more than one BME board member. There are now a total of 25 NHS trusts with three or more BME members of the board; an increase of 9 trusts since 2016. |

**Box 1:** Key national WRES findings 2017, NHS England (2017)

In 2017, (based on the 2016 WRES) the Trust was pleased to have improved or maintained performance in 7 of the 9 WRES indicators. Unfortunately 2 indicators had worsened since the previous year. These were:-

- Indicator 6: staff experiencing harassment, bullying or abuse from staff in the last 12 months, and

- Indicator 8: staff reporting they have personally experienced discrimination at work from their manager/team leader or other colleagues

## 2. What we have been doing since the 2017 WRES

Progress with the Trust's WRES Action Plan 2017 is outlined in ***Attachment 2 (part 1)***.

In summary, 2017-18 has been a game-changer for the Trust in relation to workforce race inclusion. This was significantly boosted by 2 visits by Yvonne Coghill and Habib Naqvi from the NHS England WRES team in late July and early August 2017. In late July, Yvonne attended a Board Development Session and presented to Trust Board members about the case for WRES and about the Trust's position in relation to the WRES indicators. Yvonne returned the following week with colleague Habib to facilitate 2 BAME Focus Groups (one with a service user focus and one with a staff focus) in the morning, followed by leading a session on Race Equality to Trust leaders at the Trust's

Leadership Academy in the afternoon. The impact of these sessions on those who participated was considerable and galvanising our ability to achieve additional momentum behind our plans to develop greater race inclusion.

Actions that emerged from the above sessions included:-

1. Establishment of a BAME Staff Network and appointment of a chair
2. Plan to launch a Staffordshire-wide NHS BAME leadership programme
3. Highlighting of the need to improve how we prevent, respond to and support staff following incidents of racial abuse (verbal and physical), whether patient to patient; patient to staff; staff to staff.
4. Decision to make a clear statement about being an inclusive Trust where there is no place for any form of discrimination, harassment or personal abuse in all our correspondence and in a RESPECT poster campaign.
5. Need to better understand our BAME workforce and their individual and collective experiences
6. Need for direct-targeting of development information to our BAME workforce

The above have all subsequently been enacted (see detail below), although there is still work to do to continue to develop and progress in these areas, which will be the focus of our 2018 action plan (***Attachment 2, part 2***).

- Our Trust **BAME Staff Network** was launched in October 2017 and is chaired by Cherelle Laryea, Trainee Clinical Psychologist. So far, 3 network meetings have been held, with small attendances due to availability on the day etc (but a growing group overall). Cherelle is supported by the Diversity and Inclusion Lead and has a direct link to the Chief Executive.

- The Trust successfully bid for £50K to fund a **Staffordshire & Stoke-on-Trent STP BAME Leadership Programme – *Stepping Up***, aimed particularly (but not exclusively) at bands 5-7 (BAME under-representation is significantly noticeable nationally and locally at band 6 and above). Led by Combined Healthcare, we have been able to commission 120 places on this programme for the STP, to be delivered between September 2018 and March 2019.

- We have created a process-map of action to be taken when **abusive racist incidents** occur and have been ensuring that such incidents are always challenged and followed-up. We have highlighted this area for further work in our 2018 action plan.

- We have included a statement in all our Trust letters:

  ***We are a diverse and inclusive Trust and there is no place in our organisation for discrimination, harassment or personal abuse***

  Additionally, we have created and displayed a range of Trust RESPECT posters featuring Trust staff and incorporating the above statement along with a strapline ***Let's stop verbal and physical abuse together***. We will be reviewing and further developing this work in 2018-19 and substantially raising visibility with regard to this campaign.

- We have been working to understand the experiences of our BAME workforce in a number of ways, including the following:-

- Our BAME staff network groups
- BAME Tea with Maria Nelligan, Director of Nursing and AHP x2
- BAME Listening into Action (LiA) session held in May 2018 (see below for further details)
- Paper to PCD on BAME Staff Experience, including attendance by a BAME nurse who shared her personal story as well as a review of racist abuse incidents

These sessions have been extremely insightful, but we further recognise that this is a process that will take time to develop trust, and for our BAME staff to feel safe and comfortable in sharing their experiences.

- Our BAME workforce have been directly receiving emails and encouragement to consider and apply for a range of **development opportunities** (with opt-out option) via our Diversity and Inclusion Lead in addition to the usual channels.

- We held a **BAME Listening into Action** session in May 2018. This session was well-attended by our BAME workforce and from discussions 4 key themes for action were identified:-

  i. Developing our **recruitment and selection** processes for race inclusion (building in inclusion from start to finish of the process)

  ii. Developing equal and inclusive access to **development and career progression opportunities**

  iii. Learning lessons from incidents of **racist abuse** and aggression (including responding to and preventing incidents; policies & processes; posters; involving the Police; support for those affected, etc)

  iv. **Culture of inclusion** (Inclusive treatment of colleagues and addressing micro-assaults and inequalities)

  We will be undertaking an **action planning** session in relation to the above 4 themes on **20th September**. These actions will add detail to our 2018 WRES Plan.

- The Trust has also agreed to fund a one-day a week secondment to a BAME Inclusion Facilitator Role for a period of one year. This post has been out for expressions of interest but unfortunately has not yet attracted sufficient interest. Further work is required to raise interest in this role and develop confidence in the Trust's ability to progress real change through this post. (Opportunity re-opened for expressions of interest to 15 September 2018).

- The Trust additionally has a major race inclusion element planned for its ***Symphony for Hidden Voices*** Inclusion Conference in September 2018. This includes a range of presentations:-

  - Dame Elizabeth Anionwu – keynote speaker
  - Dramatic presentation of a BAME staff member's experience
  - Dramatic presentation of Windrush poem 'You called and we came' (Prof Laura Serrant)
  - Roger Mackenzie – Black mental health matters
  - BAME Reverse Mentoring

## 3. NSCHT WRES 2018 Findings

Unfortunately, despite the significantly increased focus on race inclusion through 2017-18, the Trust has seen a worsening position in a number of the WRES indicators (6 of 9) since 2017. Three indicators improved.

It is unexplained as to why there has been such a decline in our WRES data despite the positive work that has been begun over the last 12 months. It may be that a heightened focus on inequalities may have increased either confidence to report inequity or perceptions of inequity. However, we take this very seriously and our data tells us that we have much work to do to create our vision of a truly diverse and inclusive organisation.

The below sets out the detail for each specific WRES Indicator:-

**Indicator 1: Workforce profile (improvement since 2017)**

- 6% of the **clinical** workforce is BAME, reducing to 4% when medical staff are excluded (when ethnicity not know included)
- Only 2.2% of the **non-clinical** workforce is BAME
- 6.66% of the Trust's workforce (excluding bank) is BAME (5.90% in 2017) when 'ethnicity not known' are excluded (ie as per WRES template data). This is a little less than the local population BAME population (Stoke-on-Trent, Staffordshire Moorlands and Newcastle-Under-Lyme) which is 7.6% BAME (based on 2011 census). The population of Staffordshire as a whole is just over 8% BAME (8.19%).
- Excluding medical staff, most BAME clinical staff are in bands 5, 6 and 7 (predominantly band 5)
- There remain very few non-clinical BAME staff (most BAME people who are in this group are in bands 3, 4 and 5)
- BAME workforce varies across the different Trust directorates (see ***Attachment 4***) and it is noted that this will change further to the locality working restructuring that is underway at the time of writing.

**Indicator 2: Recruitment (significant worsening since 2017)**

- Relative likelihood of BAME staff being appointed from shortlisting across all posts = 1.96 (1.2 in 2017)

**Indicator 3: Disciplinaries (very significant worsening since 2017)**

- Relative likelihood of BAME staff entering the formal disciplinary process = 10.52 (1.77 in 2017). This means BAME staff are **more than ten times more likely** to enter formal disciplinary processes. [NB It is noted that the relatively small number of disciplinary cases in the Trust can more easily result in skewed data. Our 2018 data is based on a total of only 7 disciplinary cases (4 white, 3 BAME. Our 2017 data was based on a total of 20 cases (18 white and 2 BAME).]

  A review of all 3 BAME disciplinary cases has been conducted by the HR team assessing the presenting information and essentially asking 'Would the same action have been taken if this had been a white member of staff?' The review concluded that all the cases were appropriate on the basis of the presenting information. It is again emphasised that the small number of disciplinary cases involved in this year is a particular factor skewing the data.

**Indicator 4: Non-mandatory training (more equally balanced than in 2017)**

- Relative likelihood of BAME staff accessing non-mandatory training and CPD = 0.95 (0.76 in 2017) ie BAME staff are slightly more likely to access non-mandatory training and development than white staff. It is anticipated that this figure is skewed, however, by the high proportion of BAME staff in the Trust who are medical staff,

[**Foot Note:** Workforce data is as at 31/03/18 or for the period 01/04/17-31/03/18 as appropriate, with the exception of indicators drawn from the NHS Staff Survey. These indicators are based on data from the 2017 NHS Staff Survey (conducted Sept-Dec 2017)]

and thus more likely to participate in (and record participation) in continuing professional development activities.

**Indicator 5: Harassment, bullying & abuse from patients (worse than 2017)**

- 43% BAME staff (31% for white staff) experiencing harassment, bulling or abuse ***from patient, relatives and public*** in last 12 months (37% and 32% respectively in 2017).

**Indicator 6: Harassment, bullying & abuse from staff (much worse than 2017)**

- 37% of BAME staff (16% of white staff) experiencing harassment, bullying or abuse ***from staff*** in the last 12 months (2017: 25% BAME & 19% white)

**Indicator 7: Belief in equal opportunities (worse than 2017)**

- 64% of BAME staff (91% white staff) believing the Trust offers equal opportunities for career progression (2017: 86% BAME & 89% white)

**Indicator 8: Experience of discrimination at work in the last 12 months (significantly worse than 2017)**

- 21% of BAME staff reporting they have personally experienced discrimination at work from their manager/team leader or other colleagues (7% for white staff). The rates for 2017 were 17% BAME and 5% white.

**Indicator 9 (improvement since 2017)**

- The Trust's Board (voting board members only, exec and non-exec) had increased its BAME ethnicity at 8.9%, which is greater than the proportion of the overall workforce with BAME ethnicity, and also greater than the local area BAME population. The corresponding figure for 2017 was 5.8%.

As additional information, a summary of Trust performance on the NHS Staff Survey Questions linked to indicators 5-8 is included as ***Attachment 5***.

## 4. Conclusions and Next Steps

The Trust has made great strides in raising the profile of workforce (and service user) race inclusion, increasing visibility and beginning to identify and address the associated issues. This is at every level, from Board to service/team and individual staff levels. It is acknowledged, however, that some areas are more actively involved and engaged than others.

Some progress has been made in terms of developing the workforce profile to be more representative of our local population for BAME ethnicity across the organisation and at board level. However, there remain service areas, staff groups and pay bandings where BAME ethnicities are significantly absent or under-represented. We are still some way short of achieving our goal of being representative of the local community for BAME by 2020 (after medical staff excluded from the data).

There remains both an immediate and a long-term challenge around addressing a range of societal, historical, cultural and organisational factors which culminate in our BAME workforce experiencing poorer employment prospects and experiences than their white counterparts in the NHS on a range of measures.

As noted above:

- ***Attachment 2 (part 1)*** sets out the actions (and progress against these actions) that have been ongoing over the last 12 months to help us to realise our goals in relation to race equality.

- ***Attachment 2 (part 2)*** sets out the actions for the remainder of 2018-19 to achieve progression further along this journey towards BAME workforce inclusion.

## 5. Recommendations

Committee members are asked to:-

1. Note the progress with actions from WRES 2017

2. Approve the 2018 WRES report, including the outline action plan for 2018-19

3. Commit to taking personal action to deliver tangible progress on this critical agenda throughout your own area of responsibility

END

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**ATTACHMENT 1**

## SubmissionTemplate
## Workforce Race Equality Standards 2017/18 template

Answer Required
Auto Populated
N/A

| | INDICATOR | DATA ITEM | | MEASURE | 31st MARCH 2017 WHITE Prepopulated figures | 31st MARCH 2017 WHITE Verified figures | 31st MARCH 2017 BME Prepopulated figures | 31st MARCH 2017 BME Verified figures | 31st MARCH 2017 ETHNICITY UNKNOWN/NULL Prepopulated figures | 31st MARCH 2017 ETHNICITY UNKNOWN/NULL Verified figures | 31st MARCH 2018 WHITE Prepopulated figures | 31st MARCH 2018 WHITE Verified figures | 31st MARCH 2018 BME Prepopulated figures | 31st MARCH 2018 BME Verified figures | 31st MARCH 2018 ETHNICITY UNKNOWN/NULL Prepopulated figures | 31st MARCH 2018 ETHNICITY UNKNOWN/NULL Verified figures | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Percentage of staff in each of the A/C Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce | | 1a) Non Clinical workforce | | | | | | | | | | | | | | |
| | | 1 | Under Band 1 | Headcount | 1 | 1 | 0 | 0 | 0 | 0 | 6 | 5 | 0 | 0 | 0 | 0 | |
| | | 2 | Band 1 | Headcount | 24 | 24 | 0 | 0 | 1 | 1 | 16 | 28 | 0 | 0 | 0 | 0 | |
| | | 3 | Band 2 | Headcount | 37 | 37 | 0 | 0 | 1 | 1 | 38 | 40 | 0 | 0 | 2 | 0 | |
| | | 4 | Band 3 | Headcount | 76 | 76 | 2 | 2 | 0 | 0 | 69 | 73 | 2 | 2 | 4 | 4 | |
| | | 5 | Band 4 | Headcount | 67 | 67 | 2 | 2 | 0 | 0 | 68 | 80 | 2 | 6 | 6 | 6 | |
| | | 6 | Band 5 | Headcount | 39 | 39 | 1 | 1 | 0 | 0 | 40 | 44 | 0 | 1 | 0 | 0 | |
| | | 7 | Band 6 | Headcount | 20 | 20 | 0 | 0 | 0 | 0 | 21 | 42 | 1 | 5 | 0 | 0 | |
| | | 8 | Band 7 | Headcount | 16 | 16 | 0 | 0 | 0 | 0 | 54 | 83 | 0 | 5 | 0 | 0 | |
| | | 9 | Band 8A | Headcount | 18 | 18 | 1 | 1 | 0 | 0 | 18 | 46 | 0 | 1 | 0 | 0 | |
| | | 10 | Band 8B | Headcount | 11 | 11 | 0 | 0 | 0 | 0 | 11 | 23 | 0 | 2 | 0 | 1 | |
| | | 11 | Band 8C | Headcount | 6 | 6 | 0 | 0 | 0 | 0 | 7 | 14 | 0 | 0 | 0 | 1 | |
| | | 12 | Band 8D | Headcount | 1 | 1 | 0 | 0 | 0 | 0 | 2 | 2 | 0 | 0 | 0 | 0 | |
| | | 13 | Band 9 | Headcount | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | |
| | | 14 | VSM | Headcount | 6 | 6 | 0 | 0 | 0 | 0 | 1 | 16 | 0 | 4 | 0 | 1 | |
| | | | 1b) Clinical Workforce of which Non Medical | | | | | | | | | | | | | | |
| | | 15 | Under Band 1 | Headcount | 0 | 0 | 0 | 0 | 0 | 0 | 6 | 6 | 0 | 0 | 0 | 0 | |
| | | 16 | Band 1 | Headcount | 1 | 1 | 0 | 0 | 0 | 0 | 7 | 6 | 0 | 0 | 0 | 0 | |
| | | 17 | Band 2 | Headcount | 0 | 0 | 1 | 1 | 10 | 10 | 10 | 11 | 1 | 1 | 0 | 0 | |
| | | 18 | Band 3 | Headcount | 198 | 198 | 3 | 3 | 1 | 1 | 196 | 199 | 8 | 8 | 5 | 5 | |
| | | 19 | Band 4 | Headcount | 74 | 74 | 3 | 3 | 4 | 4 | 74 | 84 | 7 | 7 | 1 | 1 | |
| | | 20 | Band 5 | Headcount | 201 | 201 | 13 | 13 | 0 | 0 | 195 | 196 | 11 | 12 | 3 | 3 | |
| | | 21 | Band 6 | Headcount | 241 | 241 | 12 | 12 | 3 | 3 | 256 | 221 | 14 | 13 | 5 | 5 | |
| | | 22 | Band 7 | Headcount | 148 | 148 | 11 | 11 | 0 | 0 | 147 | 84 | 1 | 2 | 5 | 6 | |
| | | 23 | Band 8A | Headcount | 56 | 56 | 1 | 1 | 1 | 1 | 54 | 29 | 1 | 0 | 1 | 1 | |
| | | 24 | Band 8B | Headcount | 15 | 15 | 1 | 1 | 1 | 1 | 12 | 3 | 2 | 0 | 1 | 0 | |
| | | 25 | Band 8C | Headcount | 15 | 15 | 1 | 1 | 0 | 0 | 15 | 8 | 0 | 0 | 1 | 0 | |
| | | 26 | Band 8D | Headcount | 3 | 3 | 0 | 0 | 0 | 0 | 2 | 1 | 0 | 0 | 0 | 0 | |
| | | 27 | Band 9 | Headcount | 0 | 0 | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | |
| | | 28 | VSM | Headcount | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| | | | *Of which Medical & Dental* | | | | | | | | | | | | | | |
| | | 29 | Consultants | Headcount | 11 | 11 | 1 | 1 | 0 | 0 | 17 | 11 | 1 | 1 | 2 | 2 | |
| | | 30 | *of which Senior medical manager* | Headcount | | 2 | | 0 | | 0 | | 2 | | 0 | | 0 | |
| | | 31 | Non-consultant career grade | Headcount | 8 | 8 | 7 | 7 | 0 | 0 | 7 | 7 | 5 | 4 | 0 | 2 | |
| | | 32 | Trainee grades | Headcount | 8 | 8 | 7 | 7 | 0 | 0 | 1 | 9 | 2 | 10 | 0 | 1 | |
| | | 33 | Other | Headcount | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 3 | 0 | 1 | 0 | |
| 2 | Relative likelihood of staff being appointed from shortlisting across all posts | 34 | Number of shortlisted applicants | Headcount | | | | | | | | 1906 | | 402 | | 36 | |
| | | 35 | Number appointed from shortlisting | Headcount | | | | | | | | 189 | | 45 | | 3 | |
| | | 36 | Relative likelihood of shortlisting/appointed | Auto calculated | | 0.1085897893 | | 0.1634419078 | | | | 0.0958999996 | | 0.0967606061 | | 0.0857142857 | |
| | | 37 | Relative likelihood of White staff being appointed from shortlisting compared to BME staff | Auto calculated | | 1.20 | | | | | | 1.06 | | | | | |
| 3 | Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation<br>Note: This indicator will be based on data from a two year rolling average of the current year and the previous year | 38 | Number of staff in workforce | Auto calculated | | | | | | | 1310 | 1332 | 86 | 95 | 35 | 39 | |
| | | 39 | Number of staff entering the formal disciplinary process | Headcount | | | | | | | | 4 | | 5 | | 0 | |
| | | 40 | Likelihood of staff entering the formal disciplinary process | Auto calculated | | 0.0137509546 | | 0.0240662439 | | | | 0.0030030030 | | 0.0315789474 | | 0.0000000000 | |
| | | 41 | Relative likelihood of BME staff entering the formal disciplinary process compared to White staff | Auto calculated | | | | 1.77 | | | | | | 10.52 | | | |

Answer Required
Auto Populated
N/A

| | INDICATOR | DATA ITEM | | MEASURE | 31st MARCH 2017 WHITE | | 31st MARCH 2017 BME | | 31st MARCH 2017 ETHNICITY UNKNOWN/NULL | | 31st MARCH 2018 WHITE | | 31st MARCH 2018 BME | | 31st MARCH 2018 ETHNICITY UNKNOWN/NULL | | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4 | Relative likelihood of staff accessing non-mandatory training and CPD | 42 | Number of staff in workforce (White) | Auto calculated | | | | | | | | 1332 | | 95 | | 39 | |
| | | 43 | Number of staff accessing non-mandatory training and CPD (White) | Headcount | | | | | | | | 133 | | 10 | | 8 | As best as records can show. Based on data from our LMS plus medical CPD. |
| | | 44 | Likelihood of staff accessing non-mandatory training and CPD | Auto calculated | | 0.9877769290 | | 1.3048780488 | | | | 0.0998498498 | | 0.1052631579 | | 0.2051282051 | |
| | | 45 | Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff | Auto calculated | | 0.76 | | | | | | 0.95 | | | | | |
| 5 | KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months | 46 | % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months | Percentage | 32.33% | | 37.14% | | | | 31.19% | | 43.33% | | | | |
| 6 | KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months | 47 | % of staff experiencing harassment, bullying or abuse from staff in last 12 months | Percentage | 18.92% | | 25.00% | | | | 16.13% | | 36.67% | | | | |
| 7 | KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion | 48 | % staff believing that trust provides equal opportunities for career progression or promotion | Percentage | 88.67% | | 85.71% | | | | 91.29% | | 64.29% | | | | |
| 8 | Q17. In the last 12 months have you personally experienced discrimination at work from any of the following?<br>b) Manager/team leader or other colleagues | 49 | % staff personally experienced discrimination at work from Manager/team leader or other colleague | Percentage | 4.89% | | 16.67% | | | | 6.73% | | 20.69% | | | | |
| 9 | Percentage difference between the organisations' Board voting membership and its overall workforce<br>Note: Only voting members of the Board should be included when considering this indicator | 50 | Total Board members | Headcount | | 11 | | 2 | | 0 | | 11 | | 2 | | 0 | |
| | | 51 | of which: *Voting Board members* | Headcount | | 3 | | 1 | | 0 | | 3 | | 1 | | 0 | |
| | | 52 | *Non Voting Board members* | Auto calculated | | 8 | | 1 | | 0 | | 8 | | 1 | | 0 | |
| | | 53 | Total Board members | Auto calculated | | 11 | | 2 | | 0 | | 11 | | 2 | | 0 | |
| | | 54 | of which: *Exec Board members* | Headcount | | 6 | | 2 | | 0 | | 7 | | 1 | | 0 | |
| | | 55 | *Non Executive Board members* | Auto calculated | | 5 | | 0 | | 0 | | 4 | | 1 | | 0 | |
| | | 56 | Number of staff in overall workforce | Auto calculated | | 1309 | | 82 | | 25 | | 1332 | | 95 | | 39 | |
| | | 57 | Total Board members - % by Ethnicity | Auto calculated | | 84.6% | | 15.4% | | 0.0% | | 84.6% | | 15.4% | | 0.0% | |
| | | 58 | Voting Board Member - % by Ethnicity | Auto calculated | | 75.0% | | 25.0% | | 0.0% | | 75.0% | | 25.0% | | 0.0% | |
| | | 59 | Non Voting Board Member - % by Ethnicity | Auto calculated | | 88.9% | | 11.1% | | 0.0% | | 88.9% | | 11.1% | | 0.0% | |
| | | 60 | Executive Board Member - % by Ethnicity | Auto calculated | | 75.0% | | 25.0% | | 0.0% | | 87.5% | | 12.5% | | 0.0% | |
| | | 61 | Non Executive Board Member - % by Ethnicity | Auto calculated | | 100.0% | | 0.0% | | 0.0% | | 80.0% | | 20.0% | | 0.0% | |
| | | 62 | Overall workforce - % by Ethnicity | Auto calculated | 0.00% | 92.4% | 0.00% | 5.8% | 0.00% | 1.8% | 0.00% | 90.9% | | 6.5% | | 2.7% | |
| | | 63 | Difference (Total Board -Overall workforce ) | Auto calculated | | -7.8% | | 9.6% | | -1.8% | | -6.2% | | 8.9% | | -2.7% | |

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**ATTACHMENT 2**

**TRUST WRES ACTION PLAN**

**Part 1: Progress with 2017 WRES Actions**

| ACTION | By Who | By When | Notes, Comments, Progress |
|---|---|---|---|
| 1. Establish systems for routine detailed analysis of staff and patient data by ethnicity and discussion at Trust and Directorate leadership meetings. Need to ensure ESR, Lorenzo, Ulysses are all able to capture the data and enable the Trust to analyse it to inform future decision making<br>- Data by band, by staff group, by Directorate, by service etc<br>- eg how many staff nurses do we have above band 5 in inpatient services?<br>- Understand service provision to BAME service users<br>Seek to better understand:-<br>- What is the experience of our BAME patients?<br>- What is the experience of our BAME staff? | Lesley Faux | Dec 2017<br><br>PART COMPLETE<br><br>Some action to carry forward to 2018-19 re BAME service user experience | Summary information shared on Trust website by ethnicity, clinical/non-clinical and banding. Workforce ethnicity report produced by Directorate, March 2018 and refresh planned pending completion of Locality Working new staff structures.<br><br>Experience of our BME service users – to be addressed through Directorate EDS2 approach for 2017-18 (see action 1 above). Also PCD session on BAME Staff Experience 12.03.18 – session postponed – need to rearrange. |
| 2. Report on ESR, Lorenzo, Ulysses to inform future decision making. This will include Serious Incidents, detention under the MHA, service access and utilisation<br>- Data by band, by staff group, by Directorate, by service etc<br>- eg how many staff nurses do we have above band 5 in inpatient services?<br>- Understand service provision to BAME service users<br>Seek to better understand:-<br>- What is the experience of our BAME patients?<br>- What is the experience of our BAME staff? | Lesley Faux | COMPLETE Apr 2018<br><br>Action to develop further in 2018-19 | The implementation of the new ROSE system led to an initial increase in the size of the gap in ethnicity data for service users. This gap was greater at the time of pulling the 2017-18 data than in the previous year (over 20% of patients (some £5k people) with ethnicity not known). Directorate summaries available on request.<br><br>Directorate workforce summaries shared with Directorates March 2018 and enclosed in this report (Attachment 4). There was a small rise in ethnicity not known.<br><br>BAME listening events held to establish the experience of BAME service users and staff. See below. |

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| 3. Work to eliminate barriers to BAME staff entering employment a level through the organisation.<br>Specifically, introduce a new interview approach ensuring diverse panels for diverse shortlists (ie that all BAME interview candidates will experience having a BAME person on the interview panel in Trust interviews)<br>Task and Finish Group led by HR to be established to design and implement pilot process and monitor effectiveness | | Mar 2018 | Pilot process trialled with mixed success in NOAP and new PICU for March 2018. Revised principle is to strive to have BAME representation on all interview panels where there is identified under-representation to be considered for 2018-19 and revised process agreed and implemented as part of response to BAME LiA. |
| 4. HR to work with staff side and new BAME Staff Network to develop new support measures and mechanisms for BAME staff who are subject to disciplinary processes and to ensure fairness of approach. (See Birmingham Trusts model as one possible approach). | Kerry Smith | Mar 2018 | A review of all BAME disciplinary cases has been conducted by HR and staff side essentially asking 'Would the same action have been taken if this was a white member of staff?'. All 3 cases were concluded to have been appropriate and equitable. |
| 5. Trust Inclusion Forum now to be established in 2017-18. Group to perform critical challenge around delivery of diversity and inclusion through the Trust<br>Membership to include :-<br>- NED<br>- Exec Director<br>- D&I Lead<br>- Directorate Heads<br>- Analyst / Performance Rep | Lesley Faux | Nov 2017<br><br>ACTION SUSPENDED | ACTION SUSPENDED in discussion with Alex Brett, December 2017. To review with new Workforce Director when in post. Continue as current in meantime. |
| 6. Positive Action BAME leadership development programme – ambition to be the first STP to establish and implement this in England | Caroline Donovan (in STP OD and Leadership Workstream SRO role) | Mar 2018 | 3 cohorts to be delivered for Staffs STP: Sept-Oct 2018; Nov-Dec 2018; Feb-March 2019. Launch event 7 Sept to raise profile and confirm commitment to stress the need for culture change to ensure climate of readiness for change for participants completing the programme and returning to their organisations post-completion. NSCHT currently has approx 10 staff with places on this programme. |

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| 7. Spotlight services that are doing good work in BAME inclusion (eg Minds positive action programme for reaching BAME communities access to IAPT services) | | Oct 2017 To plan further sharing of good practice through 2018-19 | LF to work with Comms Team re further spotlighting opportunities.<br>Case study to be provided to WMids NHS Leadership Academy Inclusion platform re IAPT approach (COMPLETED). |
| 8. Mentoring, support and encouragement for BAME nursing/clinical staff who wish to progress their careers. Considering within this:-<br>- develop BAME specific mentoring support for BAME staff not subject to preceptorship mentoring as a positive action means of addressing societal imbalances and inequities in R&S.<br>- invite Trust Board to develop mentoring relationships, including positive action to encourage staff in protected characteristic groups to seek high level mentoring support<br>- Support and encouragement to gain additional experience<br>- Support to build confidence<br>- Encouragement to participate in development opportunities<br>- Career / Performance mentoring<br>- Continue to promote development opportunities for all groups of staff, including encouraging and supporting BAME staff to access leadership development.<br>- Continue to support BAME staff to seek to access career progression, including particularly within nursing and other professional healthcare roles.<br>- Additionally, work to develop BAME-specific development opportunities including mentorship and Trust to lead in development of a local BAME leadership programme across the STP area.<br>- Take action to analyse data on non-mandatory training experienced by BAME staff with medical staff EXCLUDED after quarters 1 and 2.<br><br>All Trust leaders to actively support and encourage BAME staff to increase their experience and exposure across the Trust and beyond and to encourage to apply for career development posts | Maria Nelligan, Director of Nursing & AHP to lead | Dec 2017 | Maria Nelligan held 2 x 'Tea and Talk' sessions with BAME nursing and HCSW staff in October and December 2017. Action taken on emerging issues (eg development opportunities)<br><br>BAME LiA held in May 2018. Follow up action planning session taking place 20 September. 4 key themes that emerged from the first session will be addressed. A further session is being held on 19th December, including BAME nursing, HCSW, AHP and scientific/professional staff.<br><br>FURTHER ACTION: Analysis of non-mandatory training of BAME staff compared to white staff completed as part of WRES 2018. Appears favourable for BAME staff, but need to review excluding medical staff.<br><br>Our 2018-19 actions will feature provision of coaching, mentoring and reverse mentoring involving staff with BAME ethnicity. |
| 9. Positive BAME Role Models – seek BAME staff at every level to be diversity role models for the Trust. Share story on website, etc. Role Model pin / award? | Dr Adeyemo, Medical Director, to | Dec 2017 | • Dr Buki Adeyemo role modelling championing race equality by leading communications about Stand Up to |

| | | | |
|---|---|---|---|
| | | | Racism Day, by seeking to have #20BAMEconversations, and sharing progress with these on Twitter (also see action 44)<br>• Tendai Chirawu attended the NHS Employers Women Leaders' Conference 2017 in October.<br>• Cherelle Laryea and Claudia Oakley attended WRES 2017 Conference, also in October.<br>• Cherelle Laryea profile to be shared early January 2017.<br>• Further role models anticipated to emerge from developing BAME Network and from those Trust staff attending the Staffordshire Stepping Up Programme. |
| 10. Keeping all staff involved and having positive conversations about ethnicity and racial equality. 'It's OK to ask' about ethnicity (with well-intentioned curiosity) etc. Raising awareness about BAME experience and micro assaults in society, workplace etc | Lesley Faux | Dec 2017 | Race Equality stand at Harplands in August 2017 and again in October-November 2017 for Black History Month.<br><br>The August 2017 stand particularly shared information from Yvonne Coghill presentation and raised awareness about findings on the challenges of being black, Asian or from another ethnicity in the UK. Staff Networks stand (including BAME network) in Harplands December 2017.<br><br>It's OK to ask leaflets are shared at events such as Vaisakhi Festival, Stoke Pride etc.<br><br>World Religions Day information shared January 2018. Plans for further awareness raising around religions and cultures through 2018-19. |

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| | | | Sharing of BAME nurse experience at PCD in March and report on racist abuse of staff. |
| 11. Bespoke Task and Finish Group to deliver Preventing Racial Abuse / 'zero tolerance' education campaign:<br>- RESPECT Poster campaign with images of our own BAME (and other) staff.<br>- Coordinated 'It's not OK' / 'Draw the Line' campaign and approach to go alongside our RESPECT posters currently in development:- around:-<br>- clear statement in all patient and service user letters that 'It's NOT OK' to abuse NHS staff including racist abuse, harassment or bullying<br>- same message in patient literature given to patients on admission<br>- supporting poster campaign in public/patient areas re above<br>- racist discrimination, bullying or abuse in the workplace 'It's NOT OK' and that decisive action will be taken where there is evidence of this by Trust workers - poster campaign in staff areas?<br>- also re the balancing of the 'what not to do' (as above) with positive messages about Proud to CARE values about how we like to treat people and be treated etc<br>- Flow-chart to be developed re response to and support following personal abuse.<br>- Follow up with individuals who are subject to abuse and ask them what measures were and weren't effective in making them feel valued, safe and supported. | Lesley Faux | Dec 2017 COMPLETE | Trust RESPECT posters produced and displayed widely featuring Trust statement on 'no place for discrimination, harassment or abuse'.<br><br>Trust statement included in Trust letterhead and in letter template on Lorenzo from January 2018.<br><br>Report on staff racist abuse taken to PCD in March along with an account of a BAME staff nurse experience.<br><br>Further action is planned in 2018-19 to further raise visibility of this campaign and to develop our approach to preventing and supporting staff following racist incidents. These are 2 of the action areas from our BAME LiA session and action planning taking place on 20 September. Process map of response to racist incidents to be taken for further to LiA Action Planning session 20 September |
| 12. Developing our links with local BAME communities through public engagement events, religious community visits etc<br>– twin focus of raising awareness about mental health and promoting the Trust as an employer of choice | Lesley Faux | Mar 2018 | The Trust attended the Stoke Gurdwara on 5th Nov (Guru Nanak birthday celebrations) and received a very positive reception. Access Team represented along with Patient Experience and D&I. Female attendees expressed the desire for staff representing support for anxiety & depression, domestic abuse and suicide to attend to talk about services and self |

| | | | |
|---|---|---|---|
| | | | help. A number of individuals expressed interest in employment opportunities and working at the Trust. Further Trust attendances at the Temple to be planned.<br><br>The Trust again participated in the Vaisakhi Sikh festival in May.<br><br>The Trust was welcomed to Hanley Central Mosque in February and visits are to be arranged for members of the mosque to visit the Harplands and for clinicians to visit the mosque to share information about mental health and Trust services.<br><br>Additional religious resources have been obtained for the Harplands, including key texts from the Bahai, Hindu and Jewish faiths.<br><br>We plan to do further education and awareness raising about different cultures and religions through 2018-19. |
| 13. Staff empowered to have positive discussions about ethnicity including:<br>- Establish offer of a BAME staff network<br>- Develop further opportunities for staff at all levels to be involved<br>- Further BAME focus group meeting(s) | Cherelle Laryea | Mar 2018 | A number of BAME staff network meetings have been held since the network launch in October 2017. Awareness raising has been repeated through Newsround and through stands at Feel Good Friday sessions etc. There is a small but growing membership. Meetings have been less frequent than may otherwise have been the case because of the Tea with Maria and BAME Listening into Action sessions, which have also given BAME staff a voice. Promotion of the network is planned for the Inclusion Conference on |

| | | | |
|---|---|---|---|
| | | | 7 September. |
| 14. Positive outreach to seek information about issues and experience BAME service user and staff perspective:-<br>- Direct positive action communications / surveys<br>- Senior team to make positive outreach when undertaking team visits etc to ask BAME service users and staff what their experience has been like and what could have been improved<br>- Reverse Mentoring by Board with BAME staff | | Mar 2018 | Tea with Maria sessions<br>Buki's BAME 20 conversations<br>CEO Blog and Newsround<br>Staff stories<br><br>Reverse mentoring not yet in place but is a programme topic for the inclusion conference on 7 September with a view to subsequent implementation. |
| 15. Continue to work to support BAME bank staff into substantive employment where the individual desires this. Support and encourage BAME bank workers to aspire to more regular substantive employment.<br>- Set up system to notify bank workers of training opportunities.<br>- Bank staff PDRs and clinical supervision | Lynne Pulley | Dec 2017 | in place – training opportunities shared with Bank Coordinator and also a new group email is in place from November 2017 in which D&I Lead shares education opportunities with BAME staff<br><br>BAME Leadership Programme launched |
| 16. Trust recruitment campaigns in 2017-18 to include photos and case studies of Asian/Asian British ethnicity.<br>Encourage block recruitment whenever possible as this is proven to increase the likelihood of appointing BAME staff and staff from other minority groups. | Kerry Smith | Dec 2017 | Further action: HR Team BAME profiles to be developed and shared.<br><br>Inclusive Recruitment is one of the 4 key areas for action emerging from the BAME LiA session in May and action planning on this is taking place on 20 September. |
| ****NEW ACTIONS AGREED BY MEDICAL DIRECTOR AS BELOW, OCTOBER 2017****<br>1. To engage in 20 conversations about race and ethnicity with a range of people and contexts (staff, service users, carers) and keep a brief record of each discussion by end December. Plan shared on Twitter and each conversation referenced on Twitter as it happens.<br>2. To lead a campaign to encourage BAME staff to record their ethnicity by personally emailing staff who do not have ethnicity details recorded by end November – message out by email from Dr Adeyemo direct to relevant staff, responses by early January 2018<br>3. To personally take an interest in one or two BAME members of staff and encourage them to develop their leadership skills and experience and take opportunities to develop their careers (by end December) – progress report pending | Buki Adeyemo | March 2018 COMPLETE | Dr Adeyemo has also additionally taken on a national role on the NHS England WRES Advisory Group. |

| | | | |
|---|---|---|---|
| 4. To role model support for 'Give Racism the Red Card' day on 2 October 2017 by wearing an item of red and by Tweeting about personal commitment to this COMPLETE | | | |

**Part 2: WRES Action Plan for 2018**

Following the BAME LiA Taking Action on Race Inclusion session on 20th September 2018, chaired by Caroline Donovan, the following was agreed to implement urgent and effective action on race inclusion:-

- New ***Inclusion Council*** to be established from those who attended. BAME attendees to be released to attend this meeting by personal request of CEO. This group will focus on Race Inclusion initially, but will eventually move to covering the range of inclusion issues / protected characteristics.
- ***5 WRES project groups*** established as below. Each group has a Project Lead and a BAME sponsor, with a clinical sponsor where appropriate.
- WRES Project groups to meet weekly (in person, by phone, by email as appropriate on each occasion) – BAME sponsors to be given half day release from their role at personal request of CEO.
- WRES Project groups to report into Inclusion Council. Each group to develop and implement meaningful and effective action on their action topic.
- Demonstrable progress anticipated over the first 3 months (Oct-Dec 2018)

| WRES ACTION PRIORITIES | By Who | By When | Notes, Comments, Progress |
|---|---|---|---|
| **WRES Action Area 1** - ***Developing Inclusive HR Processes***<br><br>(Links with WRES indicators 1, 2, 3 and 9)<br>To develop action including:<br>- inclusive recruitment and selection processes from start to finish (consider: BAME representation on interview panels; bulk recruitment; monitoring and challenge processes; use of positive action)<br>- disciplinary and grievance processes (consider RCN Cultural Ambassadors programme)<br>- workforce equality info processes<br>- bank and agency staff | **Project Lead:** Cherie Cuthbertson<br><br>**BAME Sponsor:** Tes Zaheer | Weekly action group<br><br>Feed into monthly Inclusion Council | |

| | | | |
|---|---|---|---|
| **WRES Action Area 2** - ***Supporting the development of our BAME***<br><br>(Links with WRES indicators 4 and 7)<br><br>Developing systems to support equal and inclusive access to career development, leadership development and education development opportunities. May include:<br><br>- buddy system for all BAME staff<br>- coaching and mentoring of BAME staff<br>- BAME staff developing skills as coaches and mentors<br>- Reverse mentoring<br>- Developing educators and trainers from BAME ethnicity<br>- Raising cultural, race and faith awareness<br>- 'Public Narrative Training' – social movement theory and call to action<br>- Ongoing support post-programme for 'Stepping Up' participants | **Project Lead:** Sue Slater<br><br>**BAME Sponsor:** Tanisha Molloy<br><br>**Clinical Sponsor:** TBC | Weekly action group<br><br>Feed into monthly Inclusion Council | |
| **WRES Action Area 3** - ***Reporting, learning & improving from incidents***<br><br>(Links with WRES indicators 5 and 6)<br><br>**Reporting, learning and improving following incidents** and incidences of racism, racist abuse and aggression<br><br>- preventing incidents<br>- responding better to incidents (saying 'That's not acceptable')<br>- supporting people better when subject to incidents<br>- policies, processes and SOPs<br>- posters (link with comms group)<br>- involving the Police | **Project Lead:** Dean Burgess / Frazer Macdonald<br><br>**BAME Sponsor:** Desi Somers<br><br>**Clinical Sponsor:** Dr Buki Adeyemo | Weekly action group<br><br>Feed into monthly Inclusion Council | |

| | | | |
|---|---|---|---|
| **WRES Action Area 4** - ***Creating a culture of inclusion***<br><br>(Links with WRES indicators 6, 7 and 8)<br><br>Developing action to deliver:<br>- developing understanding of BAME experience and how we treat each other day-to-day<br>- inclusive treatment of colleagues<br>- values and behaviours - clear standards of expected and unacceptable behaviour<br>- policies, training, leadership styles, service user involvement & experience<br>- addressing micro-assaults and inequalities as well as macro-assaults and inequalities<br>- include considering religion, culture, language, accents, food, etc. | **Lead:**<br>Neil Clarke with TBC (delegated by Maria)<br><br>**BAME Sponsors:**<br>Tendai Chirawu<br>Ayo Abbis<br><br>**Clinical Sponsor:**<br>Dr Dennis Okolo | | |
| **WRES Action Area 5 – *Communication for Inclusion***<br><br>(sits across the 9 WRES indicators)<br><br>Developing and delivering on communication for inclusion:–<br>- clear communication on expectations around inclusion<br>- developing deeper understanding of diversity, inclusion and what it means to be person-centred<br>- staff feedback mechanism (including feedback from trainees and exiting employees; app)<br>- Effective BAME network<br>- Engaging with our agency and bank staff<br>- Posters<br>- Leaflets and Info<br>- BAME champions<br>- Inclusion Events ..starting with #WearRedDay #19Oct #ShowRacismTheRedCard | **Project Lead:**<br>Joe McCrea<br><br>**BAME Sponsors:**<br>Nikita Duncan and Susan Gombedza | | |

**Additional WRES Workforce Information in relation to WRES Indicato**

North Staffordshire Combined Healthcare NHS Trust

**ATTACHMENT 3**

**NSCHT Workforce Ethnicity by Staff Group**

Data as at 31 March 2018

**All Trust staff**

| Ethnic Origin | Add Prof Scientific &Technical | Additional Clinical Services | Administrative & Clerical | Allied Health Professionals | Estates & Ancillary | Medical | Nursing Regd | Students | Total | Excluding Medical | Medical |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Any White ethnicity | 164 | 321 | 279 | 52 | 70 | 26 | 444 | 2 | **1358** | 1332 | 26 |
| Any BAME ethnicity | 13 | 16 | 8 | 1 | 0 | 32 | 19 | 0 | **89** | 57 | 32 |
| Undefined or not stated | 3 | 10 | 7 | 0 | 0 | 3 | 14 | 0 | **37** | 34 | 3 |
| **Grand Total** | **180** | **347** | **294** | **53** | **70** | **61** | **477** | **2** | **1484** | **1423** | **61** |

| Ethnic Origin | Add Prof Scientific & Technical | Additional Clinical Services | Administrative & Clerical | Allied Health Professionals | Estates & Ancillary | Medical | Nursing Regd | Students | Total | Excluding Medical | Medical |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Any White ethnicity | 91.11% | 92.51% | 94.90% | 98.11% | 100.00% | 42.62% | 93.08% | 100.00% | **91.51%** | 93.61% | 42.62% |
| Any BAME ethnicity | 7.22% | 4.61% | 2.72% | 1.89% | 0.00% | 52.46% | 3.98% | 0.00% | **6.00%** | 4.01% | 52.46% |
| Undefined or not stated | 1.67% | 2.88% | 2.38% | 0.00% | 0.00% | 4.92% | 2.94% | 0.00% | **2.49%** | 2.39% | 4.92% |
| **Grand Total** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** |

**Clinical Staff**

| Ethnic Origin | Add Prof Scientific & Technic | Additional Clinical Services | Allied Health Professionals | Estates & Ancillary | Medical | Nursing Regd | Students | Total | Excluding Medical | Medical |
|---|---|---|---|---|---|---|---|---|---|---|
| Any White ethnicity | 164 | 321 | 52 | 70 | 26 | 444 | 2 | **1358** | 1332 | 26 |
| Any BAME ethnicity | 13 | 16 | 1 | 0 | 32 | 19 | 0 | **89** | 57 | 32 |
| Undefined or not stated | 3 | 10 | 0 | 0 | 3 | 14 | 0 | **37** | 34 | 3 |
| **Grand Total** | **180** | **347** | **53** | **70** | **61** | **477** | **2** | **1484** | **1423** | **61** |

| Ethnic Origin | Add Prof Scientific &Technical | Additional Clinical Services | Allied Health Professionals | Medical | Nursing Regd | Students | Total | Excluding Medical | Medical |
|---|---|---|---|---|---|---|---|---|---|
| Any White ethnicity | 91.11% | 92.51% | 98.11% | 42.62% | 93.08% | 100.00% | **91.51%** | 93.61% | 42.62% |
| Any BAME ethnicity | 7.22% | 4.61% | 1.89% | 52.46% | 3.98% | 0.00% | **6.00%** | 4.01% | 52.46% |
| Undefined or not stated | 1.67% | 2.88% | 0.00% | 4.92% | 2.94% | 0.00% | **2.49%** | 2.39% | 4.92% |
| **Grand Total** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** |

**Non Clinical Workforce**

| Ethnic Origin | Administrative & Clerical | Estates & Ancillary | Total non-clinical |
|---|---|---|---|
| Any White ethnicity | 279 | 70 | 349 |
| Any BAME ethnicity | 8 | 0 | 8 |
| Undefined or not stated | 7 | 0 | 7 |
| **Grand Total** | **294** | **70** | **364** |

| Ethnic Origin | Administrative & Clerical | Estates & Ancillary | Total non-clinical |
|---|---|---|---|
| Any White ethnicity | 94.90% | 100.00% | 95.88% |
| Any BAME ethnicity | 2.72% | 0.00% | 2.20% |
| Undefined or not stated | 2.38% | 0.00% | 1.92% |
| **Grand Total** | **100.00%** | **100.00%** | **100.00%** |

**NSCHT Workforce Ethnicity by Banding**
Data as at 31 March 2018

| **All Trust staff** (ethnicity not known excluded) | | **Head-count** | **%** |
|---|---|---|---|
| **White ethnicity** | Band 1 | 28 | 2.05% |
| | Band 2 | 49 | 3.58% |
| | Band 3 | 262 | 19.17% |
| | Band 4 | 152 | 11.12% |
| | Band 5 | 236 | 17.26% |
| | Band 6 | 286 | 20.92% |
| | Band 7 | 166 | 12.14% |
| | Band 8a | 75 | 5.49% |
| | Band 8b | 25 | 1.83% |
| | Band 8c | 22 | 1.61% |
| | Band 8d | 3 | 0.22% |
| | Band 9 | 1 | 0.07% |
| | Medical | 26 | 1.90% |
| | Other Grade | 36 | 2.63% |
| | **TOTAL** | **1,367** | **100.00%** |

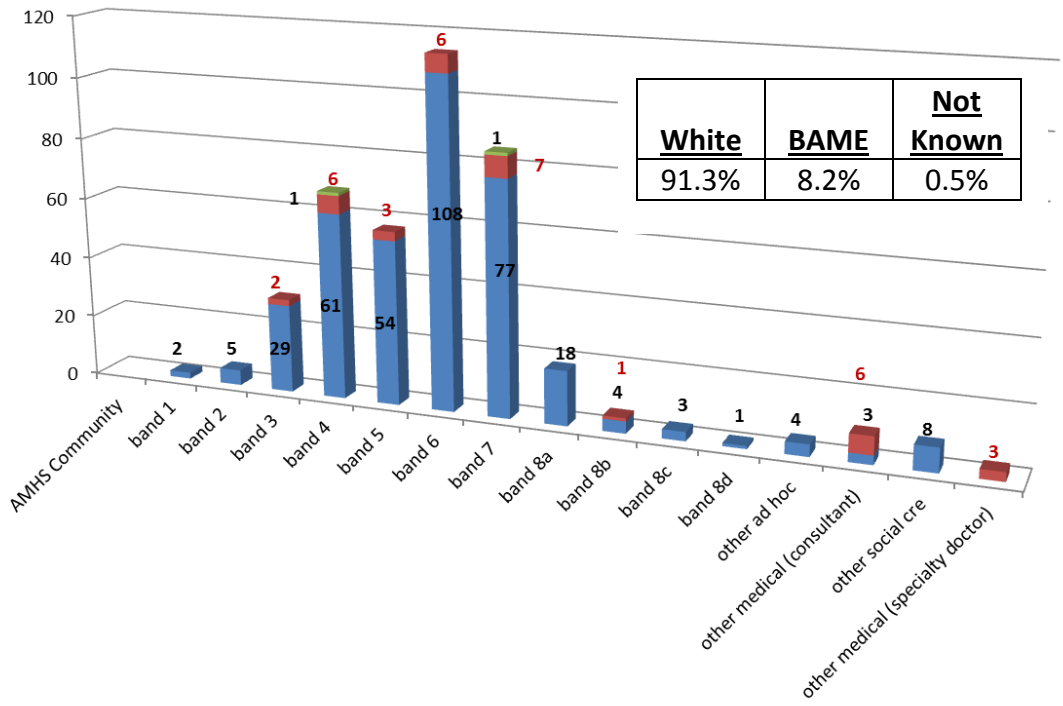
| | | **Head-count** | **%** |
|---|---|---|---|
| **BAME ethnicity** | Band 1 | 0 | 0.00% |
| | Band 2 | 1 | 1.32% |
| | Band 3 | 6 | 7.89% |
| | Band 4 | 6 | 7.89% |
| | Band 5 | 10 | 13.16% |
| | Band 6 | 12 | 15.79% |
| | Band 7 | 6 | 7.89% |
| | Band 8a | 1 | 1.32% |
| | Band 8b | 1 | 1.32% |
| | Band 8c | 0 | 0.00% |
| | Band 8d | 0 | 0.00% |
| | Band 9 | 0 | 0.00% |
| | Medical | 29 | 38.16% |
| | Other Grade | 4 | 5.26% |
| | **TOTAL** | **76** | **100.00%** |

| | | **Head-count** | **%** |
|---|---|---|---|
| **All staff** | Band 1 | 28 | 1.94% |
| | Band 2 | 50 | 3.47% |
| | Band 3 | 268 | 18.57% |
| | Band 4 | 158 | 10.95% |
| | Band 5 | 246 | 17.05% |
| | Band 6 | 298 | 20.65% |
| | Band 7 | 172 | 11.92% |
| | Band 8a | 76 | 5.27% |
| | Band 8b | 26 | 1.80% |
| | Band 8c | 22 | 1.52% |
| | Band 8d | 3 | 0.21% |
| | Band 9 | 1 | 0.07% |
| | Medical | 55 | 3.81% |
| | Other Grade | 40 | 2.77% |
| | **TOTAL** | **1,443** | **100.00%** |

**Clinical Directorate Workforce Summaries as at March 2018**

## AMH Community Directorate

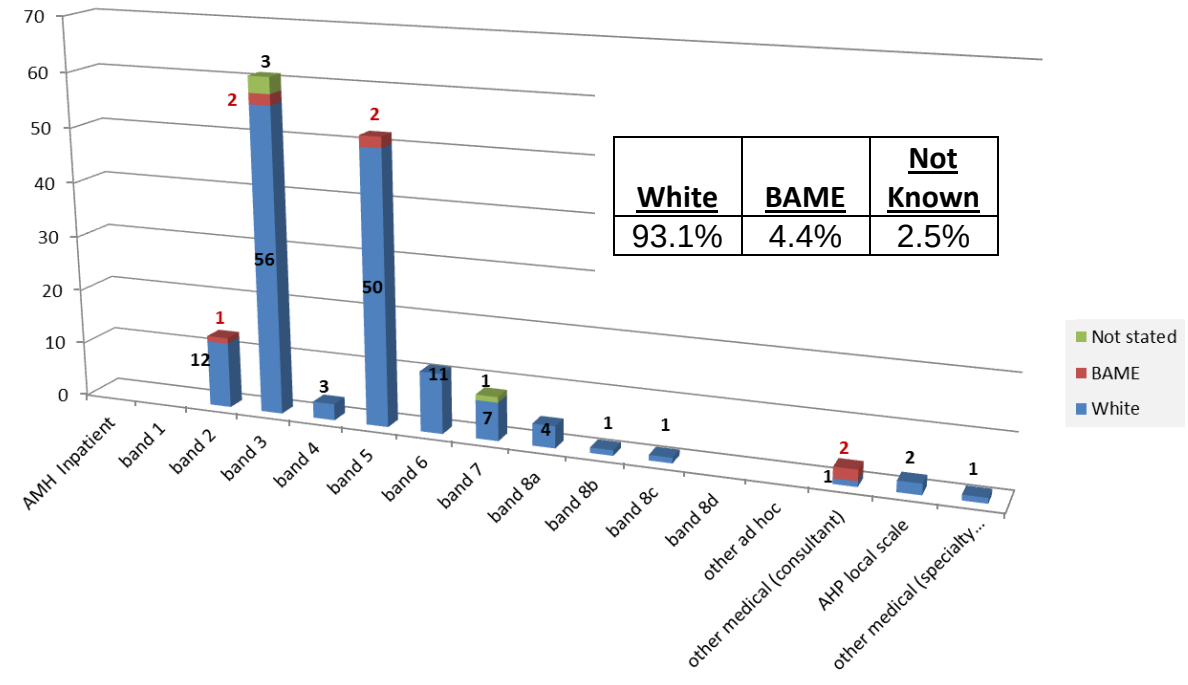
**Staff ethnicity by band, March 2018**




| White | BAME | Not Known |
|---|---|---|
| 91.3% | 8.2% | 0.5% |

## AMH Inpatient Directorate

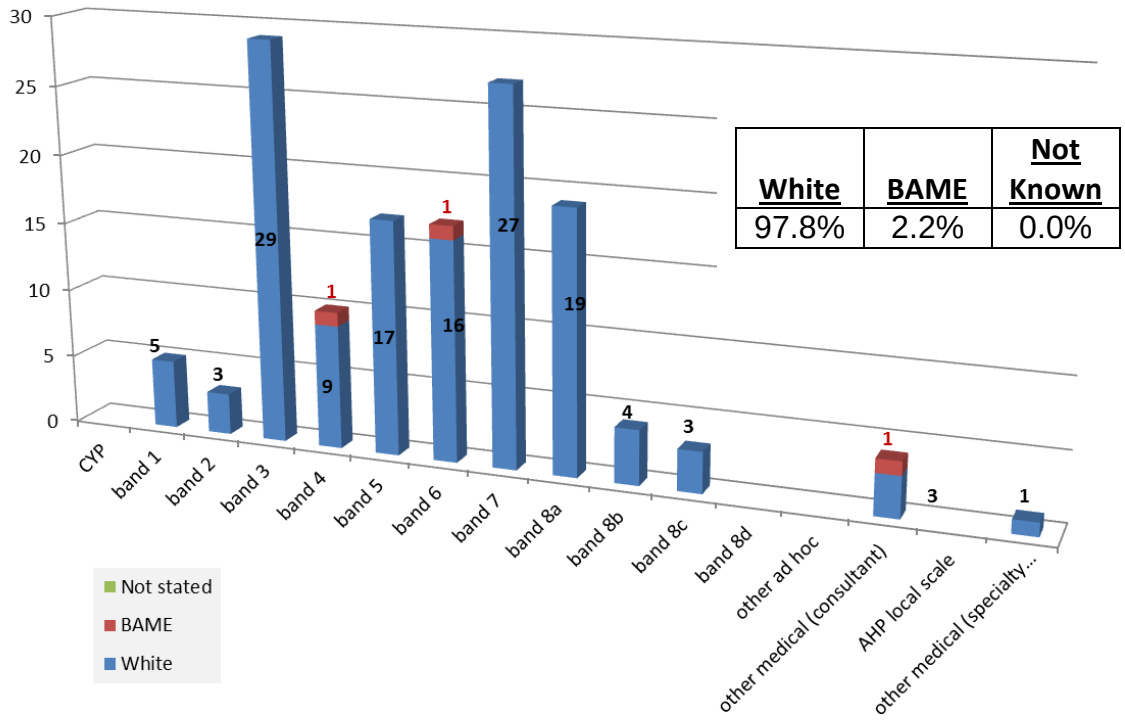
**Staff ethnicity by band, March 2018**




| White | BAME | Not Known |
|---|---|---|
| 93.1% | 4.4% | 2.5% |

## Children & Young People's Directorate

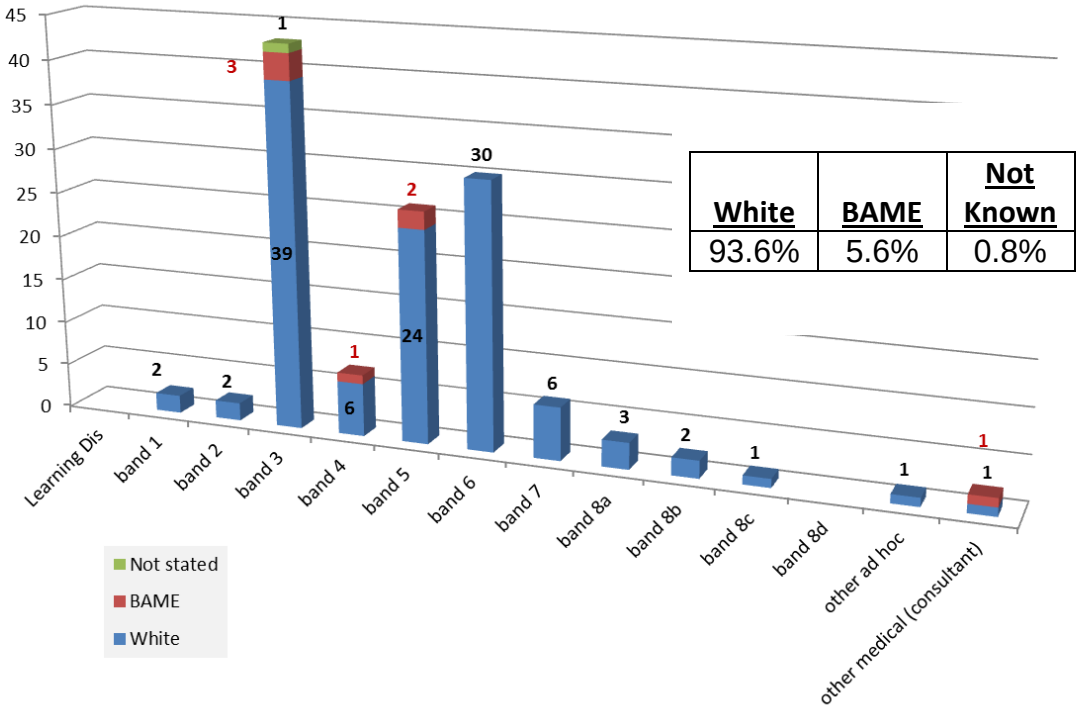
**Staff ethnicity by band, March 2018**




| White | BAME | Not Known |
|---|---|---|
| 97.8% | 2.2% | 0.0% |

## Learning Disabilities Directorate

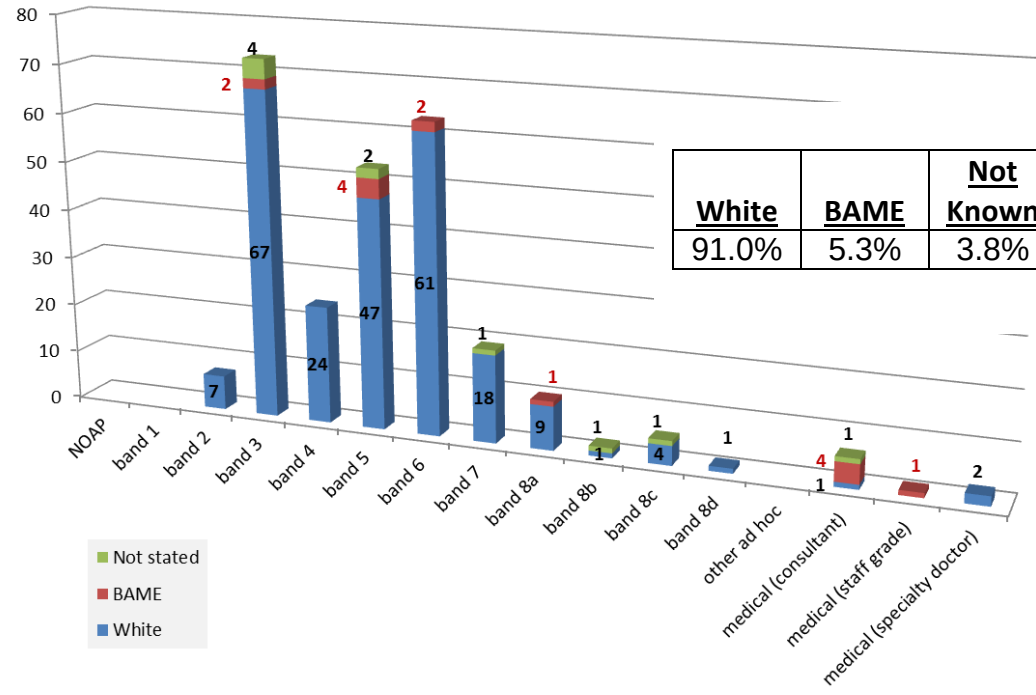
**Staff ethnicity by band, March 2018**




| White | BAME | Not Known |
|---|---|---|
| 93.6% | 5.6% | 0.8% |

## NOAP Directorate

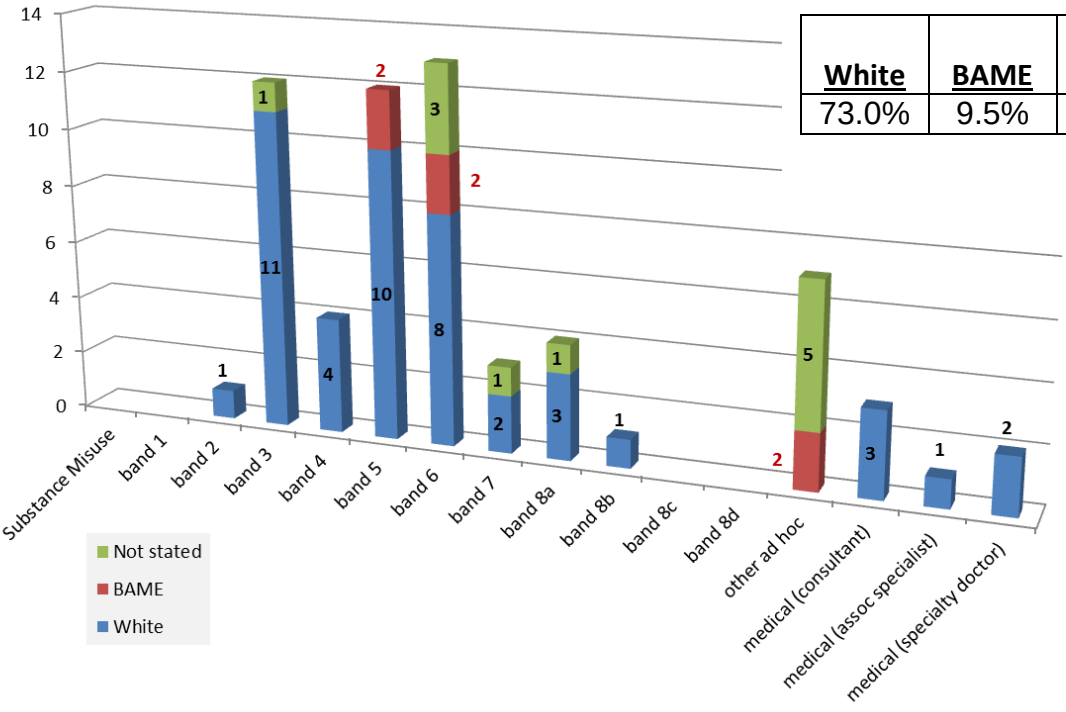
**Staff ethnicity by band, March 2018**



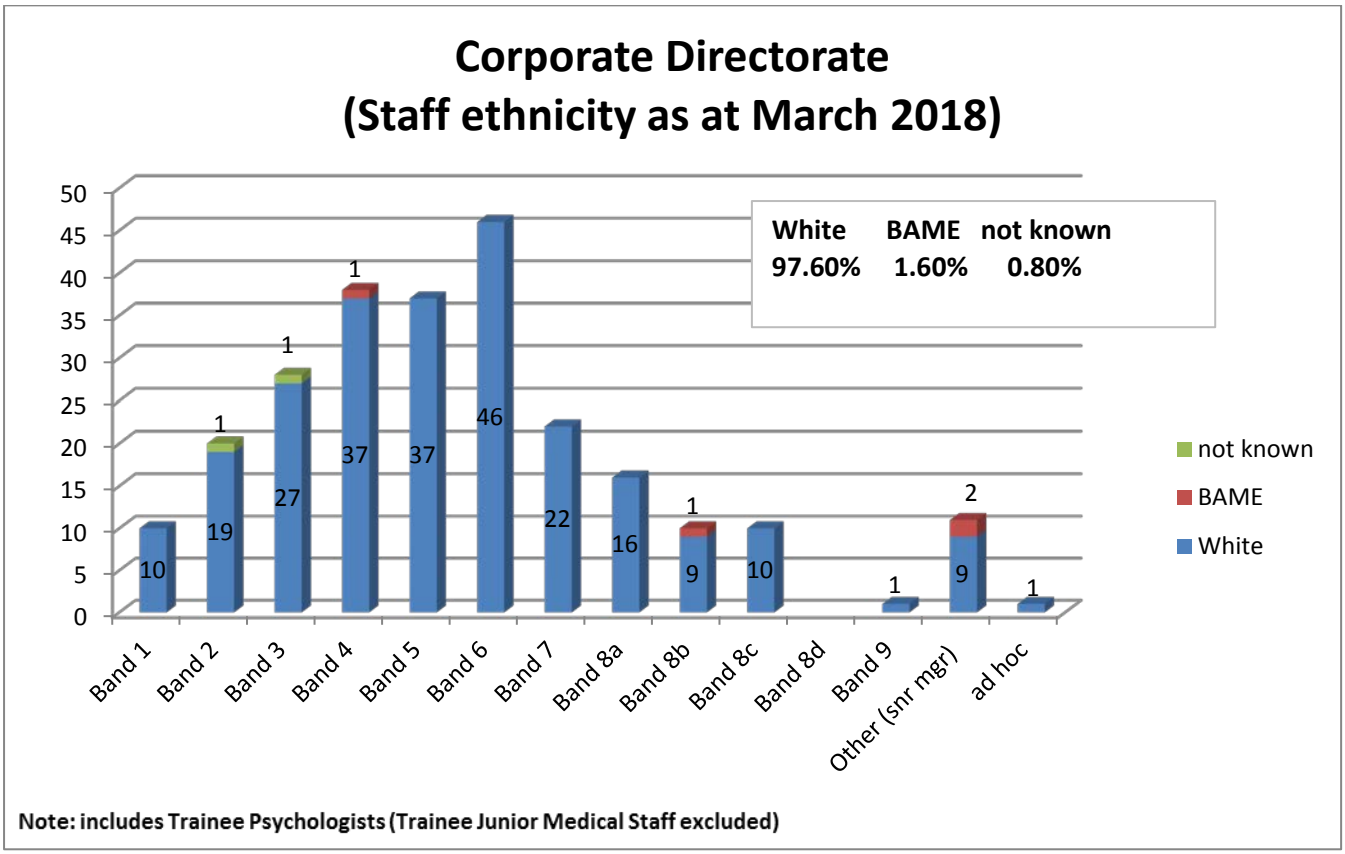

| White | BAME | Not Known |
|---|---|---|
| 91.0% | 5.3% | 3.8% |

## Substance Misuse

**Staff ethnicity by band, March 2018**




| White | BAME | Not Known |
|---|---|---|
| 73.0% | 9.5% | 17.5% |

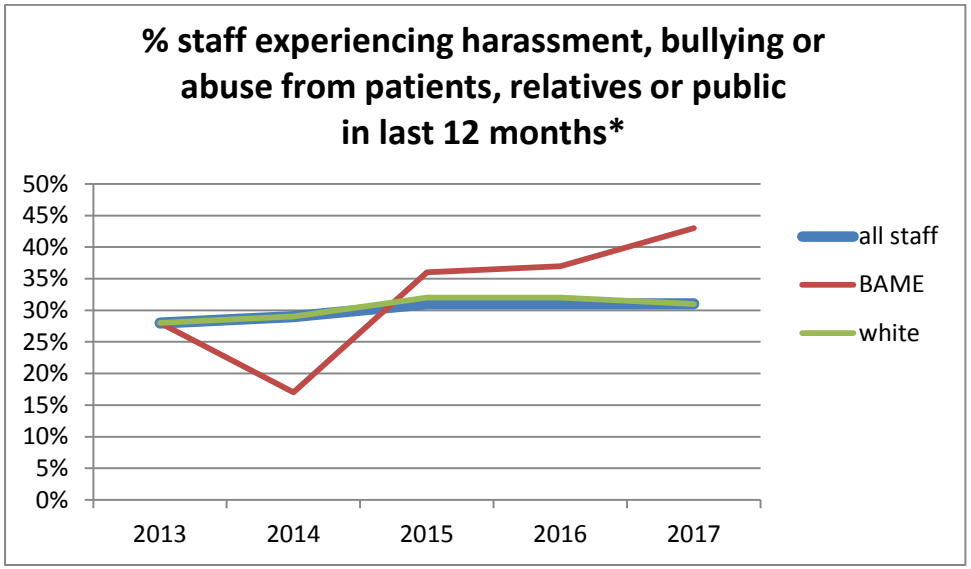


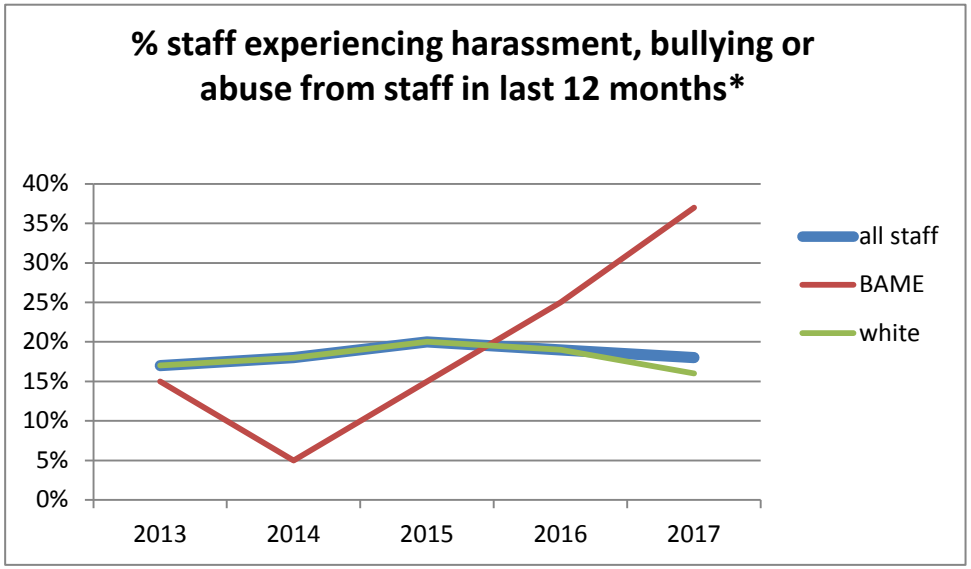

Note: includes Trainee Psychologists (Trainee Junior Medical Staff excluded)

**ATTACHMENT 5**

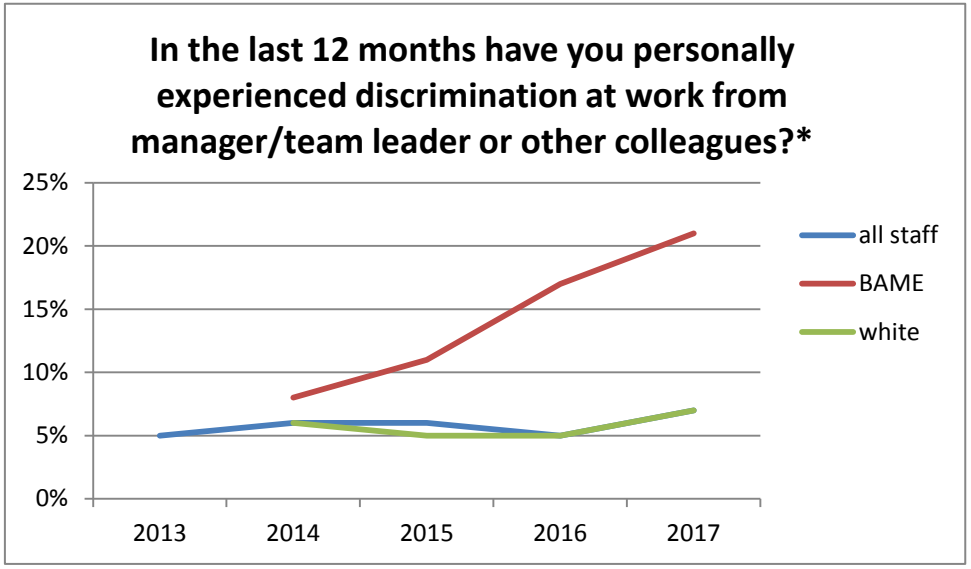
North Staffordshire Combined Healthcare NHS Trust

**Summary of Trust results for WRES indicators 5-8**
**Source:** NHS Staff Surveys 2013-2017








*Low score is better (other measures high score is better)

# SubmissionTemplate
# Workforce Race Equality Standards 2017/18 template

Answer Required
Auto Populated
N/A

| INDICATOR | | DATA ITEM | | MEASURE | 31st MARCH 2017 | | | | | | 31st MARCH 2018 | | | | | | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | WHITE | | BME | | ETHNICITY UNKNOWN/NULL | | WHITE | | BME | | ETHNICITY UNKNOWN/NULL | | |
| | | | | | Prepopulated figures | Verified figures | Prepopulated figures | Verified figures | Prepopulated figures | Verified figures | Prepopulated figures | Verified figures | Prepopulated figures | Verified figures | Prepopulated figures | Verified figures | |
| 1 | **Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce** | | **1a) Non Clinical workforce** | | | | | | | | | | | | | | |
| | | 1 | Under Band 1 | Headcount | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| | | 2 | Band 1 | Headcount | 24 | 24 | 0 | 0 | 1 | 1 | 18 | 28 | 0 | 0 | 0 | 0 | |
| | | 3 | Band 2 | Headcount | 37 | 37 | 0 | 0 | 1 | 1 | 39 | 40 | 0 | 0 | 2 | 2 | |
| | | 4 | Band 3 | Headcount | 76 | 76 | 2 | 2 | 2 | 2 | 69 | 73 | 2 | 2 | 4 | 4 | |
| | | 5 | Band 4 | Headcount | 67 | 67 | 2 | 2 | 0 | 0 | 68 | 80 | 2 | 6 | 0 | 0 | |
| | | 6 | Band 5 | Headcount | 39 | 39 | 1 | 1 | 0 | 0 | 40 | 48 | 0 | 1 | 0 | 0 | |
| | | 7 | Band 6 | Headcount | 20 | 20 | 0 | 0 | 0 | 0 | 23 | 62 | 1 | 5 | 0 | 0 | |
| | | 8 | Band 7 | Headcount | 16 | 16 | 0 | 0 | 0 | 0 | 14 | 83 | 0 | 5 | 0 | 0 | |
| | | 9 | Band 8A | Headcount | 18 | 18 | 1 | 1 | 0 | 0 | 18 | 46 | 0 | 1 | 0 | 0 | |
| | | 10 | Band 8B | Headcount | 18 | 11 | 0 | 0 | 0 | 0 | 11 | 21 | 0 | 2 | 0 | 1 | |
| | | 11 | Band 8C | Headcount | 6 | 6 | 0 | 0 | 0 | 0 | 7 | 14 | 0 | 0 | 0 | 1 | |
| | | 12 | Band 8D | Headcount | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | |
| | | 13 | Band 9 | Headcount | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | |
| | | 14 | VSM | Headcount | 6 | 6 | 0 | 0 | 0 | 0 | 1 | 18 | 0 | 4 | 0 | 1 | |
| | | | **1b) Clinical workforce** of which Non Medical | | | | | | | | | | | | | | |
| | | 15 | Under Band 1 | Headcount | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| | | 16 | Band 1 | Headcount | 1 | 1 | 0 | 0 | 0 | 0 | 7 | 0 | 0 | 0 | 0 | 0 | |
| | | 17 | Band 2 | Headcount | 9 | 9 | 1 | 1 | 10 | 10 | 10 | 1 | 1 | 9 | 0 | 0 | |
| | | 18 | Band 3 | Headcount | 198 | 198 | 3 | 3 | 1 | 1 | 196 | 188 | 6 | 6 | 8 | 9 | |
| | | 19 | Band 4 | Headcount | 79 | 79 | 3 | 3 | 4 | 4 | 79 | 69 | 7 | 3 | 1 | 1 | |
| | | 20 | Band 5 | Headcount | 201 | 201 | 13 | 13 | 0 | 0 | 195 | 186 | 11 | 10 | 3 | 3 | |
| | | 21 | Band 6 | Headcount | 241 | 241 | 12 | 12 | 3 | 3 | 258 | 221 | 14 | 10 | 6 | 5 | |
| | | 22 | Band 7 | Headcount | 140 | 140 | 11 | 11 | 0 | 0 | 147 | 84 | 7 | 2 | 5 | 6 | |
| | | 23 | Band 8A | Headcount | 56 | 56 | 1 | 1 | 1 | 1 | 54 | 29 | 1 | 0 | 1 | 1 | |
| | | 24 | Band 8B | Headcount | 15 | 15 | 1 | 1 | 1 | 1 | 12 | 3 | 2 | 0 | 1 | 0 | |
| | | 25 | Band 8C | Headcount | 15 | 15 | 1 | 1 | 0 | 0 | 15 | 8 | 0 | 0 | 1 | 0 | |
| | | 26 | Band 8D | Headcount | 3 | 3 | 0 | 0 | 0 | 0 | 2 | 1 | 0 | 0 | 0 | 0 | |
| | | 27 | Band 9 | Headcount | 0 | 0 | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | |
| | | 28 | VSM | Headcount | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| | | | *Of which Medical & Dental* | | | | | | | | | | | | | | |
| | | 29 | Consultants | Headcount | 13 | 13 | 15 | 15 | 0 | 0 | 17 | 13 | 21 | 15 | 2 | 2 | |
| | | 30 | *of which Senior medical manager* | Headcount | | 3 | | 2 | | 0 | | 0 | | 2 | | 0 | |
| | | 31 | Non-consultant career grade | Headcount | 8 | 8 | 7 | 7 | 0 | 0 | 7 | 7 | 6 | 4 | 0 | 2 | |
| | | 32 | Trainee grades | Headcount | 8 | 8 | 7 | 7 | 0 | 0 | 1 | 6 | 2 | 10 | 0 | 1 | |
| | | 33 | Other | Headcount | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 3 | 0 | 1 | 0 | |
| 2 | **Relative likelihood of staff being appointed from shortlisting across all posts** | 34 | Number of shortlisted applicants | Headcount | | | | | | | | 1998 | | 493 | | 35 | |
| | | 35 | Number appointed from shortlisting | Headcount | | | | | | | | 199 | | 25 | | 3 | |
| | | 36 | Relative likelihood of shortlisting/appointed | Auto calculated | | 0.1965897693 | | 0.1638418079 | | 0.0000000000 | | 0.0995995996 | | 0.0507099391 | | 0.0857142857 | |
| | | 37 | Relative likelihood of White staff being appointed from shortlisting compared to BME staff | Auto calculated | | 1.20 | | | | | | 1.96 | | | | | |
| 3 | **Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation**<br><br>**Note: This indicator will be based on data from a two year rolling average of the current year and the previous year** | 38 | Number of staff in workforce | Auto calculated | | | | | | | 1310 | 1332 | 86 | 95 | 35 | 39 | |
| | | 39 | Number of staff entering the formal disciplinary process | Headcount | | | | | | | | 4 | | 3 | | 0 | |
| | | 40 | Likelihood of staff entering the formal disciplinary process | Auto calculated | | 0.0137509549 | | 0.0243902439 | | 0.0000000000 | | 0.0030030030 | | 0.0315789474 | | 0.0000000000 | |
| | | 41 | Relative likelihood of BME staff entering the formal disciplinary process compared to White staff | Auto calculated | | | | 1.77 | | | | | | 10.52 | | | |

# SubmissionTemplate
# Workforce Race Equality Standards 2017/18 template

Answer Required
Auto Populated
N/A

| INDICATOR | | DATA ITEM | | MEASURE | 31st MARCH 2017 | | | | | | 31st MARCH 2018 | | | | | | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | WHITE | | BME | | ETHNICITY UNKNOWN/NULL | | WHITE | | BME | | ETHNICITY UNKNOWN/NULL | | |
| 4 | **Relative likelihood of staff accessing non-mandatory training and CPD** | 42 | Number of staff in workforce (White) | Auto calculated | | | | | | | | 1332 | | 95 | | 39 | |
| | | 43 | Number of staff accessing non-mandatory training and CPD (White): | Headcount | | | | | | | | 133 | | 10 | | 8 | As best as records can show. Based on data from our LMS plus medical CPD. |
| | | 44 | Likelihood of staff accessing non-mandatory training and CPD | Auto calculated | | 0.9877769290 | | 1.3048780488 | | | | 0.0998498498 | | 0.1052631579 | | 0.2051282051 | |
| | | 45 | Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff | Auto calculated | | 0.76 | | | | | | 0.95 | | | | | |
| 5 | **KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months** | 46 | % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months | Percentage | 32.33% | | 37.14% | | | | 31.19% | | 43.33% | | | | |
| 6 | **KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months** | 47 | % of staff experiencing harassment, bullying or abuse from staff in last 12 months | Percentage | 18.92% | | 25.00% | | | | 16.13% | | 36.67% | | | | |
| 7 | **KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion** | 48 | % staff believing that trust provides equal opportunities for career progression or promotion | Percentage | 88.67% | | 85.71% | | | | 91.29% | | 64.29% | | | | |
| 8 | **Q17. In the last 12 months have you personally experienced discrimination at work from any of the following?<br>b) Manager/team leader or other colleagues** | 49 | % staff personally experienced discrimination at work from Manager/team leader or other colleague | Percentage | 4.89% | | 16.67% | | | | 6.73% | | 20.69% | | | | |
| 9 | **Percentage difference between the organisations' Board voting membership and its overall workforce**<br><br>**Note: Only voting members of the Board should be included when considering this indicator** | 50 | Total Board members | Headcount | | 11 | | 2 | | 0 | | 11 | | 2 | | 0 | |
| | | 51 | *of which: Voting Board members* | Headcount | | 3 | | 1 | | 0 | | 3 | | 1 | | 0 | |
| | | 52 | *: Non Voting Board members* | Auto calculated | | 8 | | 1 | | 0 | | 8 | | 1 | | 0 | |
| | | 53 | Total Board members | Auto calculated | | 11 | | 2 | | 0 | | 11 | | 2 | | 0 | |
| | | 54 | *of which: Exec Board members* | Headcount | | 6 | | 2 | | 0 | | 7 | | 1 | | 0 | |
| | | 55 | *: Non Executive Board members* | Auto calculated | | 5 | | 0 | | 0 | | 4 | | 1 | | 0 | |
| | | 56 | Number of staff in overall workforce | Auto calculated | | 1309 | | 82 | | 25 | | 1332 | | 95 | | 39 | |
| | | 57 | Total Board members - % by Ethnicity | Auto calculated | | 84.6% | | 15.4% | | 0.0% | | 84.6% | | 15.4% | | 0.0% | |
| | | 58 | Voting Board Member - % by Ethnicity | Auto calculated | | 75.0% | | 25.0% | | 0.0% | | 75.0% | | 25.0% | | 0.0% | |
| | | 59 | Non Voting Board Member - % by Ethnicity | Auto calculated | | 88.9% | | 11.1% | | 0.0% | | 88.9% | | 11.1% | | 0.0% | |
| | | 60 | Executive Board Member - % by Ethnicity | Auto calculated | | 75.0% | | 25.0% | | 0.0% | | 87.5% | | 12.5% | | 0.0% | |
| | | 61 | Non Executive Board Member - % by Ethnicity | Auto calculated | | 100.0% | | 0.0% | | 0.0% | | 80.0% | | 20.0% | | 0.0% | |
| | | 62 | Overall workforce - % by Ethnicity | Auto calculated | 0.00% | 92.4% | 0.00% | 5.8% | 0.00% | 1.8% | 0.00% | 90.9% | | 6.5% | | 2.7% | |
| | | 63 | Difference (Total Board -Overall workforce ) | Auto calculated | | -7.8% | | 9.6% | | -1.8% | | -6.2% | | 8.9% | | -2.7% | |

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# REPORT TO TRUST BOARD

Enclosure No:24

| | | | |
|---|---|---|---|
| Date of Meeting: | 26th September 2018 | | |
| Title of Report: | Locality Restructure | | |
| Presented by: | Jonathan O'Brien, Director of Operations | | |
| Author: | Jonathan O'Brien, Director of Operations | | |
| Executive Lead Name: | Caroline Donovan, Chief Executive | Approved by Exec | ☒ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| The report provides the detail of the progress on the Locality Restructure of the Trust, the consultation response to phase 3 and the final operational structure.<br><br>Phase 3 of the restructure is scheduled for implementation on 1st October 2018, from which point the Trust will operate and report on the basis of four Clinical Directorates. | Approval | ☐ |
| | Information | ☐ |
| | Discussion | ☐ |
| | Assurance | ☐ |
| Seen at: | SLT ☒ Execs ☒<br>Date: 4th September & 11th September 2018 | Document Version No. |
| Committee Approval / Review | • Quality Committee ☐<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☐<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Digital by Choice Board ☐ | |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement.☐<br>2. To provide the highest quality services ☒<br>3. Create a learning culture to continually improve.☐<br>4. Encourage, inspire and implement research & innovation at all levels.☐<br>5. Maximise and use our resources intelligently and efficiently.☒<br>6. Attract and inspire the best people to work here.☐<br>7. Continually improve our partnership working. ☒ | |
| Risk / legal implications:<br>Risk Register Reference | N/A | |
| Resource Implications:<br><br>Funding Source: | N/A | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | N/A | |
| STP Alignment / Implications: | Aligned with STP strategic direction towards locality working and population based service planning and provision. | |
| Recommendations: | Note. | |

## 1. Introduction

This paper provides an update on the transformation journey that is underway following Board approval of the locality working project on the 18th April 2018 and the associated restructure of clinical directorates. The paper is written for Trust Board on 26th September 2018.

## 2. Planned Implementation

Key to the success of the project is the phased approach to implementation.

### 2.1 Phase 1 – Clinical Directors, Associate Directors (HOD's), Deputy Director of Operations

Phase 1 commenced on Monday 30th April 2018 and was formally completed on Friday 6th July 2018. This was on schedule. Following the formal consultation, the appointment of new Clinical Directors and Associate Directors has now taken place. These followed an interview and assessment process following the consultation. Table 1 outlines appointment made.

**Table 1 – Appointments to Clinical Director & Associate Director Positions**

| Directorate | Associate Director | Clinical Director |
|---|---|---|
| Stoke | Jane Munton-Davies | Dennis Okolo |
| North Staffordshire | Samantha Mortimer | Darren Carr |
| Specialist Services | Ben Boyd | Darren Perry |
| Acute & Urgent Care | Natalie Larvin (Interim) | Carol Sylvester (Interim) |

### 2.2 Phase 2 – Configuration of Trust-wide Professional Heads

Phase 2 of the locality restructure commenced on the 4th June 2018 through formal consultation and closed on the 4th July 2018. This phase relates primarily to the senior Professional Leadership Structure within the Trust concerning Heads of Nursing, Allied Health Professionals, Psychology, Social Work and Medical Associate Directors. This phase was led by the Trust's Director of Nursing and Quality and the Trust's Medical Director.

This part of the restructure has resulted in the successful appointment of Dr Darren Perry as Head of Psychology and Mr Alastair Forrester as Head of Nursing and Professional Practice.

### 2.3 Phase 3 - Appointment of Service Managers, Quality Improvement Lead Nurses and Clinical, Psychology and AHP Leads

Phase 3 of the locality restructure focuses on the management structures within each of the newly established Directorates. These include the roles of Service Managers, Quality Improvement Lead Nurses, Clinical, Psychology and AHP Leads. The newly appointed CD's and AD's are leading this phase, including ownership of the launch and the resulting consultation under a Management of Change process.

Phase 3 launched into formal consultation with staff on Monday 16th July 2018 and closed on 14th August 2018. Formal feedback was considered and staff informed of the outcome and final Trust structure on 31st August 2018. It should be noted that several changes were made as a result of the conversation with staff directly or indirectly involved in the process.

The managerial appointments for the new configuration of four Directorates will be concluded after the final assessment day on 27th September 2018. From October 2018 the Trust will report and operate from a four Directorate structure and this is currently on schedule from a Directorate and Corporate services standpoint. Phase 4, associated with transformational changes of services within new Directorates, will then commence from October 2018.

## 3. Summary

In the time period since the Trust Board approved the restructure of operational directorates in April 2018, a significant amount of work has been completed to ensure that the restructure is delivered within the planned timescale, with the Trust being ready to operate on the basis of four Clinical Directorates from October 2018.

## 4. Recommendations

The Trust Board is asked to:

- Receive the report.
- Note the significant progress and work completed by all teams to September 2018.
- Receive a further update on implementation in October 2018.

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*Enc.*

*Appendix 1 – Consultation Response*

*Appendix 2 – Final Structure*

Towards Outstanding
The journey continues...

# Our Locality Structure

NHS
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| Professional Heads | | |
|---|---|---|
| Head of Nursing | 8B | 1.0WTE |
| Head of Social Care | 8B | 0.2WTE |
| Head of AHPs | 8B | 0.2WTE |
| Head of Psychology | 8D | 0.4WTE |
| Assoc Medical Director | Med | 0.2WTE |
| Deputy Director - MACE (Pharmacy) | 8D | 0.2WTE |

| Executive Director of Operations | | |
|---|---|---|
| Deputy Director of Operations | 8D | 1.0WTE |

Clinical Lead roles are aligned to Directorates but operate cross-Trust and act as subject matter experts in their respective fields.

## Stoke Community

| | | |
|---|---|---|
| Clinical Director | Med/8D | 0.4WTE |
| Associate Director | 8C | 1.0WTE |
| Service Manager | 8A | 2.0WTE |
| QI Lead Nurse (Matron) | 8A | 1.0WTE |
| Psychology Lead | 8C | 0.2WTE |
| AHP Lead | 7 | 0.2WTE |
| Social Work Lead* | 7 | 0.2WTE |

Clinical Lead - OP - 8C/Med - 0.3WTE

| | |
|---|---|
| Service Manager 8 - North Stoke | Core Locality Service - Adult CMHT<br>Core Locality Services - Older People<br>Core Locality Services - CAMHS<br>IAPT |
| ANEW & NEB | Outreach Team Older People<br>Care Home Liaison/Physio<br>Memory Services<br>Vascular Wellbeing<br>Primary Care Dementia |

| | |
|---|---|
| Service Manager 7 - South Stoke | Core Locality Service - Adult CMHT<br>Core Locality Services - Older People<br>Core Locality Services - CAMHS<br>IAPT |
| Meir, Stoke & Longton | DOLS/BIA/Stoke AMPH Team*<br>ASD Assessment<br>Growthpoint<br>Parent & Baby<br>Cooperative Working |

*Associated with Stoke Section 75 agreement.

## North Staffs Community

| | | |
|---|---|---|
| Clinical Director | Med/8D | 0.4WTE |
| Associate Director | 8C | 1.0WTE |
| Service Manager | 8A | 2.0WTE |
| QI Lead Nurse (Matron) | 8A | 1.0WTE |
| Psychology Lead | 8C | 0.2WTE |
| AHP Lead | 7 | 0.2WTE |

Clinical Lead - CAMHS - 8C/Med - 0.3WTE

| | |
|---|---|
| Service Manager 6 - Newcastle | Core Locality Service - Adult CMHT<br>Core Locality Services - Older People<br>Core Locality Services - CAMHS<br>IAPT |
| North, Central & South | Liaison & Diversion<br>Criminal Justice Team<br>IPS / Step On<br>Early Intervention<br>Dual Diagnosis |

| | |
|---|---|
| Service Manager 5 - Moorlands | Core Locality Service - Adult CMHT<br>Core Locality Services - Older People<br>Core Locality Services - CAMHS<br>IAPT |
| Leek & Biddulph.<br>Moorlands & Werrington | CAMHS Yellow House<br>Schools Psychology<br>Eating Disorders<br>ASD School Age<br>Sustain (CAMHS)<br>MH Youth Offenders Team |

## Specialist Services

| | | |
|---|---|---|
| Clinical Director | Med/8D | 0.4WTE |
| Associate Director | 8C | 1.0WTE |
| Snr Service Manager - SMS | 8B | 1.0WTE |
| Service Manager | 8A | 3.0WTE |
| QI Lead Nurse (Matron) | 8A | 1.0WTE |
| Psychology Lead | 8C | 0.2WTE |
| AHP Lead | 7 | 0.2WTE |

Clinical Lead - LD - 8C/Med - 0.3WTE
Clinical Lead - SM - 8C/Med - 0.2WTE
Clinical Lead - Neuro - 8C/Med - 0.1WTE

| | |
|---|---|
| Service Manager 4 - Learning Disabilities & CAMHS IP | Dragon Square<br>Assessment & Treatment<br>Community L'Dis<br>Community Learning Dis Team<br>Healthcare Facilitation<br>Intensive Support Team<br>Medical Services - LDis<br>Darwin Centre |

| | |
|---|---|
| Service Manager 3 - Neuro & Rehab | Florence House<br>Summerview<br>Hillcrest<br>Ward 5 - Neuro<br>Neuro Community Services<br>Neuro PSD Daycare<br>Neuropsychology<br>Out of Area / Resettlement Team |

| | |
|---|---|
| Snr Service Manager - SMS & Service Manager 2 - SMS | One Recovery North<br>One Recovery Staffs Medical<br>SMIS Stoke Community<br>Stoke Heath Prison<br>SM Business Team<br>SM Inpatients (EMU)<br>SM Medical |

*Substance misuse management is linked directly to contractual agreements with commissioners and funding sourced through bespoke contracts. The level of management support will increase or decrease depending on individual contracts.

## Acute & Urgent Care

| | | |
|---|---|---|
| Clinical Director | Med/8D | 0.4WTE |
| Associate Director | 8C | 1.0WTE |
| Service Manager | 8A | 1.0WTE |
| QI Lead Nurse (Matron) | 8A | 2.0WTE |
| Psychology Lead | 8C | 0.2WTE |
| AHP Lead | 7 | 0.2WTE |

Clinical Lead - AMH - 8C/Med - 0.4WTE

| | |
|---|---|
| Service Manager 1 - Urgent Care | *Access Team**<br>*Home Treatment Team (Adult)**<br>*IOU (Adult/Subs Misuse)**<br>*Community (Street) Triage**<br>*Place of Safety**<br>*Site Managers**<br>*High Volume Users** |
| | Mental Health Liaison Team<br>CAHMS Central Referral Hub<br>Childrens Paediatrics |

*To combine to form Crisis Care Centre from April 2019

| | |
|---|---|
| Matron 1 - Adult Inpatient | Wards 1, 2, 3<br>PICU<br>Acute Nurse Practitioners<br>Acute Therapies |
| Matron 2 - Older Adults | Wards 4, 6, 7<br>Physiotherapy<br>ECT Team |

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Towards Outstanding
The journey continues...

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# Response to feedback from consultation on Locality Restructure

September 2018

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# Introduction

Faced with demanding service and performance expectations, in an environment where there is increased NHS and external competition, the Trust must ensure that service delivery is driven by patient needs, expectations and priorities.

The work driven through the Sustainability and Transformation Partnership (STP) has indicated that service user and patient preference is to have services delivered closer to their homes and, as a result, are moving to introduce locality working for health and care services.

In response to this and with a continued aim of improving patient services, the Trust has embarked on a wide scale project to introduce and enhance locality based services.

The Trust is moving to a new structure of four (4) Directorates, two of which will service the ten (10) locality teams across Stoke on Trent and North Staffordshire.

An anticipated outcome of this would be to avoid any unnecessary secondary care admissions and referrals, enable improved arrangements for discharge from service with appropriate referral back into the community, along with improving the general health and well-being of the population within their own local community. It will allow us to truly integrate our services with primary, community and social care services.

Given the depth and breadth of the changes in delivery of services, the transition to the new ways of working for the Trust has been undertaken in a phased approach. Phases 1 and 2 were completed in May and June 2018 and resulted in the appointment of the new Associate Directors and Clinical Directors in the Trust.

The consultation relating to the proposal at Phase 3 affects the directorate level senior management teams and was launched in July 2018. The consultation concluded on the 14th August 2018. This paper and appendices summarises responses to feedback received during this consultation period from those affected and confirms the finalised structure for Directorate level leadership and management.

# Original Proposal

The Management of Change consultation was launched on 16th July 2018 through a number of consultation meetings held at a range of locations across the Trust. All staff directly affected by the proposal were invited to attend as well as union representatives from RCN and UNISON.

The proposed directorate level senior management team structure was shared as set out on the next page.

**Towards Outstanding**
**The journey continues...**

# Initially proposed Structure

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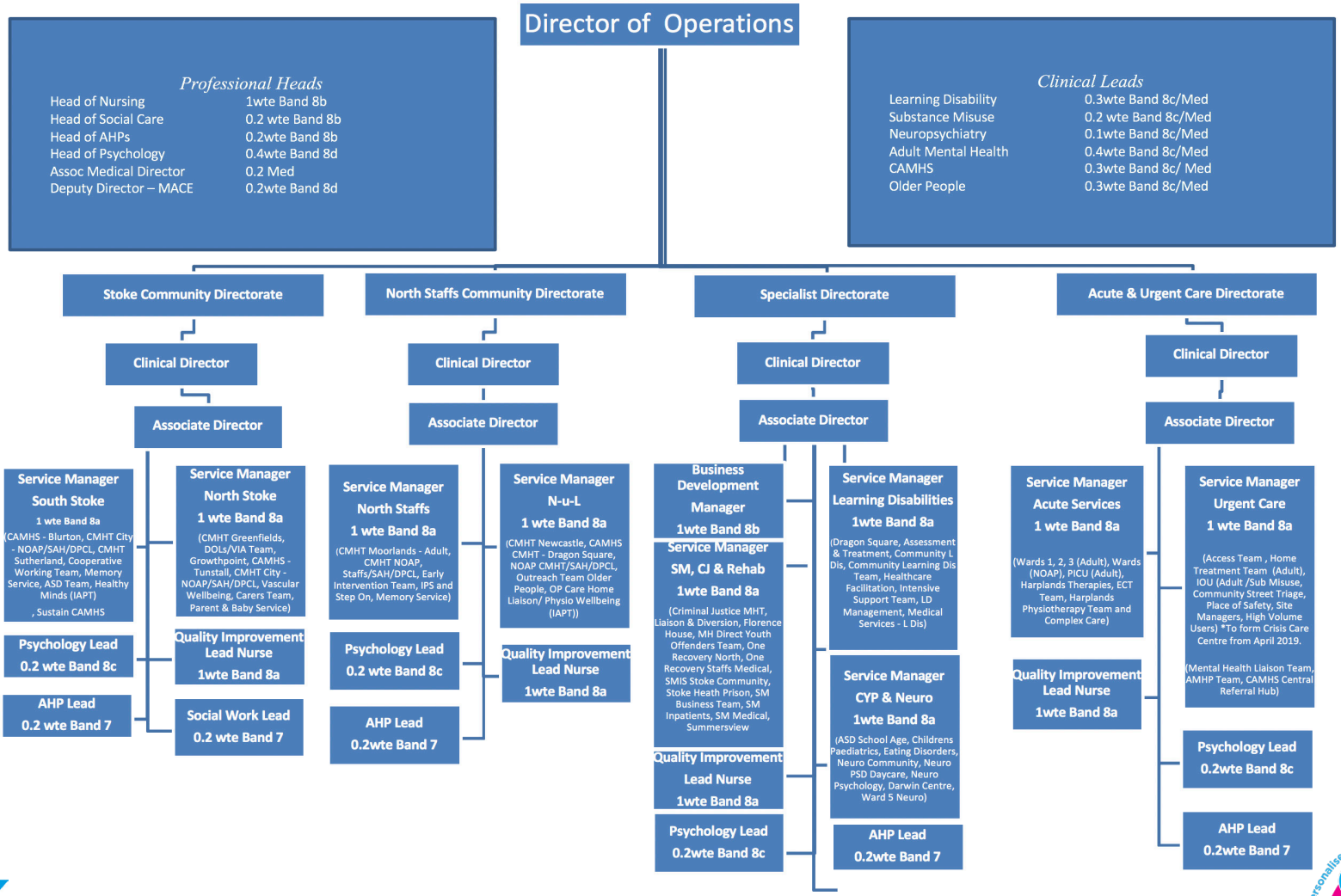


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In the initial consultation, the summary of workforce changes proposed was as follows:

| Role | Current Budgeted Establishment (WTE) | Current Staff in Post (WTE) | Current Headcount in Post | Proposed Staffing in Post (WTE) | Variance between Establishment and Proposed (WTE) |
|---|---|---|---|---|---|
| Service Manager (8a) | 12.6 | 11.6 | 13 | 0 | -12.6 |
| Matrons/Clinical/Governance Lead | 5.9 | 5.2 | 7 | 0 | -5.9 |
| Psychology Lead (8d) | 1.6 | 1 | 1 | 0 | -1.6 |
| (Locality) Service Manager (8a) | 0 | 0 | 0 | 10 | 10 |
| Quality Improvement Lead Nurse (8a) | 0 | 0 | 0 | 4 | 4 |
| Psychology Lead (8c) | 0 | 0 | 0 | 0.8 | 0.8 |
| AHP Lead (7) | 0 | 0 | 0 | 0.8 | 0.8 |
| Business Development Manager (8b) | 0 | 0 | 0 | 0 | 0 |
| Clinical Lead (8c/Medical) | 0 | 0 | 0 | 1.6 | 1.6 |
| **Total** | **20.1** | **17.8** | **21** | **17.2** | **-2.9** |

## Consultation Process

Through the 30 day consultation process, staff directly affected were invited to give their feedback and comment on the proposal through a variety of means including

- 1:1 meetings;
- submission of profile forms;
- team meetings; and
- feedback on a dedicated microsite.

# Finalised Structure

As a result of the feedback received through the consultation process, we have made a number of changes to the final structure, taking into account the comments of staff. These changes have related not only to the make up of the management structure itself, but the placement of some of the teams within the new structure and make-up of individual service areas.

The feedback from our staff and staff side representatives has been invaluable in allowing us to make the right changes and co-produce the new structure with our staff. The table below outlines the changes we have made to the management resource as a result of feedback. The diagram on the next page, which has also been published on the microsite, details the placement of individual services, linked to the professional leadership and management resource.

We have also published the final job descriptions on the microsite, which have been edited to align with feedback and changes made.

| Role | Current Budgeted Establishment WTE | Current Staff in Post WTE | Current Headcount in Post | originally proposed WTE | Finalised WTE | Variance between current Establishment and Finalised WTE | Variance between originally proposed WTE and finalised WTE |
|---|---|---|---|---|---|---|---|
| Service Manager (8a) | 12.6 | 11.6 | 13 | 0 | 0 | -12.6 | 0 |
| Matrons/Clinical/Governance Lead | 5.9 | 5.2 | 7 | 0 | 0 | -5.9 | 0 |
| Psychology Lead (8d) | 1.6 | 1 | 1 | 0 | 0 | -1.6 | 0 |
| (Locality) Service Manager (8a) | 0 | 0 | 0 | 10 | 8 | 8 | -2 |
| Quality Improvement Lead Nurse (Matron) (8a) | 0 | 0 | 0 | 4 | 5 | 5 | +1 |
| Psychology Lead (8c) | 0 | 0 | 0 | 0.8 | 0.8 | 0.8 | 0 |
| AHP Lead (7) | 0 | 0 | 0 | 0.8 | 0.8 | 0.8 | 0 |
| Senior Service Manager (8b) | 0 | 0 | 0 | 0 | 1 | 1 | +1 |
| Clinical Lead (8c/Medical) | 0 | 0 | 0 | 1.6 | 1.6 | 1.6 | 0 |
| Business Development Manager (8b) | 0 | 0 | 0 | 1 | 0 | 0 | -1 |
| **Total** | **20.1** | **17.8** | **21** | **18.2** | **17.2** | **-2.9** | **-1** |

In response to feedback received as well as staffing changes, some changes to team placement have also been made.

This is shown on the table on the next page.

Towards Outstanding
The journey continues...

# Our Locality Structure

NHS
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| Professional Heads | | |
|---|---|---|
| Head of Nursing | 8B | 1.0WTE |
| Head of Social Care | 8B | 0.2WTE |
| Head of AHPs | 8B | 0.2WTE |
| Head of Psychology | 8D | 0.4WTE |
| Assoc Medical Director | Med | 0.2WTE |
| Deputy Director - MACE (Pharmacy) | 8D | 0.2WTE |

| Executive Director of Operations | | |
|---|---|---|
| Deputy Director of Operations | 8D | 1.0WTE |

Clinical Lead roles are aligned to Directorates but operate cross-Trust and act as subject matter experts in their respective fields.

## Stoke Community

| | | |
|---|---|---|
| Clinical Director | Med/8D | 0.4WTE |
| Associate Director | 8C | 1.0WTE |
| Service Manager | 8A | 2.0WTE |
| QI Lead Nurse (Matron) | 8A | 1.0WTE |
| Psychology Lead | 8C | 0.2WTE |
| AHP Lead | 7 | 0.2WTE |
| Social Work Lead* | 7 | 0.2WTE |

Clinical Lead - OP - 8C/Med - 0.3WTE

| | |
|---|---|
| Service Manager 8 - North Stoke | Core Locality Service - Adult CMHT<br>Core Locality Services - Older People<br>Core Locality Services - CAMHS<br>IAPT |
| ANEW & NEB | Outreach Team Older People<br>Care Home Liaison/Physio<br>Memory Services<br>Vascular Wellbeing<br>Primary Care Dementia |

| | |
|---|---|
| Service Manager 7 - South Stoke | Core Locality Service - Adult CMHT<br>Core Locality Services - Older People<br>Core Locality Services - CAMHS<br>IAPT |
| Meir, Stoke & Longton | DOLS/BIA/Stoke AMPH Team*<br>ASD Assessment<br>Growthpoint<br>Parent & Baby<br>Cooperative Working |

*Associated with Stoke Section 75 agreement.

## North Staffs Community

| | | |
|---|---|---|
| Clinical Director | Med/8D | 0.4WTE |
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| QI Lead Nurse (Matron) | 8A | 1.0WTE |
| Psychology Lead | 8C | 0.2WTE |
| AHP Lead | 7 | 0.2WTE |

Clinical Lead - CAMHS - 8C/Med - 0.3WTE

| | |
|---|---|
| Service Manager 6 - Newcastle | Core Locality Service - Adult CMHT<br>Core Locality Services - Older People<br>Core Locality Services - CAMHS<br>IAPT |
| North, Central & South | Liaison & Diversion<br>Criminal Justice Team<br>IPS / Step On<br>Early Intervention<br>Dual Diagnosis |

| | |
|---|---|
| Service Manager 5 - Moorlands | Core Locality Service - Adult CMHT<br>Core Locality Services - Older People<br>Core Locality Services - CAMHS<br>IAPT |
| Leek & Biddulph.<br>Moorlands & Werrington | CAMHS Yellow House<br>Schools Psychology<br>Eating Disorders<br>ASD School Age<br>Sustain (CAMHS)<br>MH Youth Offenders Team |

## Specialist Services

| | | |
|---|---|---|
| Clinical Director | Med/8D | 0.4WTE |
| Associate Director | 8C | 1.0WTE |
| Snr Service Manager - SMS | 8B | 1.0WTE |
| Service Manager | 8A | 3.0WTE |
| QI Lead Nurse (Matron) | 8A | 1.0WTE |
| Psychology Lead | 8C | 0.2WTE |
| AHP Lead | 7 | 0.2WTE |

Clinical Lead - LD - 8C/Med - 0.3WTE
Clinical Lead - SM - 8C/Med - 0.2WTE
Clinical Lead - Neuro - 8C/Med - 0.1WTE

| | |
|---|---|
| Service Manager 4 - Learning Disabilities & CAMHS IP | Dragon Square<br>Assessment & Treatment<br>Community L'Dis<br>Community Learning Dis Team<br>Healthcare Facilitation<br>Intensive Support Team<br>Medical Services - LDis<br>Darwin Centre |

| | |
|---|---|
| Service Manager 3 - Neuro & Rehab | Florence House<br>Summerview<br>Hillcrest<br>Ward 5 - Neuro<br>Neuro Community Services<br>Neuro PSD Daycare<br>Neuropsychology<br>Out of Area / Resettlement Team |

| | |
|---|---|
| Snr Service Manager - SMS & Service Manager 2 - SMS | One Recovery North<br>One Recovery Staffs Medical<br>SMIS Stoke Community<br>Stoke Heath Prison<br>SM Business Team<br>SM Inpatients (EMU)<br>SM Medical |

*Substance misuse management is linked directly to contractual agreements with commissioners and funding sourced through bespoke contracts. The level of management support will increase or decrease depending on individual contracts.

## Acute & Urgent Care

| | | |
|---|---|---|
| Clinical Director | Med/8D | 0.4WTE |
| Associate Director | 8C | 1.0WTE |
| Service Manager | 8A | 1.0WTE |
| QI Lead Nurse (Matron) | 8A | 2.0WTE |
| Psychology Lead | 8C | 0.2WTE |
| AHP Lead | 7 | 0.2WTE |

Clinical Lead - AMH - 8C/Med - 0.4WTE

| | |
|---|---|
| Service Manager 1 - Urgent Care | *Access Team** <br>*Home Treatment Team (Adult)** <br>*IOU (Adult/Subs Misuse)** <br>*Community (Street) Triage** <br>*Place of Safety** <br>*Site Managers** <br>*High Volume Users** |
| | Mental Health Liaison Team<br>CAHMS Central Referral Hub<br>Childrens Paediatrics |

*To combine to form Crisis Care Centre from April 2019

| | |
|---|---|
| Matron 1 - Adult Inpatient | Wards 1, 2, 3<br>PICU<br>Acute Nurse Practitioners<br>Acute Therapies |
| Matron 2 - Older Adults | Wards 4, 6, 7<br>Physiotherapy<br>ECT Team |

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# Feedback Received

Feedback received from staff was comprehensive and invaluable and a summary of themes is described below:

## Theme One: Directorate Makeup / Placement of Services

**Key points of feedback:**

- Placement of smaller / key services misaligned or not optimised.

**Response:**
We have received a significant number of suggested small edits to the alignment of services in the new Directorates. These have included whether services should be aligned to specialist or acute Directorates, or be embedded in the locality Directorates in the longer term.

A summary of the final placement of services has been developed alongside the professional and management leadership structure. This shows these changes more clearly and where services have been placed in the new staff structure. As a result of these changes, we recognise that some within the management of change may wish to edit their preferred roles. We are happy to receive updated preferences from the staff affected

## Theme Two: Substance Misuse

**Key points of feedback:**

- Insufficient management resource for business model.
- Dilution of integrity of Substance Misuse (inclusion of other services).
- Future ability to win tenders / adapt management structure.

**Response:**
We have taken the feedback from substance misuse staff very seriously and in the final published structure, we have made a number of changes.

In response to discussions about management resource, we recognise that substance misuse operates very differently to the remainder of the Trust. We recognise that management resource is linked directly to contracting rounds. Having listened to this, we recognise the risks associated with moving to a single manager and have therefore moved to have two management posts in the area. This will be one 8B Senior Service Manager with oversight of Substance Misuse, reporting into the Associate Director and a further 8A Service Manager reporting into the 8B post. These posts are linked to the two main contracts of Stoke on Trent and Staffordshire.

We recognise that it is important to maintain the integrity of substance misuse within the new structure and having dedicated management resource. We have therefore moved the other services originally aligned to substance misuse into more appropriate Directorates.

Finally, during discussions it has been clear that the management structure in substance misuse needs to be flexible as the service adapts to the contracting environment in which it operates. The Trust is committed to this and to supporting a structure that adapts as the service changes and provides sufficient support for this business model.

## Theme Three: Psychology Structure

**Key points of feedback**:

- Insufficient management structure / loss of senior professional posts.
- Query regarding development of additional Deputy Director of Operations post.

**Response:**
The professional structures and senior professional leadership were considered and consulted on in Phase 2 of the locality project, not the Phase 3 consultation which is now currently live. Phase 2 of the locality restructure commenced on the 4th June 2018 through formal consultation and closed on the 4th July 2018.

The 8D Head of Psychology post (0.4WTE), 8C Directorate Psychology Lead (0.2WTE per Directorate) in the Trust will all be part of what we expect to be full time posts in the Trust. Hence, we fully expect to have at least a full time 8D Psychology post, supported by at least four full time posts across the Trust for which a proportion of time will be ring fenced for leadership duties. It is the intention that the management duties are within the directorate team structure in the future and the above reflects professional leadership only.

We have not included any other Band 8 Psychology posts in the current management of change processes for review, as we are keen to have a discussion with those appointed to the five most senior posts (above), about career pathways, supporting structures and development of Psychology in the future and what this needs to look like. This work will begin from October, once the new managerial structures are in place.

We will be taking a view from other Mental Health Trusts about their journey to outstanding and we can advise that we have arranged to visit Northumberland, Tyne and Wear Trust in November. The Head of Psychology and Clinical Directors have all been asked to attend this visit and as part of this work we will be looking at how our professional structures compare to theirs, including within Psychology.

This will no doubt inform how we move forward with our Psychology structure.

The Deputy Director of Operations post is a direct replacement for the Associate Director of Transformation post, which will no longer exist in the new structure. The costs have also been offset against the loss of two Head of Directorate managerial posts as we have moved from six Heads of Directorate to four Associate Directors, leading the four new Directorates. This is therefore not an additional managerial post and there has been a reduction in non-clinical posts at these levels.

### Theme Four: Quality Improvement Lead Nurse / Matron

**Key points of feedback:**

- The requirement for nursing registration for these posts.

**Response:**
We have taken a considerable amount of time to consider the feedback on this point and the consultation responses which have queried the nursing registration required for these posts.

The new Directorate structure is designed to ensure there is embedded leadership for all the main staff groups within the core Directorate leadership team. There will be Directorate professional leads for Psychology, AHP and Nursing. In the Stoke locality we will also have a social work professional lead, given the Section 75 agreement and services provided on behalf of and in partnership with Stoke on Trent City Council.

We have given a lot of thought and consideration to whether we should split this role and how we can maintain nursing professional leadership within the new Directorates if this role did not require nursing registration. After extensive discussion, we feel that these posts should remain as originally specified. This is because to achieve the ambition of having all professions represented in the Directorate management teams, we would have to either split the posts or put in additional posts if this one was not providing the professional nursing leadership.

### Theme Five: Acute / Urgent Care

**Key points of feedback**:

- Structure & locality services.
- Balance of Matron / Service Management

**Response:**
We have taken a number of services out of this Directorate and located within other Directorates (e.g. the AMHP service) on the basis of refining the structure and after feedback received. The final services linked to this Directorate are therefore revised and shown in the structure diagram. It should be noted that most of these services will come together under The Hazelhurst Centre once building work is completed in April 2019.

We have also strengthened the Quality Improvement Lead Nurse (Matron) element of this Directorate, putting in an extra post in place of one of the two Service Manager posts. In doing so, we have confirmed that the inpatient areas and services within Harplands Hospital (as indicated in the final structure) will report managerially to the QILN (Matron) posts, who will report to the Associate Director.

## Detailed feedback from the localities website

The Trust created a dedicted website to support the consultation process. This generated the majority of feedback.

The website included:

- Latest news section;
- Description of the project aims;
- Description of project governance;
- Timeline;
- 'Hearing your Voice' webform; and
- FAQs.

The FAQs section was updated regularly and contained specific answers to specific questions raised by staff. Staff were invited to check the FAQs page initially to see if their question had already been asked and answered. If it hadn't been asked yet, staff were invited ask by using a "Hearing your Voice" form below. They could also use this form to submit a comment to the Trust. They could choose to give the Trust their name and/or team or remain anonymous.

Every question asked was answered and published on the website, which was - and remains - publicly available on the Internet. As part of the Trust's commitment to openness and transparancy, every question and answer handled by the website has being reproduced in Appendix One.

## Options

Given that there are a number of changes made to the structures through the consultation process, we recognise that this may affect staff's specified preferences. With this in mind, should your preferences have changed from those originally submitted, please indicate your final preferences on the form included at the end of this document by **Friday 7th September 2018**. If your preferences have not changed, you do not need to do anything.

## Interview Day

The Trust has also considered the best way in which to ensure that we are able to appoint the right people with the right skills into each post available within the new structure.

We take on board that the new structure brings very new roles and structures to the Trust and as such it is important that as well as assessing skills and preferences for the new posts, there is also a need to consider values, behaviours and development needs, to ensure we bring together the right teams in the new Directorates.

As normal in circumstances where there are both preferences to consider and such a change in structure, a competency based interview will take place. However we recognise that not all staff thrive in a single interview alone. Staff will therefore participate together in a group exercise, designed to bring the best out of them and to enable team fit, values and behaviours to be considered.

Given the changes in roles we appreciate that staff will need support in transitioning into their new areas. Personal assessments from the interview day will therefore be used to consider any development needs and will be taken forward to staff personal development plans once staff take up their new roles.

## Conclusion

We thank all the staff affected by this consultation for their continued professionalism, engagement and for their valuable contributions to the finalised structure. We recognise that this process can be stressful and we value your input into embedding a structure which further enhances the ability of our teams to deliver the fantastic, patient led services of which you are rightly so proud.