North Staffordshire Combined Healthcare NHS Trust

MEETING OF THE TRUST BOARD

TO BE HELD IN PUBLIC
ON Thursday 27th JUNE 2019, 10.00AM,
BOARDROOM, LAWTON HOUSE, BELLRINGER ROAD, TRENTHAM, STOKE-ON-TRENT, STAFFORDSHIRE, ST4 8HH

	AGENDA	
1.	**APOLOGIES FOR ABSENCE** *To NOTE any apologies for absence*	Note
2.	**DECLARATIONS OF INTERESTS RELATING TO AGENDA ITEMS**	Note
3.	**MINUTES OF THE OPEN AGENDA – 23rd May 2019** *To APPROVE the minutes of the meeting held on 23rd May 2019*	Approve Enclosure 2
4.	**ACTION MONITORING SCHEDULE & MATTERS ARISING FROM THE MINUTES** *To CONSIDER any matters arising from the minutes*	Note Enclosure 3
5.	**CHIEF EXECUTIVE'S REPORT** *To RECEIVE a report from the Chief Executive*	Note Enclosure 4
6.	**CHAIR'S REPORT** *To RECEIVE a verbal report from the Chair*	Note
7.	**STAFF RETIREMENTS** *To EXPRESS our gratitude and recognise staff who are retiring. To be introduced by the Chief Executive and presented by the Chair.*	Verbal
8.	**PEER MENTOR CERTIFICATE PRESENTATION** *To PRESENT the Peer Mentor Certificates* To be introduced and presented by the Director of Nursing and Quality	Verbal

9.	**REACH RECOGNITION TEAM AWARD ON EXCELLENCE** *To PRESENT the REACH Recognition Team Award to Lymebrook Team – North Staffordshire Directorate for the One Stop Clozaril Clinic.* To be introduced by the Chief Executive and presented by the Chair.	Verbal Presentation
	QUESTIONS FROM MEMBERS OF THE PUBLIC	
10.	*To RECEIVE questions from members of the public*	Verbal
	TO ENHANCE SERVICE USER AND CARER INVOLVEMENT	
11.	**SERVICE USER AND CARER COUNCIL** *To RECEIVE an update from Maria Nelligan, Director of Nursing and Quality*	Assurance Enclosure 5
12.	**AUTISM STRATEGY** *To APPROVE THE Autism Strategy from Maria Nelligan, Director of Nursing and Quality*	Approval Enclosure 6
	ENCOURAGE, INSPIRE AND IMPLEMENT RESEARCH AND INNOVATION AT ALL LEVELS	
13.	**DRAGONS DEN UPDATE** *To RECEIVE the Dragons Den Update from Dr Buki Adeyemo, Executive Medical Director*	Assurance Enclosure 7
	TO PROVIDE THE HIGHEST QUALITY SERVICES	
14.	**NURSE STAFFING MONTHLY REPORT (April 2019)** *To APPROVE the Nurse Staffing Monthly Report presented by Maria Nelligan, Executive Director of Nursing & Quality* **SAFER STAFFING ANNUAL REPORT 2018/2019** *To APPROVE the Safer Staffing Annual Report presented by Maria Nelligan, Executive Director of Nursing & Quality*	Assurance Enclosure 8 Approval Enclosure 9 Presentation
15.	**QUALITY ACCOUNT** *To RECEIVE the Quality Account presented by Dr Buki Adeyemo, Executive Medical Director*	Assurance Enclosure 10
16.	**SERIOUS INCIDENTS ANNUAL REPORT** *To RECEIVE the Serious Incidents Annual Report presented by Dr Buki Adeyemo, Executive Medical Director*	Assurance Enclosure 11

17.	**MORTALITY SURVEILLANCE ANNUAL REPORT** *To RECEIVE the Mortality Surveillance Annual Report presented by Dr Buki Adeyemo, Executive Medical Director*	Assurance Enclosure 12
18.	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK ENHANCED REPORT (PQMF 2019/20) – Month 1** *To RECEIVE the Month 1 Performance Report presented by Lorraine Hooper, Executive Director of Finance, Performance and Estates*	Assurance Enclosure 13
	CREATE A LEARNING CULTURE TO CONTINUALLY IMPROVE	
19.	**Received as Item 8 in Closed Board**	
	MAXIMISE AND USE OUR RESOURCES INTELLIGENTLY AND EFFICIENTLY	
20.	**FINANCE REPORT – MONTH 1 (2019/20)** *To RECEIVE the Month 1 Financial position presented by Lorraine Hooper, Executive Director of Finance, Performance and Estate*	Assurance Enclosure 14
21.	**ASSURANCE REPORT FOR FINANCE, PERFORMANCE AND ESTATES COMMITTEE** *To RECEIVE the Finance, Performance and Estates Committee Assurance report from the meeting held on the 17th June 2019 from Tony Gadsby, Chair/Non-Executive Director*	Assurance Enclosure 15
22.	**ASSURANCE REPORT FOR AUDIT COMMITTEE** *To RECEIVE the Audit Committee Assurance report from the meeting held on the 24th May 2019 from Tony Gadsby, Chair/Non-Executive Director*	Assurance Enclosure 16
23.	**ASSURANCE REPORT FOR PRIMARY CARE COMMITTEE** *To RECEIVE the Primary Care Committee Assurance report from the meeting held on the 20th June 2019 from Tony Gadsby, Chair/Non-Executive Director*	Assurance Enclosure 17 To Follow
24.	**ASSURANCE REPORT FOR BUSINESS DEVELOPMENT COMMITTEE** *To RECEIVE the Business Development Committee Assurance report from the meeting held on the 6th June 2019 from Joan Walley, Chair/Non-Executive Director*	Assurance Enclosure 18
	ATTRACT AND INSPIRE THE BEST PEOPLE TO WORK HERE	
25.	**No items for discussion**	
	CONTINUALLY IMPROVE OUR PARTNERSHIP WORKING	

26.	**HIGH POTENTIAL SCHEME BRIEFING** *To RECEIVE for information the High Potential Scheme Briefing from Linda Holland, Director of Workforce, Organisational Development and Inclusion*	Assurance Enclosure 19
	CONSENT AGENDA ITEMS	
27.	**TOGETHER WE ARE BETTER (STP DIRECTORS REPORT) – MAY 2019 UPDATE** *To RECEIVE for information the Together We're Better (STP Directors Report) May 2019 Update from Peter Axon, Chief Executive Officer*	Information Enclosure 20
	ANY OTHER BUSINESS	
	The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday 25th July 2019 at 10:00am.	
	MOTION TO EXCLUDE THE PUBLIC *To APPROVE the resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admissions to Meetings) Act 1960)*	
	THE REMAINDER OF THE MEETING WILL BE IN PRIVATE	
	DECLARATIONS OF INTEREST RELATING TO AGENDA ITEMS	Note
	SERIOUS INCIDENTS	Assurance
	PERFORMANCE	Approve
	ESTATES	Assurance
	WORKFORCE AND AGENCY	Assurance
	ANY OTHER BUSINESS	

TRUST BOARD

Minutes of the Open Section of the North Staffordshire Combined Healthcare NHS Trust Board meeting held on Thursday 23rd May 2019 At 10:00am in the Boardroom, Lawton House, Bellringer Road, Trentham, Stoke-on-Trent, Staffordshire, ST4 8HH

Present:

Chairman:

Tony Gadsby
Vice Chair / Non Executive

Directors:

Dr Keith Tattum
GP Associate Director

Peter Axon
Chief Executive

Linda Holland
Director of Workforce, Organisational Development and Inclusion

Maria Nelligan
Executive Director of Nursing and Quality

Lorraine Hooper
Director of Finance, Performance and Estates

Patrick Sullivan
Non-Executive Director

Janet Dawson
Non-Executive Director

Russell Andrews
Associate Non-Executive

Dr Buki Adeyemo
Executive Medical Director

Joan Walley
Non-Executive Director

Chris Bird
Director of Partnerships and Strategy

Jonathan O'Brien
Executive Director of Operations

In attendance:

Laurie Wrench
Associate Director of Governance

Jenny Harvey
Union Representative

Joe McCrea
Associate Director of Communications

Lisa Wilkinson
Corporate Governance Manager (minutes)

Retirees
Brigid Ellis, Practice Nurse Moorcroft Medical Centre
Amanda Hulson, Practice Nurse, Moorcroft Medical Centre
Andy Cooper, Building Officer, Estates

Members of the public:
Chris Bailey – Eight2Eight
Gavin Morris - 02
Thea Costa – Service User
Sue Parkes – Quality Improvement Lead

REACH Recognition Individual Award
Richard Bagnall, Registered Nurse, Acute and Urgent Care
Jayne Underwood – Clinical Ward Manager
Carol Sylvester – Clinical Director

The meeting commenced at 10:00am.

107/2019	**Apologies for Absence** David Rogers, Chairman	**Action**
108/2019	**Declaration of Interest relating to agenda items** No declarations of interest.	
109/2019	**Minutes of the Open Agenda – 25th April 2019** The minutes of the open session of the meeting held on 25th April 2019 were approved.	
110/2019	**Matters arising** The Board reviewed the action monitoring schedule and agreed the following:- ***247/2018 – Person Centredness Framework –*** *Agenda item* ***85/2019 – CEO Update – New appointments –*** *Job Descriptions reflect the sustainability agenda and interview processes in the final stages of being set up and will include the ability to address the sustainability agenda.* ***93/2019 – Nurse Staffing Month Report February 2019 –*** *A survey monkey is being devised to go out to the inpatient staff and results from this feedback will come to July Trust Board.* ***94/2019 – Enhanced Performance Quality Management Framework Month 11*** *– There is ongoing work to ensure that metrics are aligned to relevant services. Given the timing of the cycle of business the outcome of this work will be reflected from Quarter 1.* ***99/2019 - Self- Certification G6 and FT4 (Provider License) –*** *Non-Exec Directors assurance regarding conforming to the requirements of the Provider License is provided through the arrangements with External Audit in terms of the Annual Governance Statement and Annual Report. Internal audit provide assurance to the Executive Team throughout the year that systems and processes are robust and identify areas of concern for action. Additionally, External Audit required the Director of Finance and Chair of the Audit Committee to declare compliance with management arrangements of how assurance is delivered.* ***104/2019 – Any Other Business – Trade Unions and STP –*** *Correspondence set to STP Programme Director requesting better engagement between trade unions and STP work programmes. Jenny noted there is a meeting scheduled.*	

	68/2019 - Nurse Staffing Monthly Report January 2019 *– We have commenced the review for the Safer Staffing review which will come to the June Board which will provide an updated position* ***Noted***	
111/2019	**Chief Executive's Report** This report updates the Board on activities undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest. **Five Year Plan** The draft Five Year Plan requires completion by November 2019. Our Executive Team and the STP will be working together on this. Aligned to that is the timing of the Partnership Strategy refresh which Chris Bird will be overseeing. In June 2019 we are scheduled to have a three way Executive conversation with the Midlands Partnership Foundation Trust (MPFT) and the University Hospital of North Midlands (UHNM). This will be an inaugural meeting about how as providers we can be more productive to support the five year plan and programmes of work on the ground. **Exec to Exec Forum** There is an Exec to Exec Forum arranged with MPFT specifically to discuss common ground around the mental health and learning disability elements of the Five Year Plan and the narrative and ambition we want as a collective in Staffordshire. **Our Awards Success Continues** The Trust was proud to host Positive Practice's Children & Young People's Mental Health Awards. Not only were we highly commended for the Inpatient Care award for The Darwin Centre, as well as Liaison and Intensive Support Service for The Hub, but we won the Partnership Working/Co-Production award. Chloe Jackson, one of the young volunteers on our CAMHS Trailblazer project, has been absolutely invaluable in her input into the project, so winning Champion of the Year was so well deserved. Our Estates Team won two awards at the Partnerships Bulletin Partnership Awards 2019. They took home The Public Sector Team of the Year Gold Award for how they worked together and managed to maintain services whilst going through major management of change with the Estates team, dealing with the collapse of Carillion and delivering the Trust's biggest capital project to the key parameters of time, cost and scope. Secondly, they won the Silver Award for Best Operational Project for	

	Harplands Hospital. This was a joint award to both the Trust Estates team and Imagile Professional Services for the way that they work so well together for their partnership working on the PFI and particularly for dealing with the collapse of Carillion as a provider of services on that contract. The Trusts Finance Department also won the NHS Public Finance Award. Congratulations to everyone involved in this string of continued successes. **Building Resilience Through Staff Networks** The Trust has recently launched its BAME, LGBT and Neurodiversity Staff Networks. We are also keen to support the establishment of other networks where there is demand. Our Staff Networks will each have a direct route to a Trust Board member. Peter highlighted that a Reverse Mentoring Exercise is being undertaken by our own Executive Members. Joan Walley referred to the Executive meeting planned to discuss the Five Year plan and added that the big issue is around the inequalities across Staffordshire and Stoke-on-Trent and asked that we use this as an evidence base regarding the levels of deprivation there are in the whole of Staffordshire. Joan asked that Keele University be particularly involved in these discussions. Joan also referred to discussions had at Business Development Committee regarding significant cuts across Staffordshire in Tier 1 and 2 learning disability services which has led more to a market economy. Joan asked that the Committee be involved in the way the work is being taken forward highlighting that we are now in a situation where we could easily have piece meal provision for people with a learning disability and their families. We need a strategic look across the whole area. Peter agreed there have been issues historically and there remain big challenges, we need more clarity on what our role is and what our opportunity is to make more of a role in the system and Business Development Committee may be the route to do that. Chris Bird highlighted the need to consider proposals from both local authority areas for 2019/2020 that will inform discussions at the Committee. Joan added that part of her concern was that when this was discussed at Committee there was a sense that Staffordshire County Council had baseline figures but those figures were not available for Stoke-on-Trent. ***Received***	

112/2019	**Chair's Report** No items to note. ***Noted***	
113/2019	**Staff Retirements** **Brigid Ellis – Practice Nurse, Moorcroft Medical Centre** Brigid commenced RGN training at Central Middlesex Hospital in 1981. She worked as a Staff Nurse locally at Stafford and Stoke in 1983 with a short time in the community as an Enrolled Nurse in a local care home - this was her first experience of primary care nursing. Brigid's main focus until 2003 was Staff Nurse in various specialities with a particular interest in Endocrinology. This was followed by a short placement as a District Nurse before joining Moorcroft in 2004, and so began a long and fruitful relationship with the practice during which time Brigid has developed her practice nursing skills to the highest level and provides the very broad spectrum of patient care required in modern general practice. Brigid is well respected by patients and colleagues and leaves a very large pair of boots to fill; we wish her all the very best for her well-earned retirement Brigid was presented with a certificate from the Vice Chair, Tony Gadsby and nursing badge from Maria Nelligan, Director of Nursing and Quality. **Amanda (Mandy) Hulson – Practice Nurse, Moorcroft Medical Centre** Mandy commenced RGN training in 1984 at the University Hospital of North Staffordshire. After starting her career at UHNS, Amanda worked as a Staff Nurse on the Parent and Baby Unit in Hanley before joining the District Nursing team in 1990 as a Community Staff Nurse. Mandy worked alongside the practice as a District Nurse until joining Moorcroft in September 2010. Mandy has become a pivotal member of the practice nursing team and provides a high level of complex patient management which is essential in primary care today Mandy has decided to reduce her work commitment and we wish her the very best for these well-deserved changes. However, we are delighted (and very relieved) that Mandy will be returning to us and	

	will continue to offer the high level of care and dedication that the practice and the patients value so much. Mandy was presented with a certificate from the Vice Chair, Tony Gadsby and nursing badge from Maria Nelligan, Director of Nursing and Quality. **Andrew Cooper – Building Officer, Estates Team** Andy commenced work with the NHS in December 1979, initially at the City General Hosptial before moving to Bucknall Hospital as a Building Officer. Later he moved to Stanfields Hospital and then to St Edwards where he was heavily involved in the site closure and the subsequent move to Harplands Hospital. After a short spell based at Bagnall Hospital he returned to Bucknall Hospital and finally to Trentham Lakes as an integral part of the current Estates Team. Andy has been involved in the design and project management of many schemes within this time including major refurbishments and extensions to Summers View and Florence House and other similar projects within the Learning Disabilties Service. After thirty nine and a half years with Combined Healthcare and 46 years working in total he has decided it's time for retirement. Andy's retirement aim is 'to do all the things he has not had time to do whilst working' and we wish him all the best for the future. Andy was presented with a certificate from the Vice Chair, Tony Gadsby. ***Noted***	
114/2019	**REACH Recognition Individual Award** **Richard Bagnall – Deputy Ward Manager Ward 7, Acute and Urgent Care** Richard has been the Deputy Ward Manager on ward 7 for nearly 3 years and for the last 4 months he has been Acting as the Ward manager. Richard demonstrates excellent leadership skills and has applied innovation to improve patient care and engagement of staff members. Richard is continually motivating staff to engage in innovative practice to improve the patient experience. He has devised new ways of working by introducing a whole team approach when attending to patient's personal care during the morning. This has improved staff morale and has ensured a better experience for patients. Richard has implemented a "ward 7 weekly review" which updates	

	the ward staff on patient movement, staffing of the ward, updates on performance and areas to focus on to maintain high standards. Staff report that this makes them feel valued and supported by Richard. Richard has also implemented an Inpatient Safety Matrix action plan which he completes following the ISM peer Audit. This includes sharing good practice and improvements made and an action plan for further improvements This approach has had a positive impact on ISM results for ward 7. Staff, patients and carers report that Richard is an excellent member of the team, that he is always approachable, warm and compassionate with a "can do attitude". Staff report that they feel valued and supported and feel privileged to work alongside Richard on ward 7. The impact of Richard being in post is; - staff feel valued and supported - there has been an increase in staff morale - patient experience has improved - performance has improved Richard demonstrates all of the Trusts values, he is approachable, responsible and demonstrates excellent leadership and he exceeds in providing compassionate care. ***Noted***	
115/2019	**PATIENT STORY – THEA COSTA'S STORY** Maria Nelligan, Director of Nursing and Quality introduced Thea Costa to the Board. Sue Parkes, Quality Improvement Lead attended the meeting today to support Thea. Maria introduced Thea who had a key role in May's Nursing Conference by sharing her story of recovery following an attempt on her life with the help and support of her Community Mental Health Team, at the Sutherland Centre. To commemorate Mental Health Awareness Week Thea was asked to attend Trust Board to give a brief outline of this journey and what Mental Health services could learn from her experiences. Thea described herself as being from a middle classed background of ethnic minority, born and educated in England. A teacher by profession who ran businesses with her ex-husband. Unfortunately Thea suffered 34 years of emotional and physical abuse. Thea told the Board it was something that was not talked about as she felt she must not discuss it as she did not want her two sons to think this was	

	'ok', therefore she chose to keep it a secret whilst at the same time becoming a pillar of the community and a president of many different organisations. She described that she was 'living a nightmare' and was unable to discuss it with no one. Thea explained how unbeknown to herself she was having a 'mental breakdown.' Thea was helping others taking them to the Priory sitting and talking for them whilst going through her 'own hell'. Theas children grew up, married and moved on. Thea explained, 'In my mind it was time for me to leave, but not through divorce, I decided taking my own life was the best way to do it so I planned the suicide attempt down to the last detail but was unsuccessful and given a 20% chance of survival as all my organs were shutting down, I caught pneumonia, could not walk or use my hands and was unconscious at the Royal Stoke Hospital for five weeks.' Thea explained when she regained consciousness on Christmas Eve she had no idea why she was there but slowly through flashbacks and talking to people she began to recall events. Thea talked about the help she received from some wonderful nursing staff and doctors but explained that she also encountered a few, 'through no fault of their own,' who were not as compassionate or empathetic, doing their jobs but she felt not to the best of their ability. Thea felt that people who have been through a trauma and face recovery need the professionals to have enough time to help them with the detail as opposed to worrying about targets and 'tick boxes.' Thea told the Board that since the Nursing Conference she had been approached by various departments who have asked her to speak at their meetings and so far she has found the response has been incredible. Thea explained that through the help she has received she now has a life. Thea added, 'I am a survivor my intention is to give back and I am now part of the peer mentoring group, I want to be amongst people who have been through and are going through what I have experienced to tell them there is life, hope and help and we need to show people where to go for this help.' Joan Walley thanked Thea for sharing her story and asked Thea in terms of the career change she had mentioned if she had any idea of the range of jobs that are available. Thea said she would like to push forward with the peer mentoring as it 'is superb' but she was unsure as to whether it was 'big enough' or if there was enough opportunity for people. Thea reflected on the care she had received at the Sutherland Centre and referred to a member of staff who had helped Thea and others, she felt she was a true professional and her approach was one of honesty. Maria thanked Sue Parkes for supporting Thea and helping her to tell her story.	

	Noted	
116/2019	**QUESTIONS FROM MEMBERS OF THE PUBLIC** There were no questions from the members of the public present.	
117/2019	**SERVICE USER AND CARER COUNCIL** Wendy Dutton, Chair of the Service User Carer Council provided a verbal update. The Service User Care Council continue to source resilience and are hopeful different pathways including the Peer Mentorship Programme will help to get people involved. The Observe and Act Training is ongoing and receiving a good response from service users. The Council continues with recruitment through to induction. There is a Workshop planned with a focus on discharge planning, Maria Nelligan will be attending. Russell Andrews commented having taken part in a recent induction day the input from Wendy was very powerful and exemplified the issue of putting the service user at the centre of everything we do. Russell added that it was as a very positive day and he was proud to be part of it. Wendy thanked Russell and explained that it actually helps her to remain well as expressing and discussing her journey is part of her recovery. ***Noted***	
118/2019	**PERSON CENTREDNESS FRAMEWORK PRESENTATION** Maria Nelligan, Director of Nursing and Quality provided a presentation. Maria explained that we aspire to be truly person centred in all that we do in order to recognise and respect each and every one of us (service users, carers and staff) as unique individuals. Maria talked about the person centred principles and progress made. Next Steps are to: • Launch One-Page Profiles today • Develop and launch internal and external webpage with person centred resources: – One-page profiles – Wellness Recovery Action Plan – This is Me Leaflets	

	– Communication Passports – What I Like Posters – Health Action Plans – PBS tools • Promote and continuously develop person centredness resources, co-produced with service users and carers Profiles were displayed in the Boardroom. Joan Walley asked if we had thought about applying this to future meetings / discussions with our other partners at a strategic level. Peter Axon advised this would be considered going forward. Dr Adeyemo commented 'if we get it right with the simple things we will get it right with everything.' This will then be a thread that runs through the organisation. Patrick Sullivan reflected on Thea Costa's patient story adding one of the most powerful things about Thea's journey was the power of the individuals she could relate to that made such a difference to her which must remind us of how important it is to relate to individuals in the proper way. Following the Panorama documentary that was aired yesterday learning disability services are about to receive some negative press but Patrick advised he has been to some good units that have put this into practice. You see a profile of the individual then you immediately have a sense of how to help them if they were struggling that day and it is easy to engage in a conversation and work with people, it reminds us what we are here for. ***Received***	
119/2019	**REDUCING THE RISK OF SUICIDE AND SELF HARM IN PEOPLE WITH A LEARNING DISABILITY: HEALTH SERVICE JOURNAL (HSJ) AWARD PRESENTATION SUMMARY** Dr Buki Adeyemo, Executive Medical Director presented a summary to the Board. In 2016, Combined developed a local suicide strategy and signed up the local multi-agency Zero Suicide ambition. With further investment in risk assessment and clinical interventions for self-harm and suicide, staff were supported to attend the 'Connecting with People' training programme, which included both suicide response and self-harm prevention. It was identified that the tools and strategies used within the training were not accessible to the learning disability population. Of note: • The Learning Disability team identified a need that people with learning disability would need additional support in engaging in assessment and interventions;	

	• Adapted and simplified the 'Connecting the People' SAFETool resource, making it accessible, relevant and helpful to people with a Learning Disability; • Adaption of the SAFETool increased confidence in staff and facilitated an open conversation around self-harm and suicide to empower feelings of connectedness with wider social networks; • Presentation delivered at the Health Service Journal (HSJ) Award Ceremony, on the 9th May 2019, for the Innovation in Learning Disability Safety Award; Feedback from the HSJ panel was positive, acknowledging that the innovation was important and that the passion for service user care and adaptations for people with learning disabilities was evident. Joe McCrea highlighted that there is a Trust podcast in relation to this and positively we have had over fifty listeners to this in the last six days. Joan Walley asked if this is something we do for our own staff or for other providers. Dr Adeyemo confirmed the plan is to spread wider in the future. Tony Gadsby asked if there is a commercial opportunity for us. Dr Adeyemo confirmed there would be and this will come back to next month's Trust Board as part of the Dragon's Den update. Joan Walley highlighted that there have been a number of discussions recently relating to opportunities for training contracts and procurement in terms of training in suicide awareness and added there seems to be a lot of separate initiatives ongoing. Joan asked where in the Trust this is coordinated. Dr Adeyemo advised that innovation is supported by the Research & Development Directorate working closely with Strategy. Jonathan O'Brien highlighted the Suicide Prevention Action Plan for the region reports through the Mental Health Programme of the STP and good progress is being made. Jonathan added there was a tender opportunity with the Council who were looking for a provider to provide suicide training to staff, this was a small tender in terms of value and the Trust did not pursue this however in light of the relationships built with the Council should the opportunity arise again the Trust would suggest the Council use their relationship with us and work with us so we could proactively provide their staff with this training on that basis. ***Received***	**BA**
120/2019	**NURSE STAFFING MONTHLY REPORT (March 2019)** Maria Nelligan, Executive Director of Quality and Nursing presented the report.	

	The paper outlined the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during March 2019 in line with the National Quality Board requirements. The performance relating to fill rate (actual numbers of staff deployed vs numbers planned) during March 2019 was 82% for registered staff and 93% for care staff on day shifts and 76% and 104% respectively on night shifts. Overall a 90% fill rate was achieved. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover and Ward Managers supporting clinical duties. The data reflects that Ward Managers are staffing their wards to meet increasing patient needs as necessary. Maria highlighted that annual leave usually impacts on March figures. RN day shift cover remained challenging during March 2018; the most significant increases continue to be within the Assessment & Treatment Unit where acuity remains high and a 40% increase in clinically required staffing has been required since mid-January 2019. The impact of this increase continues to be felt across all inpatient and some community areas. The MDT, Directorate Management and Executive Team are working closely with CCG colleagues to support the unit to manage these challenges. The Safer Staffing Annual Review report will be presented at June Trust Board. Jenny Harvey noted the problems in March which so many Trust's experience due to annual leave and suggested changing when annual leave commences through the year. Some Trusts are exploring this. This is something the Trust will consider. Linda will look into whether this will raise any financial issues. Medics do already use the start date as the start of the annual leave year. It was agreed this item would be discussed at the People, Culture and Development Committee who will report back to Board the outcome. Patrick Sullivan wished to acknowledge the staff that work on inpatient units given vacancy levels we have our wards are still kept safe. Patrick shared his concern that we have 60 vacancies which is two wards worth of staff and he felt this was not sustainable in the long term. Maria confirmed that vacancies are reviewed on a monthly basis and the annual report will provide more detail next month. Part of national problem is the supply of Registered Nurses work is being undertaken to address HCSW's vacancies and ensuring we have a healthy bank supply. Maria added that we are making sure we are considering every option to make us more attractive as an organisation and retaining staff. We have offered Student Nurses placements from Keele and Staffordshire this year. A more in depth conversation will be had when we receive the Annual Report as some solutions have been	**LH**

	identified. Jonathan O'Brien noted the report outlines there are 24 HCSW's vacancies, Jonathan advised that we have appointed to at least 18 of those who are in the process of joining the Trust at the moment. Maria added that we are ensuing the recruitment process is slicker and the move from bank to substantive is too. Russell Andrews talked about the statistical process control discussed at a recent Board Development session and asked would these indicators be caught in that mechanism. The Board agreed this would be helpful. Maria and Lorraine agreed to look at this going forward. ***Approved / Received***	**MN/ LHOO**
121/2019	**SAFEGUARDING ANNUAL REPORT** Maria Nelligan, Executive Director of Quality and Nursing presented the report. The purpose of this report is to outline the safeguarding work within the Trust for the period of April 2018 to March 2019, evidencing how we are making a positive difference and providing assurance of compliance to the Trust Board and partners. This year has seen the Safeguarding Team embed changes of leadership with both the Named Doctor and Head of Safeguarding coming into post just prior to April 2018. The service has continued to deliver both internal and external training packages in line with national guidance, developing additional training packages to be delivered by the team and sourcing external specialist training. Level 3 training compliance is 94% against a target of 85%. Supervision continues to be delivered on both an individual case by case basis and as a structured part of team supervision. It is planned to continue to increase participation with structured team supervision over the coming year to engage with a wider spread of teams across the Trust. This will provide an opportunity to develop both individual and team skills and knowledge through supportive discussion and challenge. Domestic Abuse is underreported nationally, there are suspected high incidences in our region and therefore additional training has been introduced for staff. Level 3 Adult Safeguarding Training has commenced this financial year.	

	Janet Dawson enquired as to why the Trust target was not 100% for learning. Maria advised that none of the Trust's targets are 100% as there can be a certain number of people on annual leave, maternity leave or secondment. We are above our target of 85%. Janet also asked how the Trust would be made aware of staff not being compliant. Linda Holland provided assurance that the Learning Management System used by the Trust alerts staff and Managers when updates are required. ***Approved / Received***	
122/2019	**DIRECTOR OF INFECTION PREVENTION AND CONTROL (DIPC) REPORT QUARTER 4 2018/19** Maria Nelligan, Executive Director of Quality and Nursing presented the report. The report updated and provided assurances to the Board for quarter four (Q4) on IPC activity including influenza within the organisation. The Board will also be briefed on our position in relation to Health Care Acquired Infections (HCAIs) and relevant issues. There were no Infection Prevention and Control (IPC) incidents reported in Q4. Only two inpatients at Combined have been symptomatic of influenza and those patients were reviewed and treated as required. Only one ward has been affected with seasonal influenza. The immunisation programme for 2018/19 commenced late September 2018 to the 31st March 2019. The Trust achieved 76% compliance for uptake of the Influenza vaccine for frontline staff. Influenza on Ward 7 affected 2 patients and 1 staff member. The Ward remained open. Norovirus on Ward 7 affected 7 patients and 13 staff members**.** The Ward was closed from the 5th February 2019 to the 12th February 2019. During the Q4 period there were no HCAIs within the Trust, including incidents of MRSA Bacteraemia or C-difficile. MRSA screening continues to be implemented with a zero positive result for this quarter. Therefore no exceptions have been reported externally. ***Approved / Received***	
123/2019	**DIRECTOR OF INFECTION PREVENTION AND CONTROL (DIPC) ANNUAL REPORT**	

	Maria Nelligan, Executive Director of Quality and Nursing presented the report. The report provided an overview of the Infection Prevention and Control (IPC) activities from 01 April 2018 to 31 March 2019, and to highlight achievements and the progress made against the priorities outlined in the Infection Prevention and Control Group (IPCG) work programme 2018/2019. The report includes a brief summary of the IPC team activities and achievements, and how we continue to raise the profile of IPC within the Trust. During 2018/2019, 4 cases of sepsis were identified; • 2 cases on Ward 2 • 1 case on Ward 3 • 1 case on Ward 7 SEPSIS awareness and recognition is a key element of the IPC team Physical Health and Deteriorating Patient education programme. The team implemented the National Early Warning Score (NEWS) in July 2017. In 2018 a review was undertaken and it is planned that NEWS2 will be implemented in the trust in 2019/2020. The Trust maintained exceptionally high PLACE scores and there is a continued review of the replacement equipment program e.g. Beds, hoists, and defibrillator machines During 2018/2019 the Team carried out audits on all inpatient and community clinical areas. The results and the audit programme is available within the report. All Trust areas achieved above the compliance score of 90% with the exception of one community based service where some environmental issues were identified. The issues were raised immediately with estates and the environmental work continues in these premises which the IPC team is supporting. Maria highlighted that there has been a change in personnel within the department. Amanda Miskell left the Trust in January 2019 and Chris McGinley commenced in post on the 1st April 2019 as the new Infection Prevention and Control Lead. The Board is asked to approve: • The Infection Prevention and Control Annual Report for 2018/2019 • The IPC audit/work programmes for 2019/2020 Dr Tattum noted the 76% influenza vaccine uptake this year and highlighted this leaves a quarter of staff unprotected. Dr Tattum asked what plans were in place this year to improve this? Maria advised the target has now been raised to 80% as a Trust we do well	

	nationally. It is difficult to get it beyond that percentage we have areas where staff are resistant and we will do some proactive work with them. We had an excellent campaign last year but it will be challenging this year to get that extra 4%. ***Approved / Received***	
124/2019	**MORTALITY SURVEILLANCE QUARTER 4 REPORT 2018/19** Dr Buki Adeyemo, Executive Medical Director presented the report. The report provided the Trust Board with assurance as to the mortality surveillance process with regards to the scrutiny of people open to Trust services who have died of natural causes before the age of 75 years. The report is for the Q4 reporting period 2018/19 and provides information for the time frame January to March 2019. During Q4 the mortality surveillance group reviewed the care of 24 people. There is no national guidance on the criteria for the level of care determination. However the mortality surveillance group considered that Good Care had been provided where there was evidence of the staff providing a good level of support, had responded quickly and appropriately to situations where deterioration in physical health was noted. Adequate Care is determined to be care where the basic standards of expected support are given. Poor Care is determined where the group consider that the actions of the clinicians did not meet the standards required by the Trust. In part these determinations are dependent upon the quality of the documentation contained within the mortality surveillance review tools and the electronic patient records. Feedback to the directorate/team on the quality of documentation is sent to the clinical teams in order to improve future entries in the patient records. There was one case where the care was assessed as being poor as there was no evidence to demonstrate that the clinical team had completed the physical health monitoring, in line with anti-psychotic medication monitoring standards. The mortality surveillance group were informed that the clinical team had already recognised that they had not met the required standards in their initial review of this person's care. Action plans have been developed to address the issues identified. This action plan is linked to a Serious Incident review and the actions will be monitored through the SI action plan review process and the community safety matrix. There were 3 reviews where the mortality surveillance group considered that Excellent Care had been given; this level of care was	

	determined in part due to the quality of the clinical notes in recording both the clinical decision making but also it was considered that there was evidence of person-centred care and collaboration. The Trust is required to report all deaths of people with Learning Disabilities to a national reviewing board based at the University of Bristol. The deaths are then allocated to regional offices for review. Since November 2017, the Trust has reported eight deaths for review under the LeDeR process. To date only one case has been fully reviewed. The person was found to have received good care and no issues were raised for the Trust. However the remaining deaths are still in the review process and there has been no further information for the Trust. Therefore due to this delay in the external LeDeR process, the Trust made the decision to include the deaths of people with Learning Disabilities in the mortality surveillance process. During Q4, the mortality surveillance group received 3 reports relating to the care of people with Learning Disabilities. In each case the deaths were recorded as expected and natural as the people were in receipt of palliative care and the care was determined to be good. ***Approved / Received***	
125/2019	**SERIOUS INCIDENTS QUARTER 3 AND 4 REPORT** Dr Buki Adeyemo, Executive Medical Director presented the report. **Quarter 3** The report covered the period from 1st October to 31st December 2018 (Quarter 3, 2018/19). During Q3, 22 incidents were reported into StEIS and have undergone or are in the process of undergoing SI investigation. **Quarter 4** The report covered the period from 1st January to 31st March 2019 (Quarter 4, 2018/19). During Q4, 37 incidents were reported into StEIS. 1 incident was downgraded following review as it was determined to be a natural cause death and will be subject to the mortality surveillance process. Therefore 36 incidents have undergone or are in the process of undergoing SI investigation. During the Q4 review of ongoing action plans the following actions have been checked as being embedded into practice: • Improvements in the quality of clinical record keeping is monitored through the safety matrix tools in use in the community and inpatient areas • The assessment of falls risk and the use of the multifactorial risk assessment on the older person's wards has been implemented	

	and maintained. There were 31 deaths reported during Q4 compared to 14 deaths in Q3. This increase is particularly noticeable with regards to the number of deaths reported by the Substance Misuse Directorate. In Q3 there were 4 unexpected deaths reported by the Directorate however in Q4, this has increased to 14 deaths reported. There were: • 16 serious incidents reported for the Specialist Directorate. • There were 8 serious incidents in the Acute and Urgent Care Directorate. • There were 10 serious incidents in the Stoke Community Directorate • There were 2 serious incidents in the North Staffordshire Community Directorate. During this timeframe the trend line shows an increasing number of serious incidents. More detail will be included in the annual report coming to Board next month. Examples of the learning themes found from this quarter and the previous Q3 investigations are also identified within the report. During Q4, there were no incidents that met the criteria for reporting under the Duty of Candour requirements. Russell Andrews noted the increase in slips, trips and falls in Quarter 2 and asked if there had been a reason identified for this increase. Dr Adeyemo advised there had been no identified rationale for this. Maria Nelligan added there are no trends for the time of year, trends tend to be around the environment, Maria highlighted that the Trust has been shortlisted for a Health Service Journal (HSJ) Award for reduction in falls. Peter Axon added the trend line will be scrutinised at Quality Committee it is a big piece of work that needs close monitoring. Dr Adeyemo noted that this was previously discussed at Trust Board in October last year, a paper has been to Board and Quality Committee recognising the single biggest impact has been Substance Misuse Services. ***Approved / Received***	**BA**
126/2019	**ENHANCED PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 12** Lorraine Hooper, Director of Finance, Performance and Estates highlighted the following: In Month 12 all indicators are within expected tolerances therefore	

	there are no exceptions to report to Trust board this month. Lorraine highlighted a lot of work has been undertaken by the Directorates around IAPT and CPA has delivered to trajectory as planned. Jonathan O'Brien noted this is the first time we have hit all contractual performance indicators which is really good for end of year. Jonathan wished to extend thanks to directorates for the work they have undertaken to provide a good year end position. This was endorsed by the Board. ***Approved / Received***	
127/2019	**ASSURANCE REPORT FOR QUALITY COMMITTEE** Patrick Sullivan, Chair/Non-Executive, presented the report for assurance from the meeting that took place on the 9th May 2019; highlighting the following: **Patient Story** Mum spoke of how she was informed that her son had cerebral palsy and a learning disability in a very insensitive way and said that this has stayed with her and affected her very deeply. For many years she just wanted to keep him safe and she could never think about his future without feeling scared and anxious. The Learning Disability Community nursing team worked collaboratively and were able to provide a range of support and interventions that focused on promoting her son's development in a very holistic way. They also maintained wider multi-agency links to enhance support and over time have supported the family to accept additional support from other helpful agencies. The great thing about their story is that through the long engagement with the service, staff have been able to see how their support has helped to shape J's progress through childhood and adolescence and his potential is very evident. Mum noted the journey and the support she received and commended the team for their work. The Committee noted once again, how powerful patient stories are. In this case, highlighting how important the first contact is in making a positive impression at the outset of a journey with services. **Reports** The Committee received the Learning from Experience Report January & February 2019 the report detailed patient related incidents / events, action and learning. Discussion was had regarding the two individuals at the Assessment and Treatment Unit, the number of incidents that have arisen and the staffing challenges experienced. Assurances were received from Unannounced Visits Q4 2018/19	

	(CCQ, Healthwatch and Trust Visits Report Q4 2018/19. The first draft of the Quality Account was received by the Committee. The document will be further refreshed following feedback from key stakeholders. The Committee will receive the next iteration virtually for review and approval given the timing of the next committee meeting. Assurance given that the Quality Account will be published on time in accordance with the Project Plan. Eliminating Mixed Sex Accommodation annual declaration of compliance was approved. **Policies** Recommendations were supported by the Committee for ratification of policies as noted below: 4.43 Prevent Policy – Approve for three years 1.14a Supervision Policy – Approve for three years New Policy - Sexual Safety and Responding to Sexual Violence Policy. Approve for three years. 3.43 Serious Placement Issues Policy – Three month extension. Joan Walley enquired as to whether the Trust concerns around our inclusion in discussions for the Action plan for delivery of the citizen's jury had been taken forward. Maria confirmed they had. ***Ratified / Received***	
128/2019	**BEING OPEN QUARTER 4 – 2018/19 REPORT** Linda Holland, Director of Workforce, Organisational development and Inclusion presented the report. The Being Open report provides a combined report of Dear Caroline, FTSU, Raising Concerns and Grievances submissions, reporting on their collective activity providing details regarding the themes, trends and patterns for assurance at Trust Board. It provides a full summary of activity covering a 12 month period for January to December 2018 and a detailed quarterly review for the period of January to 2019. Combined Being Open key themes – April 2018 to March 2019 Top three themes: - Policies, Procedures and Processes - Quality and Safety - Other Combined Being Open key themes (quarter 4) – January to March 2019 Top themes: - Employment, Bullying, Etc. - Other	

	- Staffing Levels Linda reported a slight shift in terms of submissions being received in Freedom to Speak Up and Dear Caroline route in last the 12 months, consistency in terms of low numbers in raising concerns and grievances. There is also a slight increase in the number of people identifying themselves as opposed to remaining anonymous. It is proposed that the Trust will: • Continue to utilise all four mechanisms to support staff to raise concerns and issues • Support the ongoing development of an open and transparent culture through development and embedding of the Trust Values and supporting Behaviours Framework • Continuation of the Freedom to Speak Up Guardian (FTSU) role including further embedding and development of a range of Freedom to Speak Up Champions to further support the FTSU role. Janet Dawson highlighted the need to ensure people see the trending and feedback. Joan Walley asked with the regards to the 11% 'Other' category how are we following up and involving employees who raise the issues as part of the process of providing the solution as there is no feedback contained within this report to illustrate that. Linda explained when an employee identifies themselves we do contact them on an individual basis. Where people do not identify themselves responses go back onto the intranet so everyone has sight of those we try to sign post to the right place in terms of a solution. Grievances and raising concerns go through the appropriate route. Jenny Harvey noted that Unison does not record the cases that have similar themes locally and managers who are contacted directly we try to resolve issues locally we need to find a way to triangulate with the Freedom to Speak Up Guardian. ***Received***	
129/2019	**MONTH 12 FINANCE REPORT** Lorraine Hooper, Director of Finance, Performance and Estates presented the report. The Trust Board is asked to Note: The reported 2018/19 surplus of £3,576k against a planned surplus of £2,023k. This is a favourable variance to plan of £1,553k. Audit have visited the Trust this week and Audit Committee will receive their findings tomorrow.	

	The 2018/19 CIP achievement: • Achievement of £2,699k; an adverse variance of £96k to plan. • The reported recurrent value of schemes transacted at £1,813k, 65% of target. This includes £451k which will be transacted during 2019/20 due to a timing difference. Approve: • The month 12 position reported to NHSI. • M12 expenditure on Agency of £1,987k against a ceiling of £1,987k; breakeven against the agency ceiling. • M12 Use of Resources Rating of 1. • Price cap breaches for Medics and off-framework use at M12. • M12 expenditure on Agency of £1,987k reported to NHSI. ***Received / Approved***	
130/2019	**ASSURANCE REPORT FROM THE FINANCE, PERFORMANCE & ESTATES COMMITTEE** Tony Gadsby, Non-Executive, presented the report for assurance from the meeting that took place on the 9th May 2019; highlighting the following: **Engagement, Values and Outcome Framework Pilot –** The Trust has been selected as one of four pilot sites, to trial a new value framework, designed to support trusts to drive efficiencies using internal Patient Level Information Costing Systems (PLICS.) This is expected to feed into the trust cost improvement plan for 2019/20. **Changes to the Performance Management Framework** – The Trust is preparing to launch a new performance management framework, which moves towards monitoring performance using Statistical Process Control (SPC.) Training will be provided and the framework will feature as part of the Trust Board Development session in May 2019. **Cost Improvement Programme (CIP) -** The Committee received an update for Cost Improvement for 2019/20. The final outturn position was £96k behind plan, which includes non-recurrent CIP. The recurrent value of transacted schemes as at 31st March 2019 was £1.363m, which excludes £451k of schemes that will be transacted in 2019/20 due to a timing difference. After adjusting for the 2018/19 schemes transacted in 2019/20, the final 2018/19 recurrent CIP position will be a £981k shortfall. The Committee received an update around the approach to cost improvement for 2019/20 and the progress to date against the £2.5m target. The trust has identified £1.75m (70%) for 2019/20 and £1.65m (66%) recurrently. The Director of Finance and Director of Operations outlined the actions to close the gap, to be supported by a Trust PMO. The trust also plans to develop a multiyear programme, to deliver £5m	

	recurrently by 2020/21. The Committee were assured that there was sufficient focus being placed on Cost Improvement; they were not assured around delivery of 2019/20 programme. The Committee also requested a phasing profile to be presented at the next Committee for identified schemes. **Agency Report -** The Committee received an update on the expenditure on agency for 2019/20, which was utilised within the ceiling. The Committee noted the increase in Agency run rate over the last 3 months, which is being primarily driven by Primary Care, following the integration in December 2018. The Committee outlined a need for further application of Trust Agency controls in primary care that are consistent with those exercised in other areas of the trust. The Committee also noted that at the current level of expenditure, the Trust would breach the Agency ceiling in Month 1. ***Received***	
131/2019	**ASSURANCE REPORT FOR PRIMARY CARE COMMITTEE** Tony Gadsby, Non-Executive, presented the report for assurance from the meeting that took place on the 10th May 2019; highlighting the following: **Clinical Model** The meeting received an update report from the Clinical Director on a range of metrics related to the introduction of a new clinical model. A comparison of two time periods 12 months apart shows a 28% increase in appointments with a clinician – drilling down, this represents a 20% increase in GP appointments and a 41% increase in Advanced Nurse Practitioner appointments. **Workforce** The Trust Board previously ratified a decision for the Practice to join the Hanley Primary Care Network – this is made up of additional practices including Bentilee, Bucknall and Hanley. The Team are now also able to advise that North Staffordshire Combined Healthcare will be providing PCN support to the new group; this support will focus particularly on financial management and employment services. As a verbal update to the report, the DoPS advised that a new Primary Care Task & Finish Group had been established which brought together colleagues from across a range of functions to bring a dedicated focus on a range of 'snagging issues' which require further work. The Committee agreed to receive a separate report on the progress of the Task & Finish Group at its next meeting. The meeting received an update on Primary Care workforce issues. **Finance** The Committee received the Month 12 Finance Report which shows	

	an adverse position of £74k. The Committee agreed to undertake a specific review of the forward finances to produce a "Best Case" "Forecast" and "Worst Case" for the full year with known mitigations based on the format produced for the Trust's overall position. L Hooper to take this forward as soon as is practical as it is important to ascertain the financial risk of Primary Care activity on the Trust's overall position given the £74k overspend in a quarter. It is not sufficient to note the risk is added to the register as it does not identify the action. **Performance** The Committee received the Month 12 Performance report and considered the update on the nature of the performance metrics and performance against them. QOF achievement was 94% - 512 / 545 points – this represents a 3% reduction on performance in 2017/18. QIF achievement was 76% - 62 / 81 points - this represents a 4% reduction on performance in 2017/18. The common denominator in both areas is services relating to Diabetes which equates for 56% of the shortfall. It was agreed that a QOF Plan will be developed and a clinical lead identified at Practice level who will coordinate all Diabetes related services. DNA rates for nurse appointments have remained consistent with previous months at 17% whilst DNA rates for GP appointments have reduced from an average of 13% to just over 5% **Risks** The Committee received an update on items relating to Primary Care Services on the Trust risk framework and recommended a new risk re financial performance be included. **Strategy** The Committee agreed to generate a full Board discussion on the current policy of not actively promoting our Primary Care offering to GPs. The Chair advocated that we should review this policy in the light of the move to Integrated Care Hubs and PCNs. Dr Tattum highlighted with regard to the QOF with Diabetes, the GP is reliant on the patient's cooperation. There is a suite of checks that need to be undertaken but unless they do them you will not get paid so this is difficult for all practices. DNA rates were also noted as alarming. Discussion was had to the ease in which patients can cancel appointments. The Board agreed that primary care conversations need to be at the heart of the STP agenda and clinical programmes of work. We need to deep dive into the questions we are being presented with and we have to understand them if we are to become a fully integrated care organisation. Chirs Bird noted there is some confusion around the review period as it was a four month review period, 12 months apart, not a particularly extensive period of time therefore we need to review over a longer period of time before we draw a definitive	

	conclusion, we need to be clear about the performance metrics and how we are reporting them and ensue they are systematized as a lot are being done by hand. There is an absence of comparative data. Jonathan O'Brien queried the 'level of grip' we have on the finances at the moment. We have a level of assurance as we have a process. The finances have deteriorated from where we expected them to be and if this was still a non-trust service it would have affected the GP's income, Jonathan asked to what extent this is a factor. Staff in primary care practices need to have a grip on finances and our expectations of delivery. Lorraine Hooper advised there is a lot of work ongoing between practice and finance teams about understanding what goes on where and when there is a lot of learning in there too. The way NHS account for things is different than the way GP practices do. Tony Gadsby has requested information in the forecasting which will give us the ability to show a financial deficit this year so we can look at the forecast and take actions. Chris Bird advised that a conversation has taken place at the Primary Care Committee with colleagues directly involved in the delivery of the services which left them in no doubt they have a corporate responsibility to manage the budgets in the same way as our directorates. Chris felt there is a settling down period required as we are not use to providing primary care services as they are not used to working in corporate services. Patrick Sullivan highlighted the importance of obtaining some real managerial control as there is a danger as an organisation we carry all the risk and receive no benefits from it. Janet Dawson advised she had only seen an acquisition fail before when an organisation has stepped back as the service they have acquired has been unfamiliar. We need to understand the culture of the organisation and keep a close eye on it. ***Received***	
132/2019	**ASSURANCE REPORT FRO THE EXTRAORDINARY AUDIT COMMITTEE** Tony Gadsby, Non-Executive, presented the report for assurance from the meeting that took place on the 24th April 2019; highlighting the following: **Annual Accounts 2018/19** The draft annual accounts were presented which showed an accounting surplus of £2.804m and a control surplus of £3.576m, which includes certain items which are added back for control purposes.	

	The difference between control surplus and accounting surplus primarily results from de-recognition of an overall net pension asset of £0.695m from the balance sheet, following the loss of the Staffordshire S.75 contract. This is a technical adjustment and there is no cash impact to the Trust. The Committee also were presented with a number of Key financial performance highlights for 2018/19, including a 14% reduction in Consultancy and 25% reduction in Agency expenditure compared to 2017/18. The committee also received a full assessment of the Going Concern as part of the papers, which provided a proposal to prepare accounts on a going concern basis. The committee agreed this would need to be reviewed in light of 2019/20 contract discussions. The Committee approved submission of the draft accounts. **Draft Governance Statement 2018/19** The committee received a first draft of the Governance statement for 2018/19 and agreed to feedback any comments outside the meeting. ***Received***	
133/2019	**ASSURANCE REPORT FROM PEOPLE, CULTURE AND DEVELOPMENT COMMITTEE** Janet Dawson, Non-Executive Director presented the report for assurance from the meeting that took place on the 13th May 2019. **Staff Story** The Committee received a staff story from the Step On service. The video showcased success stories from people now in work and showing the impact on their lives and confidence that this brings. The team is a great example of working with our values to produce excellent outcomes. **Workforce** Nicky Griffiths presented the metrics from Acute and Urgent Care & Specialist Services. Her comments reflected the issue we heard about at Board with resources being absorbed by a few cases where multiple staff members are required to support individuals with complex needs. While this issue is being managed at Senior Leadership Team level it was interesting to hear the impact at a service delivery level including reluctance of staff to take bank roles. Recruitment for Healthcare Support Workers has filled 18 of 24 vacancies but Registered Nurse vacancies remain. This is being addressed by the cross directorate nurse recruitment currently being undertaken. Maria Nelligan reported that feedback has been received this that	

	things have improved which is positive. **Recruitment Resourcing Ambitions** The team has delivered an excellent turnaround over the last 8 weeks, and improved candidate and hiring manager experience and resourcing outcomes. A review of band 5/6 staff nurse vacancies has been undertaken, and the Trust is making all attempts to encourage recruitment into this area. Our Employee brand is also being reviewed to allow for greater optimisation of our Outstanding rating and allow us to have a greater impact in the job market. Network meetings will commence to allow us to tap into what our people think and why they work at the Trust to build into external messaging. It was noted that flexibility is an incredibly powerful recruitment tool. However, it does require flexibility from us to deliver it to our people. Finding ways to move this forward within the Working Time Directive will take time and effort and we should look at what has been achieved elsewhere in this area. E-rostering should assist with this; however the Trust is not at that point yet. It was noted that some Trusts that have implemented flexible working arrangements have moved to three-monthly rotas. The Committee approved a proposal to reduce time for approvals to hire from five weeks to ten days for like for like recruitment within establishment, retaining appropriate governance but streamlining the process. This had already been approved by the Senior Leadership Team. ***Received***	
134/2019	**TOGETHER WE ARE BETTER – APRIL 2019 UPDATE** Peter Axon, Chief Executive circulated the report for information only.	
135/2019	**Any Other Business** No further business for discussion.	
136/2019	**Date and time of next meeting** The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday 27th June 2019 at 10.00am, in the Boardroom, Lawton House, Bellringer Road, Trentham, Stoke-on-Trent, Staffordshire, ST4 8HH	
137/2019	*** Motion to Exclude the Public** The Board approved a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted.	

The meeting closed at 12.40pm

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	28-Mar-19	68/19	Nurse Staffing Monthly Report January 2019 - We have commenced the review for the Annual Safer Staffing review which will come to the June Board which will provide an updated position.	Maria Nelligan	27-Jun-19	Agenda item
2	23-May-19	119/19	Reducing the Risk of Suicide and Self Harm in People with a Learning Disablity - Tony Gadsby asked if there was support to develop the innovation. Dr Adeyemo confirmed there would be and this will come back to next month's Trust Board as part of the Dragon's Den update.	Dr Adeyemo	27-Jun-19	Agenda item
3	23-May-19	120/19	Nurse Staffing Monthly Report (March 2019) - Jenny Harvey noted the problems in March which so many Trust's experience due to annual leave and suggested changing when annual leave commences through the year. This is something the Trust will consider. Linda will look into whether this will raise any financial issues.	Linda Holland	25-Jul-19	A position statement will be available for the July Trust Board.
			Russell Andrews talked about the statistical process control discussed at a recent Board Development session and asked would these indicators be caught in that mechanism. Maria and Lorraine agreed to look at going forward.	Maria Nelligan Lorraine Hooper	27-Jun-19	This will be reviewed as part of the roll out of the new performance framework ensuring consistent reporting with the safer staffing report
4	23-May-19	125/19	Serious Incidents Quarter 3 & 4 - During this timeframe the trend line shows an increasing number of serious incidents. More detail will be included in the annual report coming to Board next month.	Dr Adeyemo	27-June-19	Agenda item

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO OPEN TRUST BOARD

Enclosure No: 4

Date of Meeting:	23rd May 2019		
Title of Report:	CEO Board Report		
Presented by:	Peter Axon, Chief Executive		
Author:	Peter Axon, Chief Executive		
Executive Lead Name:	Peter Axon, Chief Executive	Approved by Exec	☒

Executive Summary:		Purpose of report	
This report updates the Board on activities undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People, Culture & Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Primary Care Integration Programme Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration.☒ 2. To provide the highest quality, safe and effective services ☒ 3. Inspire and implement innovation and research. ☒ 4. Embed an open and learning culture that enables continual improvement. ☒ 5. Attract, develop and retain the best people. ☒ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☒		
Risk / legal implications: Risk Register Reference	None		
Resource Implications: Funding Source:	None		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	Includes support for Muslim members of staff during Ramandan		
STP Alignment / Implications:	Includes local system update		
Recommendations:	To receive for information		
Version	Name/group	Date issued	
1.0	Peter Axon		

North Staffordshire Combined Healthcare NHS Trust

Chief Executive's Report to the Trust Board
27th June 2019

PURPOSE OF THE REPORT

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

LOCAL UPDATE

1. DEVELOPING OUR LONG TERM THINKING

It's been just over 3 months since I started as Chief Executive and I can honestly say it feels, at one and the same time, as if it was a lifetime ago and only yesterday. As the Board will know, I've been spending a lot of that time getting around to meet teams and leaders across the Trust as well as with our partners and colleagues across the Together We're Better STP.

Many thanks to everyone for making me feel so welcome and for your willingness to share your views and ideas with me - warts and all. It really has been invaluable and much appreciated.

For this latest Board Report, I thought it might also be useful to provide a 'heads up' on my comments at the latest meeting of our Leadership Academy, which featured some of the major themes I've picked up and, having reflected on what I've heard and learnt so far, some indication of where I see our overall direction of travel over the next few weeks and months.

As I told our Senior Leadership Team at the latest meeting of the Leadership Academy, they and the teams they lead are the lifeblood of Combined - they make or break it - so I want to ensure that the Leadership Academy is something they can help mould and shape and really look forward to with enthusiasm and excitement. We had a really productive brainstorming session and there were tons of ideas which our OD team will now work up.

I had the great pleasure of being able to reflect on a latest set of performance statistics that I referred to as a "summer meadow of performance green", which is fantastic. As I have been continuing my tour of teams across the Trust, a number of people had emphasised the importance of ensuring our performance reporting is as good as it can possibly be, including data quality and the way in which we report our performance. So we will be rethinking over the next weeks and months how we deal with the data quality agenda - everything from data input to training, through support for managers, to how we roll out our information reporting and - most critically - how we utilise it to continually improve the services we provide.

It's great to have arrived at an agreed financial position for the Trust for the current financial year in discussion with our commissioners and regulators and after a herculean effort from our finance team, led by Lorraine Hooper and Jonathan O'Brien, our Director of Operations. The challenge will be to deliver on not insignificant commitments on our Cost Improvement Programme - in particular looking at how and where we can go beyond non-recurrent items year on year to a genuine transformational mode, supported by increased transformational capacity across Combined. One of the things that has also come through loud and clear from my visits to teams across the Trust is that on our frontline, people have the ideas we need, but ironically often don't have the time to develop those ideas and then create the additional capacity for themselves.

I have also been reflecting on the complexity of developing Primary Care Networks and Integrate Care Partnerships. The scale of the challenge we face particularly over the next 12 months cannot be underestimated and, whilst I have no doubt that we are up to that challenge, the importance in particular of working on developing our patient pathways with partners is becoming ever clearer. Chris Bird, our Executive Director of Strategy and Partnerships will be overseeing our strategic links with key system partners over coming months and coupled with clinical and operational colleagues will ensure that our care pathways perfectly reflect healthcare system changes such as planned growth in GP services.

2. LOCAL SYSTEM UPDATE

I have really enjoyed getting to know my fellow leaders across the Together We're Better STP. Having now had the chance to take stock and reflect, I believe there are three main driver for progress.

The first are the individual Cost Improvement Plans within each Trust, which I've mentioned above.

The second are the SPRINT programmes, essentially system-wide CIP initiatives. It's particularly heartening to see that the mental health element of these initiatives is rated Green, which is a testament to the work of Jonathan and continuing partnership with our colleagues at Midlands Partnership Foundation Trust.

The third is our system wide architecture, where work continues to develop the best possible arrangements for developing our Programme Management expertise. In this respect, I think it is worth saying that we genuinely appear to have moved away from what might have been caricatured hitherto as an adversarial culture in relation to individual organisations. As a result there is an opportunity for us to reflect on what Combined Healthcare is particularly best placed to contribute to the success of our system as a whole.

One of our other strategic priorities at the STP level will be to ensure that our system response to the NHS Long Term Plan - due for November - is as high quality as possible, with the right profile and importance attached to mental health investment and services, including mental health and learning disabilities. I believe there is an opportunity for us to produce a really compelling vision for services and transformation, to drive ourselves and the services we provide forward. This will include articulating why the case for investment is rooted in our local communities and the needs of our service users.

3. WE'RE REACH-ING HIGHER THAN EVER

At the end of last week, I had the real pleasure of sitting down with colleagues to decide the overall winners and highly commended awards for REACH 2019. These were chosen from a shortlist which has been whittled down from a record 336 nominations received. Many thanks to everyone who has taken the time to submit a nomination.

This year, the shortlisting has been carried out by a wider cross-section of individuals across Combined than ever before - involving the entire Board including Executive and Non-Executive Directors, Associate Directors, Clinical Directors, staff side and the Service User and Carer Council - each with an equal say and vote in the shortlisting process.

We also entered our third year of our Proud to CARE Award – which is unique in that it is voted on solely by our frontline staff.

The sum total of all these efforts means that REACH 2019 – celebrated on 4th July at the Moat House Hotel – will be the Trust's most popular and most open celebration of its staff in Combined's history.

4. STEPPING UP PROGRAMME CELEBRATES ALUMNI

A personal highlight of the month was having the opportunity to open the Staffordshire and Stoke BAME Conference and Stepping Up Alumni event. Our staff came together at The Bridge Centre to celebrate the stepping up graduates, plus educate staff and students on personal journeys that current staff have taken.

Each of our brilliant Stepping Up graduates explained their journey they took to where they are now. The conference was about celebrating diversity but also about addressing deep societal and systemic issues that mean that not all of our NHS colleagues enjoy the same experiences and opportunities as others. The key theme for the Accelertor event was personal journeys.

Speakers included:

- Patrick Nyarumbu: Director of Nursing - North Midlands, NHS England. Presentation on "Career reflections and insights"
- Owen Chinembiri: Senior analytical manager, workforce race equality (WRES) Team, NHS England.
- Mueid Kaleem, Stoke Pharmacist and known from the ITV show "School for Stammerers". Mueid talked about his journey and leadership qualities
- Dr Helen Waite, from Lancaster Unversity . Talked about "understanding how and why change is experienced across the course of an individual's career"
- Gaynor Walker; Equality and Health Inequalities coordinator, NHS England and NHS Improvement. Talked about "How can we contribute? Changing the environment of the organisation.
- Executive Medical Director, Dr Buki Adeyemo. Took us on her personal journey

The event ended with 3 focused group discussions:

- "Why I'm no longer talking to white people about race" by Reni Eddo-Lodge
- Educational story telling exercise and group discussion. Referencing the book "Small great things" by
- Stepping up Graduates and Senior Leaders - what has changed, what hasn't changed and what further help is needed?

5. OUR AWARDS SUCCESS CONTINUES

Another monthly Board Report – another chance to celebrate continuing Awards success.

Last month saw no less than three of our teams being celebrated at the HSJ Value in Healthcare Awards. The Executive Team were represented by Jonathan O'Brien, our Director of Operations.

And whilst we didn't land the main prize, it was a fabulous achievement to have made it to being finalists. Congratulations to our Rapid Falls Improvement Team, All Age Mental Health Liaison Service and the Healthy Minds Integrated Long Term Condition Service. You really do us and your colleagues proud.

Congratulations to everyone involved in this string of continued successes.

6. MORE REASONS TO BE 'PROUD'

We celebrated Pride Month by inviting our staff sign up to become an LGBT Champion, and receive the new NHS Rainbow Pin.

We now have 143 staff signed up which is around 10% of the workforce, but we would love to see much wider coverage than this showing support and respect for our LGBT service users and colleagues.

The month ended with staff from the Trust taking part, once again, in Stoke Pride. Well done to all who took part and helped fly the Combined flag for tolerance and inclusion.

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REPORT TO OPEN TRUST BOARD

Enclosure No: 5

Date of Meeting:	27th June 2019		
Title of Report:	Service User & Carer Council Report		
Presented by:	Maria Nelligan		
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 ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People, Culture & Development Committee ☒ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration.☒ 2. To provide the highest quality, safe and effective services ☐ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☒ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. ☐ 7. Take a lead role in partnership working and integration. ☐		
Risk / legal implications: Risk Register Reference	None identified		
Resource Implications: Funding Source:	None identified		
Diversity & Inclusion Implications: (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. 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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Report for Trust Board 27th June

Service User and Carer Council

Educational Workshop

29th May 2019

The session commenced with a presentation with key points :-

- **Care Co-ordination**

Care co-ordination should be a dynamic team approach, with the team member most involved in the care of a Service User/Carer at any particular part of their journey taking the lead role. It should not be an individual's 'title' as it is a function of all the MDT.

- **Care Plans**

Explicit flow charts from the Care Planning Policy were reviewed and debated at length. Utilising these to ensure clarity of expectations for ALL involved, some suggestions of useful additional information were made. Time frames around Care Plan Approach (CPAs) for example were thought to be potentially particularly useful to improving the process.

- **Assurances**

Processes that are in place were discussed; CQC, Healthwatch, Announced, Unannounced and PLACE visits and Observe and Act and Audit.

- **Workshop for Wellbeing Academy**

These needs to continue as they are really useful and the suggestion was to share information with centres and teams.

- **Unplanned/ Sudden discharge**

On discussion it was felt to be difficult to ascertain how much was anecdotal and how real numbers could be ascertained. However, it was felt that it was occurring and causing stress and potentially was detrimental to some service users and carers ongoing health and warranted a review.

It was a lengthy discussion, sensitivity in approaching the concept of recovery focussed care and discharge being part of the discussion along the journey, from the beginning to potential transfer back to the care of a GP for instance. What the service offers and can be expected to deliver being made clear at the start of the service user's journey with supportive leaflets and information. The need to ensure that people with enduring mental health issues and long-term deteriorating conditions having these factors included in any discussions was made very clear and again information leaflets given to support this decision making.

Difficulties in getting some GP's to provide psychiatric medication/prescription was highlighted. Dr Okolo was able to offer information about discussions taking place to address this.

Actions;

- Slides from presentation to be shared
- To encourage debate and discussion of points covered at team level
- To develop a task and finish group
- To review accessibility of information for service users and what to expect form services

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REPORT TO OPEN TRUST BOARD

Enclosure No: 6

Date of Meeting:	27th June 2019		
Title of Report:	Autism Strategy		
Presented by:	Maria Nelligan, Executive Director of Nursing and Quality		
Author:	Alastair Forrester, Head of Nursing and Professional Practice		
Executive Lead Name:	Maria Nelligan, Executive Director of Nursing and Quality	Approved by Exec	☒

Executive Summary:	Purpose of report	
Our draft autism strategy was developed following a review of a number of key national policy documents. This has enabled the identification of eight priority areas, these have been summarised into our Trust Autism Strategy and provide a strong basis for developing and providing high quality services for people with autism. Once approved, the strategy will be developed into a work plan to identify key leads for each of these areas. It is crucial that this strategy is developed in partnership with our service users, their carers, families and key stakeholders; consultation will therefore be ongoing and will help the strategy to evolve. We will also develop a 'steering group' who will oversee the strategy and the implementation of an agreed action plan. The action plan will set out timescales, leads and expected outcomes and will be reviewed annually.	Approval	☒
	Information	☒
	Discussion	☐
	Assurance	☐
Seen at:	SLT ☐ Execs ☒ Date: 7th May 2019	Document Version No. V8
Committee Approval / Review	• Quality Committee ☒ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Primary Care Committee ☐	
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration. ☒ 2. To provide the highest quality, safe and effective services ☒ 3. Inspire and implement innovation and research. ☒ 4. Embed an open and learning culture that enables continual improvement. ☒ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☐	
Risk / legal implications: Risk Register Reference	None	
Resource Implications:	Potentially some future training resource may be needed; this will be picked up through TNA's and Strategic TNA's.	

Funding Source:		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	Members of staff who are delivering and implementing this strategy will need to ensure that they have received appropriate training in diversity and inclusion.	
STP Alignment / Implications:	None	
Recommendations:	To receive the report for approval and information	
Version	Name/group	Date issued
v5	SUCC	Virtually
v6	Executive Meeting	7th May 2019
v7	Quality Committee	9th May 2019

North Staffordshire Combined Healthcare NHS Trust

Autism Strategy

June 2019

1. Introduction

What is autism?

Autism is a lifelong developmental disability that affects how people perceive the world and interact with others.

People with autism see, hear and feel the world differently to other people. If you are autistic, you are autistic for life; autism is not an illness or disease and cannot be 'cured'. Often people feel being autistic is a fundamental aspect of their identity.

Autism is a spectrum condition; this means that all people with autism share certain traits but they may require different levels of support. Some people may be able to live a relatively independent life whereas others may require more support in certain situations or settings or at particular times in their life.

Some people with autism also have learning disabilities, mental health issues or other conditions, meaning people need different levels of support. All people on the autism spectrum learn and develop. With the right sort of support, all can be supported to live a more fulfilling life of their own choosing.

Source: The National Autistic Society (www.autism.org.uk).

A more detailed diagnostic criterion for autism can be found through the following links / documents:

https://images.pearsonclinical.com/images/assets/basc-3/basc3resources/DSM5_DiagnosticCriteria_AutismSpectrumDisorder.pdf

https://www.autism.org.uk/about/diagnosis/criteria-changes.aspx

https://www.who.int/classifications/icd/en/

Health Needs of People with autism

The National Autistic Society (2018) estimates at least one third of people with autism are experiencing severe mental health difficulties including generalised anxiety disorder, depression, obsessive compulsive disorder (OCD) and bipolar disorder. Epilepsy and sleep problems are more common in people with autism, as well as sensory and motor difficulties including sensitivity to light, sound, touch, balance and pain, which can lead to distressing sensations and behaviours (DH 2014; NHS Choices 2016).

Learning disabilities are more common among those with autism than in the general population. NAS estimates between 44% and 52% of people with autism also have a learning disability (NAS 2018).

When combined with the central features of autism these additional needs can result in people having a complex set of needs often requiring specialist assessment and support from a range of different services.

Equality

We also know that people with autism may face inequality in society, be stigmatised or face discrimination (DH 2014). Furthermore, it has been suggested that there may be an under-diagnosis of autism in females (NAS 2018), which can result in unmet need among these individuals and their families. People with autism from Black, Asian and Minority Ethnic (BAME) communities may face additional challenges related to discrimination, engagement and accessing help and support.

2. Background and National Policy Context

The Autism Act, passed in 2009, was the first disability specific law in England. It placed a duty on Government to produce a national strategy, and directed public bodies to improve opportunities for people with autism.

The government launched a national autism strategy, Fulfilling and Rewarding Lives, in 2010, and an updated version, Think Autism, in 2014. This was supported in March 2015 by 'Statutory Guidance for Local Authorities and NHS organisations' supporting the implementation of the Adult Autism Strategy. It is these reports that have influenced the North Staffordshire Combined Healthcare Autism Strategy.

The Government's vision is that:

"All adults with autism are able to live fulfilling and rewarding lives within a society that accepts and understands them. They can get a diagnosis and access support if they need it, and they can depend on mainstream public services to treat them fairly as individuals, helping them make the most of their talents".

In 2014 Think Autism (DH, 2014) updated the national autism strategy and described 15 priority challenges for action ("I" statements) these were based on detailed consultation and research into the views of people with autism and their families.

In 2016 the National Institute for Health and Clinical Excellence (NICE) issued updated clinical guideline 1424: Autism spectrum disorder in adults: diagnosis and management. Its purpose was to improve access and engagement with interventions and services, and the experience of care, for people with autism.

A recent 2017 report "Personal tragedies, public crisis", from Autistica (Building brighter futures through autism research) cites research indicating that people with autism are at heightened risk of mental health problems such as depression and anxiety, epilepsy, and other diseases including diabetes and heart disease.

Whilst further research is needed the report also recommended that health services should review methods of identifying people with autism on NHS registration systems, provide a named healthcare coordinator, maximise uptake of health checks and undertake local case reviews of early deaths of people with autism.

Nationally work has commenced on a Learning Disability Mortality Review (LeDeR). Although the LeDeR programme does not review deaths of people with autism if they do not also have a learning disability, it is recognised that many of the actions from this review will also benefit people with autism.

3. Local Context and Key Drivers

Our autism strategy was developed following a review of the local requirements identified within Public Health England's Autism Self-Assessment Exercise 2016 (PHE 2017). We have also reflected the national requirements and position including the 'Statutory Guidance for Local Authorities and NHS Organisations to support implementation of the Adult Autism Strategy' (DH 2015).

This has enabled the identification of eight priority areas – summarised below, which provide a strong basis for developing and ensuring high quality services for people with autism.

Locally the Trust is commissioned to provide autism assessment and treatment for young people. However the service for adults is limited to a small number of assessments only, the Trust is in ongoing discussions with commissioners in how to take this forward.

Our Approach

It is crucial that our autism strategy is developed in partnership with service users, their carers and families. Going forward we plan to hold engagement sessions with key stakeholders, such as our local authority providers. This will be achieved through a variety of approaches including - consultation groups, service user forums, engagement questionnaires and team presentations.

4. Our Strategy/Priority Areas

Priority Area 1 : Training	
What we need to do	**How we will achieve this**
Increase understanding and acceptance amongst professionals of the needs of people with autism.	• We will work in partnership with people with autism, families, partners and carers in the development and delivery of autism training. • We will identify recognised training provision and develop some of our staff to become autism accredited trainers. • Autism awareness training to be included as part of Trust induction training and will

	be mandatory for all staff. • We will provide additional training to those areas and teams where there is a higher prevalence of people with autism who use our services. • We will ensure that every inpatient and community service has an identified autism champion who will support awareness, early identification and appropriate staff support. • Longer-term we will explore opportunities to deliver autism specific training to primary care services. • We will also explore opportunities to work encourage other public sector partner such as the Police to deliver training to relevant staff groups.

Priority Area 2 : Recognition, referral and assessment	
What we need to do	**How we will achieve this**
Ensure that our services for people with autism are responsive. Ensure appropriate signposting to appropriate services and organisations following diagnosis. In particular, where to go for help/advice in the future.	• We will review our minimum waiting times and benchmark these against other services. • We will review the current referral and assessment process and the support that is available for those awaiting assessment. • We will review how we support staff to recognise autism and any associated co-morbidities. Recognising that earlier referral and diagnosis may decrease the likelihood of additional needs e.g. anxiety, depression etc. • We will engage with staff and service users to explore options for pre and post diagnostic support.

Priority Area 3 : Transition Planning	
What we need to do	**How we will achieve this**
Ensure that we actively work towards the key NICE recommendations in relation to those young people who are eligible for transition to adult services.	• We will ensure that young people with autism who are accessing our CAMH Services are reassessed at around 14 years to establish the need for continuing treatment into adulthood. • We will strengthen links between adult and children services to work together to

We will ensure that we support young people to reach their potential and develop independence as they move towards adulthood.	identify young people preparing for adulthood and ensure effective seamless transition between services. • If continuing treatment is necessary we will provide information to the young person about the treatment and services they may need. • We will involve the young person in the planning and, where appropriate, their parents or carers and provide information about adult services. • We will involve the young person in the planning and, where appropriate, their parents or carers and provide information about adult services. • We will work with partners to effectively identify the needs of young people particularly in relation to life skills and independent living skills as they move to adulthood – employment, transport, financial management. • We will ensure that our assessments provide clear and comprehensive information to enable young people, their families and carers to make informed choices as they move from children's services into adulthood.

Priority Area 4 : Involving and Supporting People (Local Planning)	
What we need to do	**How we will achieve this**
Ensure that we have up to date data relating to the number of people within North Staffordshire, as well as those using NSCHT services who have autism (diagnosed or undiagnosed). Ensure that people are able to access appropriate and effective interventions and services in a timely manner. Ensure that our services are co-ordinated, with identified professionals to support equity of access and discharge through secondary mental	• We will work with health and social care commissioners to support the development of post diagnostic services. • We will share our draft strategy and proposals with service users, families, staff and partners; we will then revise and modify the strategy to reflect the feedback received. • We will support our service commissioners to understand how services for people with autism can be delivered in the most responsive, effective and efficient manner. • We will undertake a number of engagement sessions and develop an engagement questionnaire to support the development of our autism strategy. • We will work in partnership with our local

health and learning disability services.	authorities to provide a more accurate picture of the demographic across North Staffordshire. • We will review our formal and informal partnerships to ensure that the roles and responsibilities of services are clearly defined and understood and services are better co-ordinated. • We will implement a system which enables people with autism, their families and carers to give feedback about their experience of services. • We will explore opportunities to benchmark our services with comparable provider organisations.

Priority Area 5 : Preventative Support and Safeguarding	
What we need to do	**How we will achieve this**
We will support the local authority in undertaking their duties with the Care Act (2014) by assisting in identifying situations which could impact or are impacting on the mental health of a person with autism.	• We will explore the opportunities to improve social prescribing and reduce isolation for people with autism and their families and carers. • We will link with local authorities to explore the availability of social prescribing co-ordinators who may be able to provide information and advice on housing, employment, debt and benefits, and support people with low to moderate mental health issues, including those with autism. • We will undertake timely assessments and care reviews and assist in preventing a person spiralling into a mental health crisis which may result in an inpatient admission or contact with Criminal Justice Services. • We will review the effectiveness and accessibility of our local psychological therapy services (IAPT) for people with autism. • If IAPT services are unable to help we will signpost to other appropriate support services.

Priority Area 6 : Reasonable Adjustments and Access to Information	
What we need to do	**How we will achieve this**
Ensure that our services are	• We will ensure that the Green Light Toolkit,

accessible for people with autism. Ensure that parents, young people and adults with autism can access information that is relevant to them to help them make choices about the type of support they can receive.	which was developed to improve the way that mental health services in England respond to people who have learning disabilities or autism, is revisited to ensure that the correct reasonable adjustments are made to support access to all of our services. • We will review our physical environments and identify how they may be improved to better meet the need of people with autism. • We will ensure that there is an alert on individual's case notes to identify that the person has autism. • We will ensure that care plans contain evidence of any reasonable adjustments required to support the person with autism. • We will monitor the quality of services through the use of Experts by Experience as a way of obtaining service user views. • We will review our environments and make reasonable adjustments to our existing services within resources to enhance accessibility for people with autism. • We will develop a central electronic information hub for people with autism to provide information and advice about autism and local service availability. • We will continue to develop our person centred framework with the appropriate tools and information to help us to practically apply person-centred principles in all we do.

Priority Area 7: Supporting people with complex needs and behaviours that may challenge.	
What we need to do	**How we will achieve this**
We will ensure that services are able to support people with the most complex needs including behaviours which may challenge services and those with may come into contact with the Criminal Justice System.	• Explore the development of a forensic outreach service for people with autism at risk of offending behaviour in line with 'Building the Right Support'. • We will continue to provide Positive Behaviour Support (PBS) training as part of our preceptorship program and for our LD services and we widen this to other service areas. • We will identify specific training requirements relating to autism for our

	Liaison and Diversion Services. • Longer-term we will explore opportunities to deliver autism specific training to primary care services and other public sector partners such as the Police.

Priority Area 8 : Employment for adults with autism	
What we need to do	**How we will achieve this**
We recognise that adults with autism are significantly under-represented in the labour market and that being in work and staying in work is beneficial to a person's mental health.	• Where appropriate we will work with local authorities to support skills based assessments. • We will ensure that we can effectively sign-post people to the appropriate employment support services. • We will ensure that our transition plans for young people include assessment of moving from education to employment services.

Delivering the Strategy

It is crucial that our autism strategy is developed in partnership with our service users, their carers and families. Going forward we plan to hold engagement sessions with key stakeholders.

Moving forward we will establish a 'steering group' who will oversee the strategy and the implementation of an action plan. The plan will set out timescales, leads and expected outcomes and will be reviewed annually. A progress report with be provided to the Quality Committee.

References:

The National Autistic Society (2018) About Autism. [Online] [Cited: 20.12. 2018.] http://www.autism.org.uk/about.aspx.

Department of Health (2014) Think Autism: an update to the government adult autism strategy. DH. London.

NHS choices (2016) Autistic Spectrum Disorder – Symptoms. [Online] 28 October 2016. [Cited: 22.12.2018.] http://www.nhs.uk/Conditions/Autistic-spectrum-disorder/Pages/Symptoms.aspx.

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REPORT TO OPEN TRUST BOARD

Enclosure No: 7

Date of Meeting:	27th June 2019		
Title of Report:	Briefing Paper: Dragons' Den Relaunch 2019		
Presented by:	Dr Buki Adeyemo, Executive Medical Director		
Author:	Kerri Mason, R&D Lead		
Executive Lead Name:	Dr Buki Adeyemo, Executive Medical Director	Approved by Exec	☐

Executive Summary:	Purpose of report	
Significant progress has been made to support Innovation across the Trust, with a number of developments and initiatives such as the Dragons' Den taking place. Dragons' Den was relaunched for 2019 to support and develop small–scale projects within practice, requesting financial and/or project support; To note: • Opened for applications in January 2019; supported by the Research and Development (R&D) team and co-led with the Service User and Carer Council (SUCC); • 10 applications were received, with seven invited to pitch their idea at the Dragons' Den panel event; • On the 26th April the R&D team hosted the Trust's second Dragons' Den panel event which saw six of the ideas agreed to be taken forward; • The panel felt that all of the pitches were well-presented and demonstrated a real commitment to improve service user care and experiences.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People, Culture & Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Primary Care Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration. ☐ 2. To provide the highest quality, safe and effective services ☐ 3. Inspire and implement innovation and research. ☒ 4. Embed an open and learning culture that enables continual improvement. ☐ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. ☐ 7. Take a lead role in partnership working and integration. ☐		
Risk / legal implications: Risk Register Reference	No Risk or legal implications identified		
Resource Implications: Funding Source:	Funding and Resource implications were addressed as part of the application and panel review process. All applications were approved by Directorates, who agreed resources to take forward the project. Funding sources were support through Valuemakers.		

Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	No Diversity of Inclusion implications identified	
STP Alignment / Implications:	No STP Alignment Implications identified	
Recommendations:	To receive for information and assurance purposes.	
Version	Name/group	Date issued

Report to Trust Board

Date of meeting:	27th June 2019
Report title:	Dragons Den Relaunch 2019
Director Lead:	Dr Buki Adeyemo, Executive Medical Director
Author:	Kerri Mason, R&D Lead
Purpose	For information and assurance purposes

1. Background

In 2018/19 our Innovation Board Assurance Framework (BAF) objective was to relaunch Dragons' Den with a focus on Innovation and Valuemakers. The relaunch was supported by the Research and Development (R&D) team and co-led with the Service User and Carer Council (SUCC).

The focus of the Dragons' Den' relaunch was to support and develop small–scale projects within practice, requesting financial and/or project support. Dragons' Den linked in with Trust's successful Valuemakers Programme aiming to maximise the use of resources intelligently and efficiently through innovative ideas which focused on; innovative ways of delivering better services for the same money, utilising innovations to conduct something more effectively/efficiently or introducing new ways of working.

Reflecting the format of the television programme, applicants were given an opportunity to pitch their ideas to Trust decision makers via a Dragons' Den panel.

2. Application and Selection

The relaunch of 'Dragons Den' opened for applications in January 2019. Dragons' Den utilised an expression of interest format, using a staged approach, whereby applications were initially reviewed by the R&D team to ensure completeness and subsequently reviewed by the Associate and/or Clinical Directors. Directorates were asked to confirm if the idea was feasible and in line with Directorate priorities.

If successful, applicants would receive financial support, as and where appropriate, and if funding was not being sought, support and advice on how to take the idea forward. Each project was limited to a maximum of £2000, however each case judged on a case-by-case basis.

In total 10 applications were received; two were progressed through another route and one required further development. Seven applicants were invited to pitch their idea at the Dragons' Den panel event.

3. The Event

On the 26th April 2019 the R&D team hosted Dragons' Den panel event. The event was the Trust's second Dragons' Den event, taking forward successful applicants from the review process. Applicants were given 15 minutes to present and pitch their idea to a Combined "Dragons".

Our Finalists

- **Jay McNeil**: **Trans Youth Cultural Exchange** – Aimed to form links between the Children and young people's group and the world's first school for trans youth in Chile;
- **Helen Perry: Enabling Independence in the Community for Road Safety**. Pitched to develop an video-based assessment package for Learning Disability, focusing on road safety skills;

- **Stephanie Hutton: Anthology of Hope** – Looked to extend the idea behind the Wellbeing Academy's 'Writing for Wellbeing' classes and encourage creative writing ,with a wellbeing focus, offering more workshops from staff and people with lived experience who write;
- **Katie Lear-Thompson: Video Rehab and Movement Therapy** – Pitched to purchase a MOTOmed bike and Spoteee, a system of virtual reality videowalk and cycle routes all around the world, patients can explore distant locations while exercising;
- **Dr Becky Chubb: Frailty Simulation Suit** – Came the Dragons' Den to pitch her idea to purchase a frailty simulation suit to improve the understanding and empathy of healthcare staff when managing frail older people;
- **Matthew Doughty: Sexual Vulnerabilities video Education Support Tool** – Pitched to create an evidence- based assessment tool to measure vulnerability within sexual relationships for people with learning disabilities;
- **Ann Cox (presented by Leah Benson): Social prescribing in CAMHS** - Aimed to develop a support bespoke group packages of workshops to look at team building, resilience and activity for managing over activity children and young people.

Watch our Dragons' Den finalist and panel sharing their project and experiences here

This positive event saw six of the ideas agreed to be taken forward. The panel felt that all of the pitches were well-presented and demonstrated a real commitment to improve service user care and experiences. All applicants received their outcome letter and are currently working with Finance and R&D team to progress their idea further.

All successful applications were asked to complete an evaluation of their project, with the aim to disseminate across the Trust and write up as a publication.

4. Progress since Dragons' Den

Since Dragons' Den significant progress has been made to support Innovation across the Trust, with a number of developments such as an Innovation process mapping and Intellectual Property (IP) event, to support finalists from Dragons' Den and clinicians across the Trust with their project or idea.

Building on the process mapping work with the Academic Health Science Network (AHSN), processes and pathways for Innovation are currently under review. An Innovation Pathway Development workshop is planned for the 23rd July to explore how "Combined embraces Innovation". The workshop will be held at Lawton House and will showcase current innovations, review existing processes and explore how we will progress innovation further.

To further develop Innovation within the Trust, the AHSN have supported developing links with local companies and Keele University Business Bridge, which will aim to better support commercial opportunities.

5. Recommendations

Receive for information purposes

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REPORT TO OPEN TRUST BOARD

Enclosure No: 8

Date of Meeting:	27th June 2019		
Title of Report:	April 2019 Monthly Safer Staffing Report		
Presented by:	Maria Nelligan, Executive Director of Nursing & Quality		
Author:	Alastair Forrester, Head of Nursing & Professional Practice		
Executive Lead Name:	Maria Nelligan, Executive Director of Nursing & Quality	Approved by Exec	☐

Executive Summary:	Purpose of report	
This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during April 2019 in line with the National Quality Board requirements. The performance relating to fill rate (actual numbers of staff deployed vs numbers planned) during April 2019 was 86% for registered staff and 96% for care staff on day shifts and 76% and 109% respectively on night shifts. Overall a 94% fill rate was achieved. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover and Ward Managers supporting clinical duties. The data reflects that Ward Managers are staffing their wards to meet increasing patient needs as necessary.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☒ Execs ☐ Date: 11th June 2019	Document Version No.	
Committee Approval / Review	• Quality Committee ☒ • Finance & Performance Committee ☐ • Audit Committee ☐ • People, Culture & Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Primary Care Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration. ☐ 2. To provide the highest quality, safe and effective services ☒ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☐ 5. Attract, develop and retain the best people. ☒ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☐		
Risk / legal implications: Risk Register Reference	Delivery of safe nurse staffing levels is a key requirement to ensuring that the Trust complies with National Quality Board standards.		
Resource Implications: Funding Source:	Temporary staffing costs. Budgeted establishment and temporary staffing spend.		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	None		
STP Alignment / Implications:	None		
Recommendations:	For assurance		

Version	Name/group	Date issued
	SLT	11th June 2019
	Quality Committee	Virtual approval
	Trust Board	27th June 2019

1 Introduction

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

2 Background

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

In addition to the monthly reporting requirements the Executive Director of Nursing & Quality is required to review ward staffing on a 6 monthly basis and report the outcome of the review to the Trust Board of Directors. A comprehensive annual report for 2017 was presented to April 2018 Board and the recommendations agreed. Additionally a mid-year review was reported to Board in November 2018. A further comprehensive annual report will be received Recommendations relating to Safer Staffing Reviews are progressed and monitored through the Safer Staffing Group.

3 Trust Performance

During April 2019 the Trust achieved a staffing fill rate of 86% for registered staff and 96% for care staff on day shifts and 76% and 109% respectively on night shifts. Taking skill mix adjustments into account an overall fill-rate of 94% was achieved. This has increased from an overall fill-rate of 90% in March 2019.

Where 100% fill rate was not achieved, staffing safety was maintained on in-patient wards by nurses working additional unplanned hours, cross cover, Ward Managers (WMs) and the multi-disciplinary team (MDT) supporting clinical duties and the prioritising of direct and non-direct care activities. Established, planned (clinically required) and actual hours alongside details of vacancies, bed occupancy and actions taken to maintain safer staffing are provided in Appendix 1. A summary from WMs of issues, patient safety, patient experience, staff experience and mitigating actions is set out below.

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

4 Care Hours per Patient Day (CHPPD)

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

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

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

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

5 Impact

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

5.1 Impact on Patient Safety

There were five incidents reported of a reduction in ward nurse staffing levels during April 2019. Four incidents were due to increased patient acuity at the Assessment and Treatment Unit and PICU. One incident related to a staffing shortfall at the Edward Myers, Intoxicated Outpatient Unit (IOU).

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

5.2 Impact on Patient Experience

Staff prioritise patient experience and direct patient care. During April 2019 there were thirteen occasions when patient activities had to be cancelled as a result of staffing shortfalls. Ten of these incidents occurred at Ward 1, of which seven were successfully rescheduled. In total this resulted in 4.5 hours when patient activity could not be rescheduled.

5.3 Impact on Staff Experience

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

- 190 staff breaks were cancelled (equivalent to approximately 4% of breaks). Any time accrued due to missed breaks is taken back with agreement of the Ward Manager.

- There were 8 occasions reported during April when staff supervision sessions had to be cancelled to support safe staffing levels.

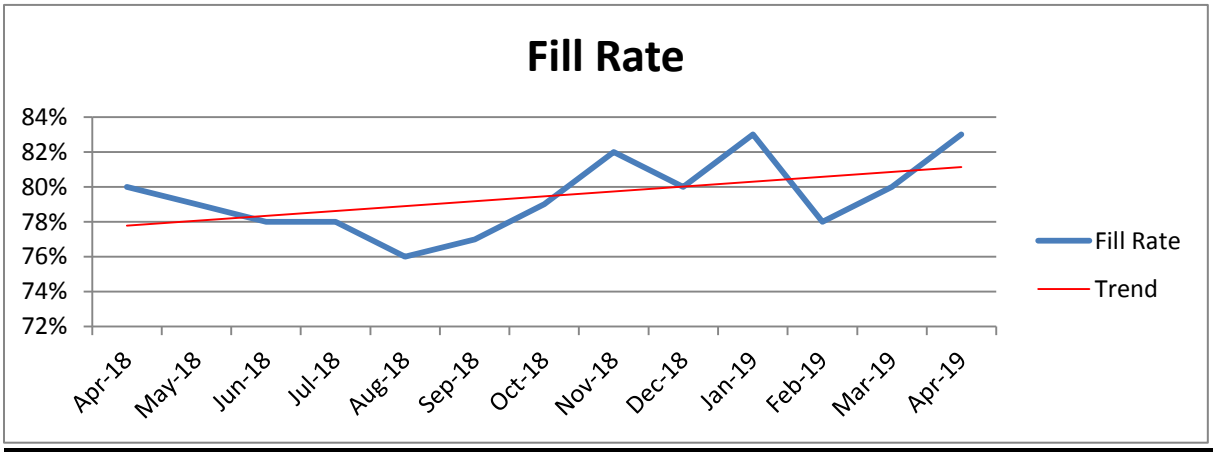
- 2 staff Personal Development Reviews (PDR) had to be cancelled to support safe staffing levels during April 2019.

5.4 Mitigating Actions

Ward Managers and members of the multi-disciplinary team have clinically supported day shifts to ensure safe patient care. There was also a total of 439 RN shifts that were covered by HCSW where RN temporary staffing was unavailable. A total of 196 HCSW shifts were covered by RN staff where HCSW temporary staffing was unavailable. Additionally, as outlined in section 5.3, staff breaks have been shortened or not taken (time is given in lieu) and wards have cross covered to support safe staffing levels. There were 23 occasions (44.5 hours in total) when additional support was provided by members of the multi-disciplinary team to maintain safe staffing levels.

5.5 RN Staffing Fill Rate & Recruitment

In line with the national picture, RN recruitment remains challenging. The RN 12 month fill rate increased in April 2018 and the graph below demonstrates an overall upward trend (linear series 1) over the past 12 months. The Trust is continuing to work proactively to recruit to these vacancies.



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

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

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

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

A total of six HCSW apprenticeship opportunities have been identified within our ward inpatient areas and the Trust is also supporting the STP graduate apprentice scheme with two posts, one at Ward 3 and one at Ward 7.

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

A recent advertising campaign for the recruitment of Registered Nurses has resulted in the recruitment of 19 newly qualified RN's who will be commencing with the Trust from September 2019 onwards. We initially attracted 24 new RN's however, a number of these have now chosen to accept positions closer to home.

A subsequent recruitment campaign has attracted a further 10 RN applications.

6. Summary

Safe staffing reporting continued to highlight challenges in staffing wards during April 2019; the Trust did however experience an increase in its fill rate of registered nursing shifts during April 2019. We continue to see a significant number of RN vacancies being filled by newly qualified RNs and the Trust continues to employ a number of strategies with the support of the HR and communication teams to attract RNs during this national shortage.

Following participation in the NHSI Retention Support Programme the Trust Recruitment and Retention Action Plan continues to be monitored via the Safer Staffing Group.

During April 2019 a total of 7 Registered Nurses left the Trust; this equated to 5.30 WTE. Of these 0.40 WTE (1 post) was from ward inpatient areas (Assessment and

Treatment) and 4.90 WTE were from community services, of which 3 RN's took age related retirement and 4 resigned due to a better reward package or promotion opportunity.

7. Recommendations

The Trust Board is asked to:

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

Appendix 1 April 2018 Safer Staffing

	Registered Nurses						Care Staff						Registered Nurse		Care Staff		Total Nursing Staffing		
Date	Day Establishment Hours	Day Clinically Required	Day Actual	Night Establishment	Night Clinically Required	Night Actual	Day Establishment Hours	Day Clinically Required	Day Actual	Night Establishment	Night Clinically Required	Night Actual	Day Fill Rate (%)	Night Fill Rate (%)	Day Fill Rate (%)	Night Fill Rate (%)	Overall RN %	Overall Care Staff %	Overall Staffing
Ward 1	1290.00	1290.00	1128.73	333.00	333.00	405.40	1125.00	1125.00	797.65	666.00	999.00	988.45	87.5%	121.7%	70.9%	98.9%	94.5%	84.1%	88.6%
Ward 2	1290.00	1290.00	1008.33	666.00	666.00	388.00	1485.00	1485.00	1393.23	999.00	999.00	1116.27	78.2%	58.3%	93.8%	111.7%	71.4%	101.0%	88.0%
Ward 3	1290.00	1290.00	1164.43	666.00	666.00	467.50	1125.00	1125.00	1245.18	666.00	677.10	837.10	90.3%	70.2%	110.7%	123.6%	83.4%	115.5%	98.8%
Ward 4	1455.00	1455.00	1278.70	333.00	333.00	403.50	1125.00	1125.00	1235.40	999.00	999.00	918.35	87.9%	121.2%	109.8%	91.9%	94.1%	101.4%	98.1%
Ward 5	1290.00	1290.00	1005.98	666.00	666.00	345.60	1125.00	1530.00	1677.07	666.00	999.00	1307.30	78.0%	51.9%	109.6%	130.9%	69.1%	118.0%	96.7%
Ward 6	1290.00	1290.00	817.35	666.00	666.00	345.00	1305.00	1710.00	1956.47	666.00	999.00	1263.50	63.4%	51.8%	114.4%	126.5%	59.4%	118.9%	93.9%
Ward 7	1290.00	1290.00	908.50	333.00	333.00	356.10	1125.00	1125.00	1608.23	999.00	999.00	1004.20	70.4%	106.9%	143.0%	100.5%	77.9%	123.0%	103.5%
Assessment & Treatment	930.00	930.00	1361.50	666.00	666.00	444.90	1485.00	3510.00	2509.48	666.00	2664.00	2655.77	146.4%	66.8%	71.5%	99.7%	113.2%	83.7%	89.7%
Darwin Centre	1290.00	1290.00	1027.18	666.00	666.00	344.10	1125.00	1260.00	1386.65	666.00	666.00	1021.35	79.6%	51.7%	110.1%	153.4%	70.1%	125.0%	97.4%
Edward Myers	930.00	930.00	868.72	333.00	333.00	333.00	765.00	765.00	685.50	666.00	666.00	619.70	93.4%	100.0%	89.6%	93.0%	95.1%	91.2%	93.1%
Florence House	615.00	615.00	572.25	321.60	321.60	321.50	900.00	900.00	758.25	321.60	321.60	321.50	93.0%	100.0%	84.3%	100.0%	95.4%	88.4%	91.4%
Summers View	900.00	900.00	638.50	321.60	321.60	322.50	900.00	900.00	956.00	643.20	643.20	596.22	70.9%	100.3%	106.2%	92.7%	78.7%	100.6%	90.9%
PICU	975.00	1002.00	979.23	666.00	666.00	576.10	810.00	1323.00	992.57	666.00	721.50	885.10	97.7%	86.5%	75.0%	122.7%	93.2%	91.8%	92.5%
Totals	14835.00	14862.00	12759.42	6637.20	6637.20	5053.20	14400.00	17883.00	17201.68	9289.80	12353.40	13534.80	85.85%	76.13%	96.19%	109.56%	82.85%	101.65%	93.84%

Date	Total Hours Per Day	Patients	CHPPD	Safe staffing was maintained by	RN Vacancies	HCSW Vacancies	Bed occupancy	Movement
Ward 1	3550.98	367.00	9.68	Nurses working additional unplanned hours, altering the skill mix and the support of the wider MDT	-2.08	4.79	87%	↓
Ward 2	4094.33	623.00	6.57	Nurses working additional unplanned hours and altering the skill mix	3.94	4.09	94%	↑
Ward 3	4239.22	461.00	9.20	Nurses working additional unplanned hours and altering the skill mix	2.02	1.30	96%	↑
Ward 4	4367.70	414.00	10.55	Nurses working additional unplanned hours, altering the skill mix and the support of the wider MDT	1.84	3.08	72%	↓
Ward 5	4780.95	421.00	11.36	Changes to Nurses skill mix	6.29	2.97	101%	↑
Ward 6	4897.32	439.00	11.16	Changes to Nurses skill mix	5.11	0.07	98%	↑
Ward 7	4405.53	586.00	7.52	Changes to Nurses skill mix	2.25	6.28	96%	↓
Assessment & Treatment	7092.65	134.00	52.93	Changes to Nurses skill mix	2.36	-1.12	83%	↔
Darwin Centre	4232.78	338.00	12.52	Nurses working additional unplanned hours, altering the skill mix and the support of the wider MDT	4.76	1.54	96%	↑
Edward Myers	2506.92	290.00	8.64	Changes to Nurses skill mix	2.35	-1.57	78%	↑
Florence House	2091.00	191.00	10.95	Changes to Nurses skill mix	-0.28	0.07	100%	↔
Summers View	2633.22	259.00	10.17	Changes to Nusres skill mix	2.99	2.55	100%	↓
PICU	3673.00	109.00	33.70	Nurses working additional unplanned hours, altering the skill mix and the support of the wider MDT	3.00	0.80	89%	↓
Totals	52565.60	4632.00	11.35	**Total**	**34.55**	**24.85**		

Appendix 2 Staffing Issues

- At the end of April 2019, there were 34.55 WTE RN vacancies in in-patient areas. This is a reduction of of 1.69 WTE from the March position. A majority of these vacancies continue to be within Wards 5 & 6 and the Darwin Centre. Our overall vacancy figure does continue to show a positive reduction throughout this financial year, demonstrating that we have not only been able to successfully recruit new Registered Nurses but, we have also retained a large proportion of these nurses. We continue to advertise for the remainder of the vacancies in a variety of part and whole time roles.

- At the end of April 2019, there were 24.85 WTE HCSW vacancies reported within in-patient wards. This is an increase of 0.32 WTE from March 2019. A majority of these vacant posts are within wards 1, 2, & 7 and were created following the transaction of Safer Staffing establishment recommendations from the April 2018 Annual Safer Staffing report. We are continuing to actively recruit to these posts and have recently interviewed and offered posts to 9 candidates. We are also enhancing the opportunities for HCSW's to join the Trust as part of an apprenticeship programme.

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

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

- RN night shift cover remained challenging during April 2019 however it should be noted that following the realignment of shifts in November 2018 the majority of wards now have 2 RNs on nights within their roster template. It is the 2nd night shift RN that has impacted on the night RN fill-rate.

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

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REPORT TO OPEN TRUST BOARD

Enclosure No: 9

Date of Meeting:	27th June 2019		
Title of Report:	Jan-Dec 2018 Annual Safer Staffing Review		
Presented by:	Maria Nelligan, Executive Director of Nursing & Quality		
Author:	Julie Anne Murray, Deputy Director of Nursing, AHP & Quality Mike Newton, Deputy Director of Finance		
Executive Lead Name:	Maria Nelligan, Executive Director of Nursing & Quality	Approved by Exec	☒

Executive Summary:		Purpose of report	
This reports details the findings of the safer staffing annual review for 2018. The report details the progress since the last annual review and makes further recommendations; in terms of rostered establishments Ward 6 (dementia) and Dragon Square Short Breaks require uplifts to meet current sustained demand and acuity.		Approval	☒
		Information	☐
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☒ Execs ☐ Date: 11 June 2019	Document Version No.	
Committee Approval / Review	• Quality Committee ☒ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Primary Care Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☒ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Reference	Registered Nurse recruitment is challenging locally and nationally and staffing is included within directorate and the Trust risk registers.		
Resource Implications: Funding Source:	Fund Dragon Square recurrently in line with Ofsted recommendations, this is circa £45k (1.74 WTE Band 3). Central reserves		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	None have been noted within this report.		
STP Alignment / Implications:	None noted		
Recommendations:	To approve the report recommendations.		

Version	Name/group	Date issued
Version 1	SLT	11 June 2019
Version 1	Quality Committee	Virtually 14 June 2019
Version 2	Trust Board	27 June 2019

1. Introduction

Since 2014 all Trust's in England have been required to monitor nurse staffing within in-patient wards to ensure that safe staffing levels are maintained. This monitoring comprises of monthly reporting to the Board and NHS England and an annual strategic staffing review; followed 6 months later by a comprehensive review focused on safer staffing workforce plans. The NQB Guidance (2016) advises that 'there should be individual and collective responsibility as an NHS provider board for deploying staff in ways that ensure safe, sustainable and productive services'.

To enable the Board to meet this requirement this review has:

- Identified the progress made since the previous 2017 safer staffing review
- Examined current staffing levels
- Reviewed the MDT and skill mix; exploring new roles and training requirements
- Benchmarked with other MH trusts using Care Hours per Patient Day (CHPPD) data
- Highlighted areas of best practice and quality improvement undertaken by wards to ensure efficient and effective use of resources
- Provided recommendations that include practice, workforce and establishments

1.2 Background to safer staffing

In line with the NQB requirements the Director of Nursing & Quality has provided the Board with assurance in relation to safer staffing over the past 12 months. This has been via monthly reports setting out the monthly fill-rates, the impact of fill-rates on service user and staff experience and the mitigations that are in place to maintain safer staffing within the in-patient wards.

Additionally the mid-year update on safer staffing progress was submitted to Board in November 2018.

The annual safer staffing review discussions for this review were held with individual Ward Managers and Quality Improvement Lead Nurses (Matrons) with the Deputy Director of Nursing, AHP & Quality and the Head of Nursing.

1.3 National Context to Safer Staffing Levels

The National Quality Board (2013) published guidance sets out the expectations for all Trust Boards to *"take full responsibility for the quality of care provided to patients and as a key to quality take a full and collaborative responsibility for nursing and care staffing, care and capabilities".* The NQB requirements arose from the

considerable discussion that has taken place regarding the impact nursing staffing levels have on the quality of patient care. Francis (2013), Berwick (2013) and Keogh (2013) highlight the negative impact on patient outcomes where staffing levels are not sufficient. This has been highlighted in recent high profile patient safety inquiries including the Mid-Staffordshire NHS Foundation Trust and University Hospitals of Morecambe Bay NHS Foundation Trust. Furthermore in 2005 Lankshear published a systematic review of international research that looked at the relationship between nurse staffing and patient outcomes and found that *'higher nurse staffing and richer skill mix (especially of registered nurses) are associated with improved patient outcomes'*. The House of Commons Health Committee Report (2018) on the Nursing Workforce heard evidence that *'nursing shortages are now having a negative impact on the quality and safety of patient care'* and a number of recommendations were made by the committee in relation to working conditions, pay, continued professional development, flexible career pathways, routes into nursing and flexible working.

Further guidance, specific Mental Health and Learning Disability Trusts, was published by the NQB in January 2018 and NHSI published 'Developing workforce safeguards' in October 2018, appendix 1 demonstrates the Trusts compliance with these recommendations. Additionally Mental Health Trusts have been required to report Care Hours per Patient Day (CHPPD) since July 2018 and the Trust has been reporting CHPPD monthly since then.

3. Progress since previous annual review

Previous safer staffing reviews have consistently identified shortfalls in the budgeted establishment for Summers View, Ward 5, Ward 6 and Ward 7. Ward Managers managed this by staffing to what was clinically required, using the recommended establishments as a baseline, through the use of temporary staff (bank and agency). This was to ensure that safe staffing is maintained. The 2017 Annual Safer Staffing review identified a solution to this through the realignment of budgets following the move to a mixed shift pattern; this realignment was transacted November 2018 following the opening of PICU. This resulted in all wards being allocated the required budgeted establishment for the rostered staffing levels identified in the 2017 Safer Staffing Review. **It should be noted that this realignment related to rostered nursing (registered and non-registered) only and that no additional funding was allocated to in-patient wards.**

The previous safer staffing annual report was presented to Trust Board in April 2018. It has remained challenging to maintain safe staffing during 2018, due to the opening of the PICU and the national shortage of registered nurses (RNs). Considerable effort has gone into recruitment campaigns and initiatives being supported by ward and corporate teams. Despite this, safe staffing has been maintained with staff prioritising direct patient care.

Progress achieved includes:

- Recruitment of 26 newly qualified RNs in September 2018
- Continuous improvement of the revised Preceptorship Programme to support the provision of a robust preceptorship programme for newly qualified RNs
- Implementation of SafeCare to compliment the e-Rostering system and ensure that evidence based tools are being utilised to inform safer staffing
- The Trust was rated Outstanding by the CQC following the 2018 inspection
- Registered nurses (RNs) were funded to access a variety of degree and masters level academic modules
- Wards engaged in formal Quality Improvement Programmes

The above areas are explored further within the report.

3.1 Nurse staffing levels performance Jan – Dec 2018

Overall nurse staffing levels (registered and non-registered) demonstrated a downward trend from Jan- Dec 2017 (figure 1), due to increasing acuity and dependency across wards followed by the opening of Ward 4 in late 2017. However in the past 12 months (Jan – Dec 2018) there has been a slight increasing trend (figure 2). This demonstrates that overall safer staffing levels have been maintained throughout the year.

Figure 1 Overall nurse staffing fill-rate (RN and HCSW) Jan-Dec 2017

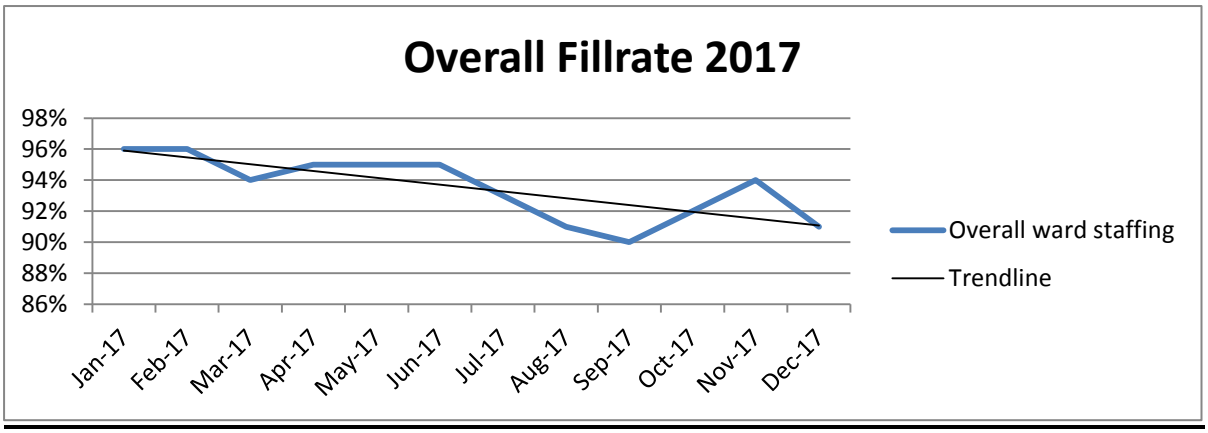
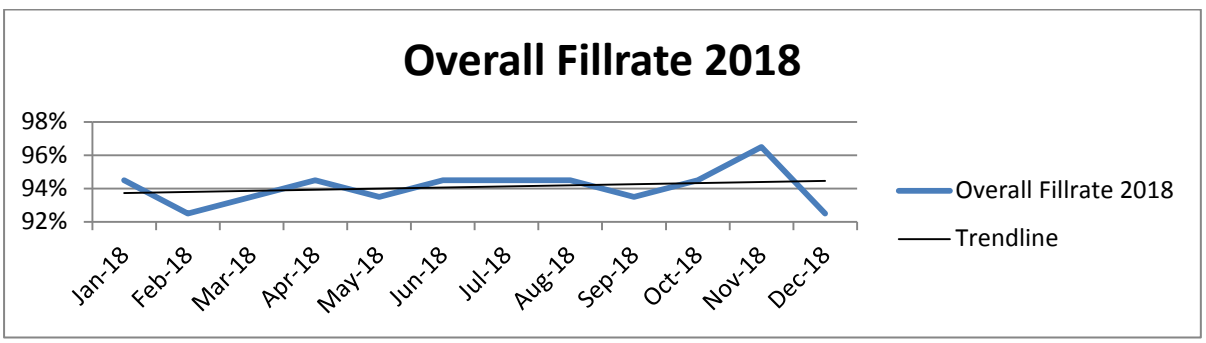


Figure 2 Overall nurse staffing fill-rate (RN and HCSW) Jan-Dec 2018



However, when considering RNs only, the trend had been stable during 2017 (figure 3) helped by the significant number of newly qualified RNs joining the Trust in Oct 2017. Nonetheless RN fill-rate showed a decreasing trend in 2018 (figure 4), this is due to the continued challenge in recruiting RNs with the current national and local shortage of registered nurses. Locally this has hindered recruitment to RN posts, furthermore the opening of Ward 4 in 2017 and PICU in 2018 increased the Trust's demand for registered nurses and despite an extensive targeted recruitment campaign, these challenges remain ongoing.

Currently HCSWs backfill a proportion of vacant RN shifts in order to ensure that there are the correct number of staff on shift. However this alters the skill-mix and dilutes the RN:HCSW ratio. Research has demonstrated that a higher RN ratio on wards improves patient outcomes. RCN guidance on safe nurse staffing levels in the UK (2007) highlights the body of research by academics (Rafferty (2007), Aiken et al. (2002) and Needleman et al. (2002)) showing the link between Registered Nurses and improved patient outcomes. Additionally Lankshear (2005) that *'higher nurse staffing and richer skill mix (especially of registered nurses) are associated with improved patient outcomes'*. Therefore, although backfilling RN shifts with HCSWs ensures that baseline staffing numbers are maintained, this dilution has the potential to impact on patient outcomes.

The dilution of skill-mix is particularly evident and impactful on nights when, due to vacancies, there are rarely 2 RNs on a ward despite the majority of wards being established for this. Additionally on nights there are less members of the MDT available to support. For example during weekday there are Ward Managers and, on acute wards, Nurse Practitioners as well as OTs and activity workers. Therefore a lower RN fillrate on days can be mitigated more readily than out-of-hours. In order for the mitigation these registered nursing posts provide to be extended this report (Section 4) contains recommendations with regards to Ward Managers and Nurse Practitioners working an out-of-hours shift each week.

Figure 3 RN fillrate Jan-Dec 2017

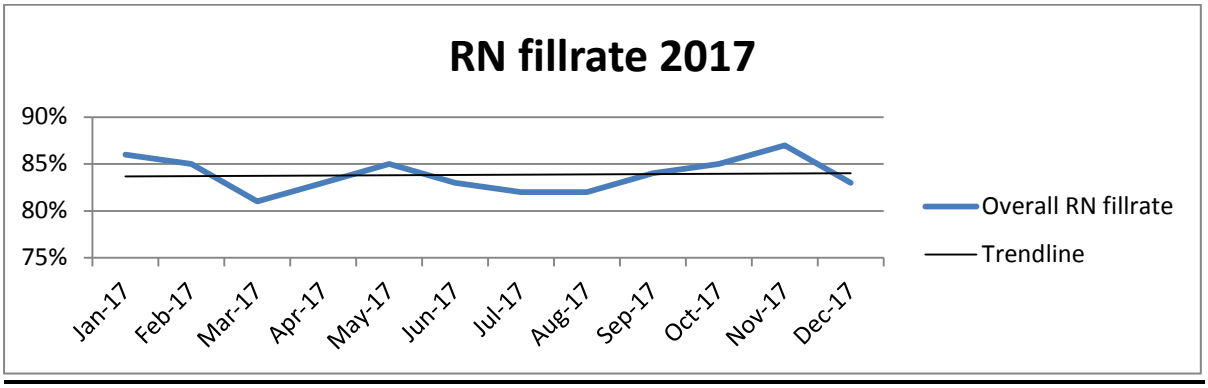
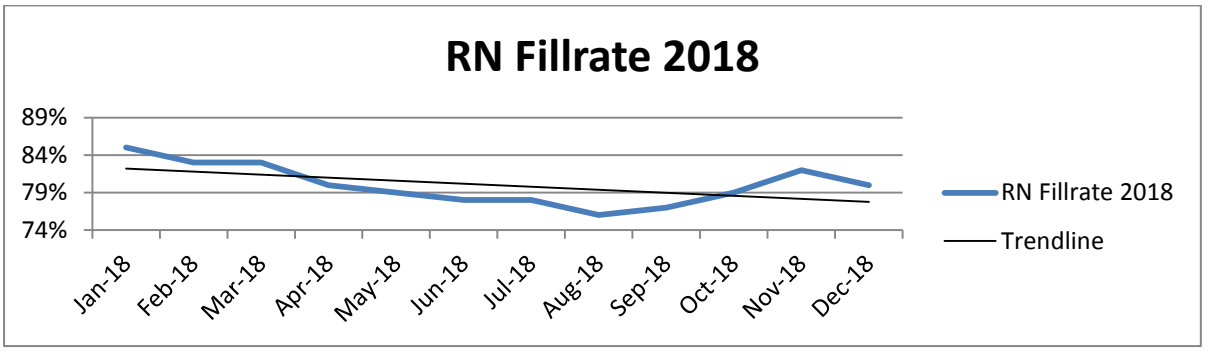


Figure 4 RN fillrate Jan-Dec 2018



3.2 Progress on 2017 Safer Staffing Recommendations

The overall progress towards the recommendations from the 2017 SS Review is summarised in appendix 2. Of the 23 Recommendations 18 have been completed and the 5 areas where further work is needed are detailed in the table below:

2017 SS Review Recommendation	Progress
Introduce Band 2 apprenticeship roles within in-patient wards to provide a start to the potential nursing career pathway and to educate non-registered staff to a level where they are in a position to apply for trainee nursing associate or pre-reg nursing training.	A model of rolling 2 year fixed term Band 2 apprenticeships has been developed and WMs and Matrons are currently taking this forward.
Workforce plans for in-patient wards should include the development of trainee advanced clinical practitioners through the apprenticeship framework to strengthen the MDT.	Discussed with Associate Directors for Urgent Care and Specialists Directorates; this will be considered within workforce plans.
Ward Clerks and Housekeepers job descriptions should be standardised and remuneration harmonised for each role.	The WM T&F Group have progressed this with the support of the HoN.
A rolling programme of rotation for Health Care Support Workers should be implemented alongside the opportunity for RNs to rotate on request.	This is currently being progressed by Matrons.
Continue to strengthen rostering practices, including effective annual leave management, through increased focus on KPIs and monitor this through monthly performance reporting	This has been challenging due to the number of new WMs and Matrons during 2018. Training and on-going support is being provided by the e-Roster & Temporary Staffing Team.

4. Safer Staffing Review Meetings

4.1 Evidence-based workforce planning and professional judgement

The NQB and NHSI expect Trusts to use evidence based tools and also professional judgement to review and determine staffing levels. During 2018 the e-Rostering module SafeCare, was implemented across all in-patient units. This module incorporates the nationally recognised evidence based Hurst Tool and comprises of a census 3 times per day in relation to patient dependency and acuity; this results in a calculation of required staffing levels to support patients on a shift by shift basis. Although the implementation roll-out is complete, local and national feedback is that embedding use of the tool, to be assured of accurate output, takes a number of months. Once fully embedded, this tool will provide more robust and reliable evidence to inform the Safer Staffing reviews. Therefore, for the next annual safer staffing review, this will support the DoN in their role in providing assurance to the Board in relation to safer staffing by informing the Annual Safer Staffing Review.

The Royal College of Nursing (RCN, 2017) concludes that sufficient numbers of registered nurses lead to improved patient outcomes, reduced mortality rates and increased productivity. Additionally, the Safe Staffing Alliance (2013), a group of senior nurses, believes RN-to-patient levels should never fall below 1:8 during the day. As in previous reviews, the majority of recommendations made within this review continue to be based on a 50:50 RN to HCSW split which meets the required 1:8 RN to patient ratio on days.

The current review has been undertaken using the Telford Model of professional judgement triangulated with a number of quantitative measures including rosters, bank use, incident reporting and care hours per patient day. On Ward 6, where the SafeCare model is well embedded (due to being a pilot ward), this has also been taken into account meaning the Hurst Tool has also been triangulated with the above sources of information. The Deputy DoN and Head of Nursing held staffing review meetings with WMs and Quality Improvement Lead Nurses (Matrons) to inform the review.

The Shelford Group have recently published an innovative, evidence based and multidisciplinary NHS safer staffing support tool for Mental Health Trusts to use (May, 2019). The Mental Health Optimal Staffing Tool (MHOST) calculates clinical staffing requirements in mental health wards based on patients' needs (acuity and dependency) which, together with professional judgement, guides chief nurses and ward based clinical staff in their safe staffing decisions. This work was commissioned by Health Education England and the license is free to NHS Trusts. The Trust is in the process of obtaining a license.

4.2 Summary of Safer Staffing review meetings

The following common themes were identified across all wards:

4.2.1 Ward Manager Turnover

- During the past 12 months there have been a high number of new WMs across the wards with Wards 1, 2, 3, 7, EMU, Darwin, A&T and SV and FH all having new WMs. This has an impact on leadership on the wards and the aspects of ward management such as e-rostering where new skills have had to be developed, this will be the same across a whole range of ward management duties.
  Recommendation 1: Due to the majority of WMs coming into post during 2018 a Clinical Leadership Programme should be commissioned to support their development and ensure robust leadership within wards.

4.2.2 Site Manager Role

- The Duty Senior Nurse role was reviewed and replaced with the Site Manager in May 2018. This increased the presence of senior nurses (Band 7) 'out-of-hours' with the aim of Ward Managers and Night Site Managers covering the majority of late and night shifts. This has strengthened night shift cover with a positive impact on Ward staffing as 2 WTE Site Managers cover the majority of nights. They are supported by Band 6 Deputy Ward Managers and Clinical Leads providing holiday cover. Previously all nights were covered by the Ward Band 6's having significant impact on wards. The seniority and experience of the Band 7 Site Managers has also impacted positively on the frequency of calls to on-call managers.

  There have however continued to be challenges in providing WM cover to the Site Manager roster due to turnover of WMs, sickness and Occupational Health restrictions. This has resulted in some Wards providing more cover than others and subsequently impacted on the leadership presence within these WM's own wards. Furthermore one WM has cited this as contributing to their decision to leave the post.

  However, the Site Manager role is due to be transferred to the Crisis Care Centre from October 2018 therefore Ward Managers will no longer be required to routinely cover this function. This gives the opportunity for Ward Managers to be released to do one clinical shift per week on their own ward. This will have the benefit of ensuring that junior members of staff are exposed to care being delivered by experienced clinicians through the role modelling of good clinical and leadership.

Recommendation 2: Once the Site Manager role is transferred to the Crisis Care Centre Ward Managers should complete one clinical shift per week on their own ward.

4.2.3 Newly Qualified Nurse Support

- A number of wards have a high number of newly qualified RNs on preceptorship; this has made rostering challenging as these RNs must always have another RN on duty with them whilst they complete preceptorship. The Trust preceptorship programme has been continually improved and developed over the past 3 years and receives positive feedback from preceptees and the preceptors who support them.
  Recommendation 3: Preceptorship programme to be reviewed annually to ensure continuous improvement in response to feedback.

4.2.4 Multi-disciplinary Teams

- The majority of wards reported having the range of MDT team that they needed within their establishments. There were some wards where the AHPs did not sit on ward budgets however since the review meetings this has been rectified. OT's are essential in supporting recovery and discharge therefore their involvement enhances patient outcomes, experience and also patient flow. During 2018 there were challenges with Occupational Therapy staffing due to maternity leave and turnover of staff however the majority of positions are filled at present.

4.2.5 Activity Workers

- Not all wards have activity workers across 7 days. This was a recommendation in the 2017 Safer Staffing Review however there has been no additional funding identified to support this.
  Recommendation 4: Wards should have activity worker cover over 7 days.
  Recommendation 5: Matrons should work with WMs to develop HCSWs and ensure that a programme of activities is accessible to all wards over weekends, including support from activity workers.

Other findings which were identified on single or smaller groups of wards are discussed in the section below.

4.3 Acute AMH In-patient Wards

- Each of the acute wards has a high number of preceptees. This means that there are a significant number of registered nurses who are developing their experience within acute care. There are however a number of senior nursing roles present within the wards who can support the development of preceptees including WMs, Modern Matrons, Nurse Practitioners and a Consultant Nurse. These senior members of the nursing team, who have extensive acute care experience and clinical expertise, are role models for junior staff and help support the development of newly qualified nurses. The majority of the time these senior nurses are on duty Monday-Friday during the day. This means that senior nursing cover is extensive at these times however 'out-of-hours' this is reduced. To address this the Site Manager role 'out-of-hours' is covered, in the main, by Band 7 Ward Managers and Night Site Managers. Recommendation 2 above suggests that Ward Managers undertake 1 clinical shift per week on their own ward. Additionally the Nurse Practitioner role could also contribute to the senior nursing presence 'out-of-hours'.

  Recommendation 6: The Nurse Practitioners should complete one shift per week within the staffing numbers to role model and develop junior staff and provide a senior presence 'out of hours'.

- Wards 1, 2 and 3 are currently piloting a 3rd Band 6 role focussed on quality. This means that there are three Band 6 nurses on each wards comprising of 1 Deputy Ward Manager, 1 Clinical Lead Nurse and 1 Quality Nurse. The Quality Nurse role includes oversight of incidents, leading on audits, sharing lessons learned and enhancing patient experience. The Matron has introduced this role with the support of the DoN and the impact will be evaluated and shared through the Directorate Meeting and the Safer Staffing Group. The role is currently funded by a Band 5 role being topped up with vacancy monies; if the expected impact of the role is attained the additional funding to top a Band 5 post up to Band 6 will need to be identified within the Directorate.
  Recommendation 7: The Acute Matron should complete the evaluation of the Quality Nurse role and feed back to the Directorate and the Safer Staffing Group who will consider the findings and if proving successful will be recommended in the SS report by the DoN.

- Across the 3 acute wards, it was identified that RNs are spending approx. 80% of their time on administration tasks. The majority of these administrative tasks relate to admission and discharge processes, this has a greater impact on the acute wards due to the high patient turnover. Staff reported that

Lorenzo was becoming more user friendly but more could be done to ensure the system is as streamlined as possible. The WMs are also keen to develop HCSW skills in relation to entering notes into the electronic patient record. **Recommendation 8:** The high level of admissions and discharges across acute wards should be considered within a review of the acute care model across urgent, acute and community teams.

- Two of the acute wards have Physician Associates on post-qualification rotation placement. There appeared to be a lack of clarity across WMs in relation to the function of the role and the supervision arrangements.
  Recommendation 9: WMs should be clear on the role of Physicians Associates (and any other staff working within their unit) and the supervision arrangements for those staff.

4.3.1 Ward 1

- Ward 1 is a 14 bedded mixed gender ward that transitioned from High Dependency Unit to General Adult Mental Health ward during 2018. Initially this resulted in service users with a higher and more complex level of need being redirected to out of area PICU units wherever possible. During the transition period Ward 1 remained on previous staffing levels of 6/6/4; since the opening of the PICU Ward 1 staffing establishment has altered to the levels recommended in the 2017 annual staffing review, that is 5/5/3. Currently Ward 1 are frequently requesting an additional member of night staff and the Quality Improvement Lead Nurse (Matron) is working with the team to understand and monitor the need for this.
  Recommendation 10: The Quality Improvement Lead Nurse (Matron) for Acute Services should continue to work with the Ward 1 WM to ensure that the staffing levels at night are being appropriately identified and that the staffing resource is being appropriately utilised.

Good practice noted within the team was the continued reduction in restraint through the use of the Trauma Informed Care model. This person centred model of care improves patient experience and recognises the need to acknowledge previous trauma and also avoid re-traumatising service users. This has been shared with other wards and services through the WM T&F Group, the Leadership Academy and the NHSE Atlas of Shared Learning. This project was shortlisted and highly commended by the Positive Practice in Mental Health Awards. Wards 2 and 3 have also trained staff in this approach and have implemented into practice.

4.3.2 Ward 2

Ward 2 have a high number of RN vacancies and a high number of preceptees. This is challenging to manage in the short term and the WM and Matron engaged with recruitment to maximise successful recruitment through joint recruitment events and strong social media presence.

Ward 2 currently have 1 HCSW rostered each shift for the Place of Safety. When the Place of Safety moves to the Crisis Care Centre in October 2019, this resource will be transferred to the Crisis Care Centre staffing establishment.

The Ward Manager has introduced the Trauma Informed Care model utilising the learning from Ward 1.

4.3.3 Ward 3

Good practice within the team included:

- The WM is currently implementing a Carers Group for the 3 acute wards; this is in liaison with relatives of previous patients following feedback from them.
- The WM has shared the wards acute care pathway project through the NHSE Atlas of Shared Learning.

4.3.4 PICU

PICU opened with 4 beds in November 2018; the team had a team building week prior to the unit opening which has helped shape the team mission and values. Staffing is currently meeting the demand and although recruitment has been challenging safer staffing has been maintained. A 6 month evaluation of the ward has been commissioned by the DoN and will be reported separately to SLT.

4.4 Older Peoples Wards

The OP wards are ward 6 (dementia), ward 7 (functional) and ward 4 (dual care). The review identified that consultant cover across wards 6 and 7 causes challenges due to the number of consultants and the other commitments of each of their roles. From a WM and Matron perspective, the efficient running of both wards is impacted upon due to the increased number of MDTs, ability to have MH Act documentation signed promptly and coordination of leave cover associated with the higher number of consultants. It has been identified that streamlining consultant cover could enable the MDT to work more efficiently and release time to frontline care. The Quality Improvement Lead nurse (Matron) has raised this with the Acute & Urgent Care (AUC) Directorate Clinical Director who is taking this forward.

Recommendation 11: The (AUC) Clinical Director is reviewing job-planning for the relevant consultant psychiatrists in conjunction with the Stoke Directorate Clinical Director and also considering how the role of ANP, currently based on Ward 4, could also support the other OP wards.

4.4.1 Ward 4

The staffing on Ward 4 has stabilised over the past 12 months with the Senior Advanced Nurse Practitioner (ANP) in post, a consistent Consultant Psychiatrist for 1 session per week and a strong MDT**.** The role of the ANP has demonstrated a reduction in patients requiring to be admitted to UHNM and the lack of reliance on the duty doctor through both these roles has been positive.

Good practice noted included:

- Falls improvement project: utilised numerous PDSA cycles and initially improved quality of care but limited impact on number of falls. A reduction in falls is now being seen. This project has been shortlisted for the HSJ Awards and has been shared on the NHSE Atlas of Shared Learning.
- Strong carers group supported by the ward team with excellent feedback from carers, a video has been made to share this good practice.

4.4.2 Ward 6

- Ward 6, an older peoples' dementia ward, continues to experience increased acuity and dependency. Currently the Ward are funded for staffing of 6/6/4 plus a twilight on a 50:50 RN to HCSW ratio. However through a significant portion of 2017/18 and the whole of 2018/19 the ward has required a minimum of one additional HCSW post on each shift giving staffing of 7/7/5. Staffing of 7/7/5 would require an uplift of 4.3 WTE HCSW, currently this is resulting in a cost pressure.

  Occupancy for Jan-Dec 2018 for Ward 6 was 87% which is slightly above our contracted obligations which are based on 85% occupancy.

  This has been highlighted to commissioners and the need for additional staffing highlighted for 2019/20 contract negotiations. However due to the new block contract the ability to request additional funding to meet the staffing needs of people with higher acuity and dependency is reduced. Furthermore the Ward 6 admission criterion, as set out in the operational policy, is broad. Therefore there is little scope for pursuing additional funding for people with the most complex needs whose acuity and dependency needs require additional staffing.

Recommendation 12: The Acute & Urgent Care Directorate should review the operational policy to ensure that the admission criteria for Ward 6 reflect the level of complexity, acuity and dependency that can be reasonably provided within the block contract. They should then work with finance to address the budget pressure.

4.4.3 Ward 7

- Currently the ward clinical staffing is appropriate however there is no Ward Clerk position. This is being explored by the Ward Manager and the Matron as all other wards have a Ward Clerk within their establishment.
  Recommendation 13: Ward 7 should have a Ward Clerk in line with all other in-patient wards and the non-rostered element of staffing should be reviewed to explore this.

Good practice noted was the learning taken from Ward 4's Falls Project that had been implemented within Ward 7 when it was noted that a high number of falls were occurring. The higher number of falls was due to a change in the service user group due to the management of demand, risk and acuity across older peoples wards. This resulted in patients with dementia being admitted to the ward. Taking the learning from Ward 4 and quickly implementing a MDT approach the team were able to rapidly reduce the number of falls.

4.5 Specialist Services

4.5.1 Ward 5

- Medical cover has been challenging on occasions; the ward has consultant psychiatry input for 1.5 sessions per week delivered by 2 consultants however prior notice of annual leave and cover arrangements are not always communicated effectively.
  Recommendation 14: Clinical Directors should ensure that medics should provide an up to date timetable to the ward in order for leave and cover arrangements to be communicated effectively.

- Additionally although there is a clear admission criteria within the Wards Operational Policy however the team find it difficult to challenge when admissions do not meet this criteria. This is being reviewed within the Neuropsychiatry review currently being undertaken within the Specialist Directorate.
  Recommendation 15: The admission criteria should be adhered to by the MDT, the Associate Director should address this in the actions following the outcome of the Neuropsychiatry review.

Good practice noted was the link with a similar unit in Newcastle to share learning. Due to the relatively few similar units across the UK it is important that any such links are developed and good practice and learning shared. Additionally the WM has shared the wards person centred care practice through the NHSE Atlas of Shared Learning.

4.5.2 Edward Myers Unit

The service is currently undergoing a challenging period with the number of beds commissioned by Local Authorities being reduced to 7 (3 Stoke and 4 Staffordshire). The unit continue to accept private patients into the remaining beds and a call-off contract is currently being negotiated with Derby County Council. From a staffing currently the ward runs on 4/4/3 staffing (50:50 RN to HCSW ratio) and includes the staffing for the Intoxication Observation Unit (IOU). The IOU staffing is 1 HCSW per shift however if there is no one in the unit they work within the main Edward Myers Unit (EMU) and support other wards on-site. As part of the STP sprint the provision of unplanned detox will commence in May 2019 therefore, at present, the staffing model will remain as 4/4/3.

Good practice noted was the physical health checks pre and post admission; due to the nature of the admissions to the unit physical health deterioration is a significant risk and these checks contribute to the mitigation of this risk to safely care for patients during their detoxification.

4.5.3 Darwin

- Darwin has undergone significant changes in the past 12 months following a CQC Mental Health Act inspection in January 2018. The implementation of the subsequent action plan has seen changes in clinical practice through engagement with young people and their families. A recent visit from the service user organisation Positive Practice in MH (PPiMH) has praised the care delivered by the MDT and the overall environment. However RN staffing on Darwin has been challenging during the past 12 months; the team are addressing this through a targeted recruitment campaign and also through the increase of student nurse placements to attract future RNs to the unit.
  Recommendation 16: The Practice Education Team will continue to work with ward and community teams to develop and offer increased placements to a range of pre-registration professions.

Good practice on the unit includes the use of ‘Coping Cards’ to help young people develop self-help skills and the involvement if the young people in developing the environment. Additionally the team were Highly Commended in the recent PPiMH CAMHS Awards.

4.5.4 Assessment & Treatment Unit

- The unit has seen a greater number of service users remaining on the unit beyond the 12 week Positive Behavioural Support pathway. This is due to more complex people being admitted and the lack of appropriate placements nationally when they are fit for discharge. The increase in complexity of the presentation of service users is having an impact on staff morale. The senior leadership team are aware of this and supporting staff with an increased presence on the unit to enable role-modelling of interventions and support in terms of supervision and enabling breaks to be taken etc. The complexity and increased needs of the current service user group has been raised with commissioners alongside the lack of appropriate residential placements locally.
  Recommendation 17: The Specialist Directorate should continue to raise the lack of appropriate residential placements for people with a learning disability and complex needs locally and the impact of this on service users and the clinical pathway with commissioners and escalate to Execs where needed.

- Additionally the historical arraignment has been for domestic input Monday – Friday and lunch preparation and clean-up to be undertaken by facilities. Therefore there is a need for clinical staff to undertake domestic duties at weekends and meal preparation and clean-up for meals outside of lunch Monday – Friday. This is challenging when the focus of clinical staff should be on direct patient care, coupled with the increasing complexity and associated acuity and dependency of service users this is not sustainable. Facilities have been pursuing this with the Ward team with a view to a 7 day facilities resource being available to support domestic and meal service across the full week.
  Recommendation 18: The unit should have domestic and meal services delivered by facilities staff as a matter of urgency to release time for frontline staff to care for patients.

4.5.5 Summers View & Florence House

Medical staffing has been challenging as, since 2015, there has not been a consistent medic. Across the 2 units there is funding for 0.5 WTE Consultant Psychiatrist however there have been a number of locums and interims arrangements over the past few years some of whom have only stayed for short periods. The Nurse Practitioner from Ward 2 has provided support however is not acting as Responsible Clinician. The Associate Director of Specialist Services is attempting to recruit permanently to the role.

Good practice noted included actively asking for patient stories on discharge and using the Recovery Star as a patient reported outcome measure (PROM).

4.5.6 Dragons Square Short Breaks

Dragon Square Short Breaks has not been included in previous Safer Staffing Reviews due to being a respite unit rather than an in-patient unit. Following the Ofsted Inspection in 2018 the DoN has requested that they be included moving forward. The Service was rated as 'Requires Improvement to be Good' during the Ofsted Inspection and a number of improvement requirements were identified including the need '*For the Registered Manager to ensure that the home has sufficient staff to provide care for each child.'*

The service supports children and young people aged between 4 – 19 years who have a severe learning disability and associated complex needs (physical health and/or challenging behaviour). including life-limiting conditions. All of the service users require frequent intensive nursing interventions to maintain their health and wellbeing. A range of specialist interventions are required which staff need specialist training to deliver. Staff also must maintain competencies relating to the safe delivery and monitoring each of these complex interventions which include:

- Specialist enteral feeding through a variety of routes e.g. Percutaneous endoscopic gastrostomy, percutaneous endoscopic jejunostomy and nasogastric
- Airway management including deep suctioning
- Ventilation care e.g. Tracheostomy/continuous positive airway pressure (CPAP) and Bi PAP
- Development of specialist care plans to meet physical and behavioural needs.

Due to the age, clinical need and vulnerability a majority of the children and young people require a staffing ratio of 1:1 and continuous visual observations (level 3). Some service users will frequently require the support of 2 staff, for example to support moving and handling, for observation due to displaying behaviours that challenge or when accessing the community.
It is also essential that service users receive meaningful levels of engagement. All engagement and activity plans require a particular level of staffing support; for consistency and safety these are developed and agreed in close consultation with both families and schools.

Since reregistering with Ofsted it has become evident that the service must meet a number of additional standards. Sufficient staffing (referred to above) requires the the Registered Manager to provide an adequate staffing level to meet a child / young person's health and social care needs, alongside providing meaningful engagement, learning opportunities and maintaining safety.

A comprehensive review of the staffing within the service was undertaken by the Head of Nursing and this identified that the current staffing establishment does not

fully meet the needs of service users. Staffing is particularly difficult during non-term time (Summer, Easter and half-term breaks), when the service is operating at full occupancy 24/7. The service frequently relies on bank and occasionally agency staff to meet staffing shortfalls during these times. However, due to the complex nature and location of the service it is often difficult to secure additional staffing at short notice. Invariably what tends to happen is that stays are cancelled in order to reduce occupancy to a level that can be safely managed with the staffing available. This in turn restricts the Trusts ability to meet the activity targets set out in our contract with commissioners.

The team work flexibly around the needs of children, for example staff often undertake 'split-shifts' when children are in school. This means that staffing is reduced when fewer children are in the unit and increased at times of higher activity. Despite this staffing can be challenging as outlined in the previous paragraph. However an uplift in staffing levels to provide one additional Band 3 HCSW day shift each day would ensure a more robust level of staffing during the periods of higher activity i.e. weekday term-time evenings and weekend term/non-term time and weekday non-term time. The additional 7.5 hour shift would be worked flexibly to ensure that staffing was targeted to the times when it was most needed and it may therefore require a late shift or a 9-5/10-6 shift. The service operates for 50 weeks of the year. To provide an additional band 3 for the mid-shift would require 1.74 WTE.

In terms of good practice the unit has responded promptly to the Ofsted feedback and following further review by Ofsted through an unannounced interim inspection in March 2019 the unit has been rated 'Improved Effectiveness'.

Recommendation 19: The establishment on Dragon Square Short Breaks should be increased by 1.74 WTE Band 3 HCSW to ensure that the needs of children can be met. This additional resource would be rostered on at times of higher activity (for example school holidays, evenings and weekends).

4.6 Summary of staffing level recommendations for Jan-Dec 2018 review

The outcome of the review, in relation to alterations in staffing levels is detailed below:

Ward	Recommendation
6	Due to the sustained demand for increased staffing across all shifts the staffing establishment on Ward 6 should be increased to provide staffing levels of 7/7/5 with an additional Band 3 HCSW on each shift. This will ensure that the dependency and acuity needs of service users can be more robustly met.
Dragon Square	Due to the intensive specialist nursing interventions and resources required to ensure that person centred meaningful activities are provided to children using the short breaks service, staffing establishment should be increased by 1 Band 3 HCSW shift each day (7.5hrs).

4.7 Comparing staffing with peers - Care hours per patient day (CHPPD)

The publication of Lord Carter's review, 'Operational productivity and performance in English acute hospitals: Unwarranted variations', in February 2016 highlighted the importance of ensuring that efficiency and quality are embedded across the whole NHS health economy. One of the obstacles identified to eliminating unwarranted variation in clinical staff distribution across and within the NHS provider sector has been the absence of a single means of consistently recording, reporting and monitoring staff deployment.

In order to provide this consistent way of recording and reporting deployment of staff providing care on inpatient wards, the Care Hours per Patient Day (CHPPD) metric was developed. Initially for Acute hospitals, the CHPPD metric has been tested and adapted for use in Mental Health and Community inpatient wards. Since April 2018 all mental health in-patient wards in England have been required to submit data to enable CHPPD to be captured.

The data captured includes planned staffing, actual staffing, number of beds, speciality and number of patients at 23:59 each day. This information is then used to determine the CHPPD for each ward. Benchmarking should be available through the Model Mental Health Trust.

Table 1 below shows a Trust level summary of the NSCHT wards CHPPD in comparison to peers nationally (mental health sector) showing February 2019 which is the latest data available:

CHPPD	RNs	HCSW	Total
Median	3.4	5.5	9.2
NSCHT	3.8	6.7	10.5
Highest	5.5	12.1	16.9

Table 1

The Trust is in the 3rd quartile nationally for CHPPD in February 2019. The table above demonstrates the Trusts position in comparison to the median and highest for peer organisations. The Trust is slightly above the median but significantly below the highest. The significance of this is difficult to analyse as Trusts will have different in-patient services requiring variable staffing levels. For example not all Trusts have Learning Disability Assessment and Treatment (A&T) Units; the staffing required to support the service users who access the Trust A&T Unit is a minimum of 1:1 and often higher. This means that the CHPPD are significantly higher for A&T in comparison to other wards. However other Trusts may have forensic units where high staffing levels are needed.

Last year's CHPPD benchmarking exercise demonstrated that two wards, Ward 7 and Darwin, were in quartile one (lowest). This was addressed in the realignment of

resources however it is not currently possible to drill down to ward level through the Model Hospital to seek assurance that this has improved through benchmarking. This is because this functionality is not available within the Model Hospital at the present time.

5. Workforce development and education

5.1 Mandatory Training

Compliance with mandatory training is monitored through monthly Performance Meetings with Directorate leads. Compliance has been increasing over the past 12 months as ward managers and their teams have dedicated effort in working towards achieving full compliance as at December 2018 the Acute & Urgent Care Directorate achieved 94% compliance and Specialist Directorate 84.9% compliance.

5.2 Continued Professional Development

In addition to mandatory training it is essential that nurses and AHPs have access to Continued Professional Development (CPD) in order to develop knowledge and skills; keeping abreast of evidence based practice and contemporary practice. However in the past few years the Health Education England budget for CPD has fallen from £205 million to £84 million. The House of Commons Health Committee (2018) recommended that this funding be re-instated and that it is ring-fenced for nursing CPD, this was followed by a 17% increase in 2018-19. There has been no confirmation yet of the CPD funding for 2019-20 however Simon Stevens has recently confirmed that CPD funding will be restored over the next five years. This will support the Trust in uplifting the academic qualifications of the nursing and AHP workforce.

5.2.1 Academic CPD

The academic modules/programmes that nursing staff undertake, as CPD, support the delivery of high quality care, career progression and retention. They also support nurses to work towards undergraduate and post graduate degrees. Due to developments within registered nurse training, the current nursing workforce consists of RNs whose pre-registration training was either certificate, diploma or degree level. Since 2013 all pre-registration nursing students' have been educated to degree level. However the DoN has previously identified that there are a large proportion of NSCHT RNs who are not educated beyond diploma level. Educating nurses to degree level brings advanced critical analysis and decision making skills which are essential in meeting the challenges of the transforming health and social care landscape. Additionally graduate RNs have been shown to improve patient safety. The DoN is a strong advocate of higher level nurse education and increasing the number of graduate nurses within the Trust is incorporated in the Nursing Strategy, however funding is needed in order to support post-registration RNs

accessing degree and masters level programmes. The Trust has supported nurses in undertaking the following academic modules/programmes during 2018:

Academic modules/programmes	**2018/19**
Physical Health	2
Holistic Health Assessment	2
Nurse Mentorship	16
Infection Control	1
BSc Professional Practice	9
MSc Health and Social Care	4
Advanced Clinical Practitioner MSc	6
Non-Medical Prescribing	4
Psychiatric Therapeutics PG Cert	1
Sensory Integration Module	4
Crisis Intervention in Mental Health	1
Eye Movement Desensitisation Reprogramming	1
Enhanced Triple P	1
Doctorate in Health Science	1

5.2.2 In-service CPD

The DoN has commissioned the Consultant Nurses to deliver an in-house CPD programme which includes the following:

- Dual Diagnosis
- Solution Focussed Therapy
- Cognitive Behavioural Therapy
- Positive Behavioural Support
- Brief Psychological Interventions

Building on the Level 1 and 2 Suicide Prevention Training implemented in 2017, higher level Suicide Prevention Training has also been delivered to 25 practitioners by Connecting with People. This will be further progressed through STP funding in 2019/20 with 8 train the trainers being developed within the Trust. This gives the Trust a strengthened position in terms of a standardised approach to suicide prevention.

Connect 5 training aims to increase staff confidence in having more effective conversations about mental health and wellbeing to help people to manage mental health problems and increase their resilience and mental wellbeing. This training has continued to be delivered during 2018 and now includes delivery to Wellbeing Academy students (service users and staff).

Physical Health in Mental Health training has been expanded to include falls, tissue viability, venepuncture, ECG and oxygen therapy.

Structured Clinical Management and DBT training has been commissioned by the DoN to strengthen staff knowledge and skills in relation to caring for people with complex needs associated with emotionally unstable personality disorder and will be delivered in 2019.

5.3 Development of Advanced Nurse Practitioners

Advanced Nurse Practitioners (ANPs) are educated to Masters level and have developed enhanced clinical and critical analytical skills and knowledge to allow them to take on expanded roles and scope of practice caring for patients. ANPs enhance the skill-mix within the MDT to help to improve capacity, clinical continuity and provide more patient-focused care by delivering safe, accessible and high quality care for patients.

Two registered nurses commenced Advanced Nurse Practitioner training through the MSc Advanced Clinical Practice during 2018. The Trust has supported 2 RNs to commence this training in each of the past 3 years therefore there are currently 6 Trainee Advanced Nurse Practitioners within the Trust (Community and In-patient).

6. New roles

6.1 Nursing Associates

In 2017 Health Education England piloted a new generic nursing role which sits between non-registered support workers and the graduate registered nurse. This new role, the nursing associate, is educated to foundation degree level and supports registered nurses in delivering patient care; the role is generic and gains experience across adult, children, learning disability and mental health services. From 2019 the role has been regulated by the NMC. However the nursing associate is not a registered nurse and will be required to work under the supervision of a registered nurse at all times. Nationally there is a drive to increase the number of trainee nursing associates by 5000 in 2018 and 7500 in 2019.

The nursing associate training costs are funded via the apprenticeship levy. In terms of pay costs, following national guidance, during training the trainee nursing associate is paid at Band 3 (or Band 4 if currently in a clinical band 4 role) and a qualified nursing associate is paid at band 4. The nursing associate role is a role within its own right but also provides a pathway into shortened pre-reg nursing courses.

The model for the nursing associate training is 2 days per week supernumerary (1 day and university and 1 day spoke placement) and 3 days per week hub placement counted ‘in the numbers’. To strengthen the versatility of the role the trust has worked with UHNM and other local providers to enable placements across organisations; this ensures that Nursing Associates have skills across specialities (adult, children, mental health and learning disabilities) and differing health-care environments (in-hospital, at home and close to home).

This role will support the Trust in ‘growing our own’ workforce within the community by supporting committed non-registered staff to develop within the organisation therefore this opportunity promotes career development. Ensuring the role is developed with clarity on the functions and skills that can be brought to safe patient care means the Nursing Associate role strengthens the MDT.

Work is also on-going with Staffordshire University to develop a shortened apprentice pre-registration nursing programme to enable Nursing Associates to develop into Registered Nurses.
Recommendation 20: Further explore the opportunity for a shortened pre-reg nursing course for Nursing Associates with Staffordshire University and develop a Proof of Concept with finance.

6.2 Pre-registration Nursing Apprenticeships

There is now a pre-registration nursing apprenticeship standard which typically takes 4 years to complete. However, due to NMC regulations relating to supernumerary status the apprentice student nurses will need to complete 2300 hours of supernumerary practice during their training. The model of the programme needs to be agreed by the University and Employer taking into account both the NMC and Apprenticeship standards. In essence the pay cost of a pre-registration nursing apprenticeship will be 3 years at a Band 3 or 4 (dependant on the persons current role) delivered over 3 to 4 years.

As the pre-registration apprenticeship is 4 years and the emerging model for transition from Nursing Associate to RN is shortened 2 year pre-reg nursing programme, the most cost-effective model is likely to be 2 years as apprentice TNA (in the numbers 0.6 WTE throughout) followed by 2 years as apprentice pre-reg nurse (supernumerary). This will be explored in the development of Proof of Concept recommended in previous section.

6.3 Physicians Associates

Physician associates (PA) work under the supervision of a doctor and are trained to perform a number of task including taking medical histories from patients, performing examinations and diagnosing illnesses; however this is not a registered

professional role. The role was introduced in the UK in 2003 however in recent years Health Education England has increasingly promoted the development of PAs. This has primarily been within acute and primary care however the role of the PA within mental health is now being explored. The Trust currently has 3 physician associates on post-qualification rotation. During reviews with Ward Managers there was a lack of clarity on the function of PA's or of the supervision arrangements therefore further work is required to understand the added value of the role within mental health MDTs.

Recommendation 21: The role of the Physicians Associate within mental health should be reviewed by the Clinical Directors in order to understand the added value the role brings and inform decision making regarding the role within MDTs.

7. E-Rostering

The Trust procured and implemented e-Rostering during 2017-18. The e-Rostering system enables WMs and MMs to ensure that rosters that are efficient and effective. All wards and 24 hour services are live with rostering and in various stages of embedding good rostering practice. Clear KPIs (eg annual leave management) have been agreed through the steering group; these are being monitored and monthly reporting will follow to highlight roster performance. The past 12 months however have been challenging due to the high number of changes in Ward Managers and Matrons (detailed previously) which have resulted in further training and development being required. The e-Rostering project manager is supporting managers to continually improve rostering practices in order to utilise staffing resources as effectively as possible. The benefits realisation targets from the business case have been monitored and the targets have been achieved. Additionally monthly performance reporting against KPIs relating to effective and efficient use of resources including management of annual leave, use of contracted hours, unused hours and additional hours commenced in April 2018 rosters. The main area for improvement is the management of annual leave. This has been raised with Quality Improvement Lead Nurses and Associate Directors who will review and report back to Senior Operational Team (SOT) to ensure that directorate governance processes are monitoring and acting upon this.

Recommendation 22: Directorate governance in relation to management of annual leave is strengthened and other rostering KPI's.

8. Temporary Staffing

The centralised Temporary Staffing Service went live in February 2017. Since then the governance of temporary staffing has significantly improved in line with the Department of Health Temporary Staffing standards (2007). Due to vacancies, acuity and the opening of an additional ward the temporary staffing service has been

supplying, on average, 97 WTE nursing staff every week across the in-patient areas during 2018 (90.6 WTE through bank and 6.6 WTE through agency). This is an increase on the previous year when 88 WTE nursing staff were supplied weekly. The breakdown between registered and non-registered staff is detailed in the table below.

Role	Bank WTE on average per week	Agency WTE on average per week
HCSW	69.8	0.9
Registered Nurse	20.8	5.7
Total	**90.6**	**6.6**

The E-rostering & Temporary Staffing Annual Report for 2017-18 demonstrated the savings achieved by the team through the increased number of bank staff enabling the Trust to use bank instead of agency. This demonstrated that temporary staffing was circa £460k less expensive; the team have continued to develop the bank to ensure that this reduction in cost pressure has been maintained. Other achievements of the team to date are:

- All temporary staffing shifts go through the correct authorisation process
- Timesheets are signed off electronically and sent directly to pay-roll
- Bank training is monitored and compliance is on an upward trajectory
- Escalation to agency is tightly managed
- Agency checks are fully completed
- On average 93% of filled shifts are filled by bank as opposed to agency
- A rolling recruitment programme is in place to maximise the number of bank available

The success of the centralised bank system has also supported the trust in achieving and maintaining one of the lowest nursing agency rates in the country (1.3% of the total nursing pay bill, Oct 2018).

9. Night Pool (Temporary Staffing)

Unlike staffing during normal office hours, throughout the night there is reduced access to other members of the MDT to support sudden increases in acuity or short notice staffing shortfalls (eg due to sickness). During the day there is a range of multi-disciplinary staff who can support wards in mitigating the impact of such events including Ward Managers, Nurse Practitioners, Matrons, OTs and Activity Workers as well as Ward Administrative staff. Due to staff identifying vulnerabilities at night a ‘night pool’ was implemented on 29 January 2018 staffed by bank and agency staff. The night pool consists of 1 RN and 1 HCSW who are allocated to any shortfalls; if

there are no shortfalls they are allocated to the area of highest acuity. The table below details when and how the pool shifts have been filled:

Pool shifts	RN		HCSW		Total	
	Shifts	%	Shifts	%	Shifts	%
Total Nights (29/01/18-31/12/18)	337	n/a	337	n/a	674	n/a
Shifts Filled by Bank	19	6%	246	73%	265	39%
Shifts Filled by Agency	197	58%	36	11%	233	35%
Shifts Unfilled	121	36%	55	16%	176	26%
Total Shifts Filled	**216**	**64%**	**282**	**85%**	**498**	**74%**
Shifts where there was no vacancy	44	13%	43	13%	87	13%

This demonstrates that RN pool staff have been available for 64% of nights and HCSW pool for 85%. This has enabled the Trust to maintain safer staffing levels and during the current climate of challenging RN recruitment, has supported the statutory requirement to have an RN on every ward on each shift. It also demonstrates that for the majority of the time the pool staff are being allocated to a vacant shift. However it does mean that for 13% of shifts there was one member of staff above requirements; this has supported the overall running of the site and ensured that staff are able to have their breaks. The pool has been essential in maintaining safe staffing during 2018 and routinely fills short-notice shortfalls in staffing (either through short-notice absence or increased acuity and dependency). It is infrequent that the pool staff is above the required minimum staffing numbers.

There is clear evidence that the pool staff are required the majority of the time and this strengthens staffing outside of normal working hours. The pool has also contributed to staff feeling that the vulnerability that they raised has been listened to and responded to by the Trust. However the majority of wards should have 2 RNs rostered on nights. This has been challenging to achieve due to RN vacancies however prioritising this over having 3 RNs on days (when there are other members of the MDT around) would strengthen staffing on nights. The RN night pool could then be reviewed.

Recommendation 23: WMs and MMs to review rosters to increase RN fill-rate on nights to enable night pool to be reviewed.

10. Quality assurance of services

10.1 External inspections during 2018

In-patient areas have been subject to a number of external inspections over the past 12 months. During 2018 the 3 NOAP wards received inspections from the CQC under the new inspection regime. The Trust has received an overall rating of

'Outstanding' from the 2018 CQC inspection and all in-patient units have been rated 'Good' or 'Outstanding' for Caring and Responsive domains. Older peoples wards have improved their rating under the Safety domain to 'Good' however have been rated 'Requires Improvement' for Effective and Well-Led. The Effective domain rating is currently being challenged. Action plans are in place to address the identified areas for improvement across both the domains.

CQC Mental Health Act inspections have been carried out on Darwin, Ward 1 and 2 and Florence House during 2018. The Darwin inspection led to a number of changes within the unit as detailed in section 4.4.3. Action plans have been implemented and progressed by each of the wards following the outcome of their inspections. These action plans are monitored by Performance supported by the Trust Governance team and through Directorate Performance meetings.

The CCG led announced visits on A&T, Ward 3 and Ward 4. Feedback from all 3 inspections was positive with minor areas for improvement suggested.

This means that all wards have had at least one external inspection in 2018 with the exception of EMU, Ward 5 and Summers View. However EMU and Summers View had internal unannounced inspections in Jan 2019 and March 2018 respectively. The next CCG announced visit will be to Ward 5 in April 2019 and therefore all wards will have had external scrutiny in the past 18 months.

10.2 External accreditation

Royal College of Psychiatry AIMS accreditation is an opportunity for services to determine that the level of care provided to service users and carers is of the highest quality. Following Wards 1 and 3 receiving AIMS accreditation during 2017, Wards 2, 6 and 7 received AIMS accreditation in 2018.

10.3 Internal reviews and assurance

Internal scrutiny during 2018 included the following:

- Weekly safety huddles led by the Deputy DoN and HoN
- Monthly safer staffing reporting to Trust Board
- Monthly Inpatient Safety Matrix (peer audits)
- Internal unannounced inspections

This range of scrutiny provides the Trust Board with assurance that whilst staffing has been challenging patient safety has been prioritised, safe staffing maintained and quality improvement has been enhanced.

11. Recruitment and Retention

In line with the national RN shortages there have been challenges in recruiting to RN posts locally; additionally the demand for RNs has increased with the opening of PICU in 2018 and Ward 4 in 2017.

The targeted recruitment campaign 'Discover your Future' has continued during 2018 with some success in attracting RNs to the trust. Additionally the early conditional offer of RN posts to nursing students from Keele University, st the end of their 2nd year, has brought new RNs into the organisation with 26 newly qualified nurses joining the Trust in October 2018.

Despite the high profile recruitment campaign RN recruitment remains challenging. Therefore extended nursing roles through Nursing Associates and Advanced Nurse Practitioners, as discussed previously, should be considered to support retention and recruitment.

The implementation of the new TRAC recruitment system is reducing the end to end recruitment time. There are however challenges with the volume of recruitment in relation to the resources available within the recruitment team therefore additional resources have been acquired on a temporary basis. The rapid recruitment required in relation to the CAMHS trailblazer also impacted on recruitment times for other areas of the Trust. The overall pressures within recruitment continue to be monitored by the Director of Workforce and Organisational Development.
The Practice Education Team have also worked with Teams to increase student placements from Staffordshire University in order to attract a wider pool of newly qualified nurses in the future.

12. Leavers

NHS Improvement (NHSI) launched a 'recruitment and retention' programme in November 2017 open to all mental health trusts. The trust has participated in this and through an assessment by NHSI was assured that we are doing all that we can to attract and retain registered nurses.

There is limited information available from leaver interviews with regards to the reasons for RNs leaving and this is being addressed by the Director of Workforce and Organisational Development who has commissioned a 12 month review. However there was anecdotal evidence during 2018 that staff had moved to private sector for higher salaries.

Recommendation 24: Monthly reporting of RN reasons for leaving to be reported within the Monthly Safer Staffing Report.

13. Incidents

The highest incident reporting categories within in-patient units are violence, self-harm and slips, trips and falls. A summary of each is provided below.

13.1 Violence and Aggression

The Trust continues to deliver the Management of Actual or Potential Aggression (MAPA) training to all clinical in-patient staff. This model is person centred and proactive; it focusses on primary and secondary preventative strategies to promote minimising the likelihood of violence arising. Where restraint is required the model promotes the least restrictive response for the minimum length of time. In line with best practice service users and staff are offered a post-incident debrief following any incident of restraint. Furthermore MAPA training is co-delivered with a service user.

The Trust has recently appointed a Restraint Reduction Lead who will lead on delivery of the Trust restrictive practice reduction strategy which is evidence based and supported by the Restrictive Practice Reduction Group.

13.2 Self Harm

The majority of self-harm on in-patient wards occurs on Ward 3 and relates to service users with a personality disorder. The DoN has commissioned training for Ward 3 staff in Structured Clinical Management which will develop staff knowledge and skills in relation to supporting people with a personality disorder. DBT awareness training is also being sourced to further develop skills across teams; this will run alongside the enhanced clinical skills training offer being delivered by the Consultant Nurses. Through the STP, linked with the Suicide Prevention Training previously discussed, 8 practitioners will be trained in Self Harm Reduction through a train the trainer approach. These initiatives will support the development of the enhanced personality disorder pathway.

13.3 Falls

In 2017 the Executive Director of Nursing & Quality convened a Falls Rapid Improvement programme. This resulted in a refreshed falls policy, including improved assessment and care planning documentation, being implemented in order to strengthen practice across in-patient areas in relation to minimising the risk of falls. Bespoke training has also been delivered. Furthermore both Ward 4 and 6, with the support of the Head of Patient and Organisational Safety, have undertaken a quality improvement project in relation to falls focussing on a person-centred approach. This initially improved quality of care but had no impact on the number of falls however through a number of PDSA cycles a reduction in falls is now being realised. The project has been shortlisted for a HSJ Value Award. Furthermore this good practice has been shared with Ward 7 who have rapidly responded to an

increase falls during 2018 and through the shared learning and a multi-disciplinary approach they have quickly seen a reduction in falls.

14. Recommended uplifts and potential funding source

The 2017 Safer Staffing Annual Review ensured that wards had the correct establishments and funded this through the realignment of resources following the change in shift patterns. Therefore this was achieved without the need for additional funding. This 2018 Annual Staffing Review established that 2 areas required additional staffing; Dragon Square and Ward 6. The actions relating to this are detailed below.

14.1 Dragon Square Uplift

An uplift of one HCSW day shift each day for Dragons Square is required. As Dragon Square is a short break service they have not been included in previous Safer Staffing reviews. Following inspection by Ofsted the need for this additional staffing has been identified.

Ward	Uplift Band 3 WTE	Uplift Cost £k
Dragon Square	1.74	45

Recommendation 25: Additional 1.74 WTE Band 3 for Dragon Square should be funded centrally through reserves.

14.2 Ward 6 Uplift

The review has identified that based on actual resource used Ward 6 require an uplift to 7/7/5 (additional Band 3 per shift and removing twilight). The potential for this requirement was identified in the 2017 review however it was recommended and agreed that this be monitored during 2018. Having continued with this monitoring and through the use of the SafeCare module it has been evidenced that over the past 18 months a minimum of an additional 1 HCSW per shift has been needed throughout.

A recommendation has been made in Section 4.4.2 in response to this (Recommendation 12).

15. Summary of Safer Staffing Recommendations

The following section summarises the recommendations made throughout this report.

Recommendation 1: Due to the majority of WMs coming into post during 2018 a Clinical Leadership Programme should be commissioned to support their development and ensure robust leadership within wards.

Recommendation 2: Once the Site Manager role is transferred to the Crisis Care Centre Ward Managers should complete one clinical shift per week on their own ward.

Recommendation 3: Preceptorship programme to continue to be reviewed annually to ensure continuous improvement in response to feedback.

Recommendation 4: Wards should have activity worker cover over 7 days.

Recommendation 5: Matrons should work with WMs to develop HCSWs and ensure that a programme of activities is accessible to all wards over weekends, including support from activity workers.

Recommendation 6: The Nurse Practitioners should complete one shift per week within the staffing numbers to role model and develop junior staff and provide a senior presence 'out of hours'.

Recommendation 7: The Acute Matron should complete the evaluation of the Quality Nurse role and feed back to the Directorate and the Safer Staffing Group who will consider the findings and if proving successful will be recommended in the SS report by the DoN.

Recommendation 8: The high level of admissions and discharges across acute wards should be considered within a review of the acute care model across urgent, acute and community teams.

Recommendation 9: WMs should be clear on the role of Physicians Associates (and any other staff working within their unit) and the supervision arrangements for those staff.

Recommendation 10: The Quality Improvement Lead Nurse (Matron) for Acute Services should continue to work with the Ward 1 WM to ensure that the staffing levels at night are being appropriately identified and that the staffing resource is being appropriately utilised.

Recommendation 11: The (AUC) Clinical Director should review job-planning for the relevant consultant psychiatrists in conjunction with the Stoke Directorate Clinical Director and also consider how the role of ANP could support the wards.

Recommendation 12: The Acute & Urgent Care Directorate should review the operational policy to ensure that the admission criteria for Ward 6 reflect the level of complexity, acuity and dependency that can be reasonably provided within the block contract. They should then work with finance to address the budget pressure.

Recommendation 13: Ward 7 should have a Ward Clerk in line with all other in-patient wards and the non-rostered element of staffing should be reviewed to explore this.

Recommendation 14: Medics should provide an up to date timetable to the ward in order for leave and cover arrangements to be communicated effectively.

Recommendation 15: The admission criteria should be adhered to by the MDT, the Associate Director should address this in the actions following the outcome of the Neuropsychiatry review.

Recommendation 16: The Practice Education Team will continue to work with ward and community teams to develop and offer increased placements to a range of pre-registration professions.

Recommendation 17: The Specialist Directorate should continue to raise the lack of appropriate residential placements for people with a learning disability and complex needs locally and the impact of this on service users and the clinical pathway with commissioners and escalate to Execs where needed.

Recommendation 18: The unit should have domestic and meal services delivered by facilities staff as a matter of urgency to release time for frontline staff to care for patients.

Recommendation 19: The establishment on Dragon Square Short Breaks should be increased by 1.74 WTE Band 3 HCSW to ensure that the needs of children can be met during non-term time as well as term time.

Recommendation 20: Further explore the opportunity for a shortened pre-reg nursing course for Nursing Associates with Staffordshire University and develop a Proof of Concept with finance.

Recommendation 21: The role of the Physicians Associate within mental health should be reviewed in order to understand the added value the role brings and inform decision making regarding the role within MDTs.

Recommendation 22: Directorate governance in relation to management of annual leave is strengthened and other rostering KPI's.

Recommendation 23: WMs and MMs to review rosters to increase RN fill-rate on nights to enable night pool to be reviewed.

Recommendation 24: Monthly reporting of RN reasons for leaving to be reported within the Monthly Safer Staffing Report.

Recommendation 25: Additional 1.74 WTE Band 3 for Dragon Square should be funded centrally through reserves.

16. Conclusion

In light of the current national shortage of registered nurses and the increasing dependency and acuity of service users it has been challenging to maintain safe staffing levels during 2018. However, Modern Matrons, Ward Managers and their teams have continued to deliver safe care and also demonstrate areas of notable practice and are commended for their achievement in doing so.

The Board are asked to:

- Note the progress in implementing safer staffing
- Approve the recommendations summarised in section 15

17. Appendices

17.1 Appendix 1 Developing Workforce Safeguards Self-Assessment

	Recommendations	Self-assessment
1	Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.	Annual and Mid-Year Safer Staffing reviews are conducted using the NQB framework. Monthly reporting is embedded and includes CHPPD from April 2018 and is published on the external website as required. Board received monthly, mid-year and annual safer staffing reports.
2.	Trusts must ensure the three components (see Figure 1 below) are used in their safe staffing processes: – evidence-based tools (where they exist) – professional judgement – outcomes We will check this in our yearly assessment.	The Trust has used both professional judgement and evidence-based tools in previous annual reviews. The implementation of the SafeCare module within Healthroster has strengthened the use of evidence based tools as the Hurst tool is embedded within this. As this is on-going on a shift by shift basis it will allow for a more robust evidence base to triangulate with professional judgement and outcomes .
3.	NHSI will base their assessment on the annual governance statement, in which trusts will be required to confirm their staffing governance processes are safe and sustainable.	NHSI have added a section to the annual governance statement specifically about staffing governance processes. In their response to this section, trusts must be able to describe or explain the extent of their compliance with the NQB guidance. As the Trust complies with NQB guidance we will be able to provide this statement.
4.	NHSI will review the annual governance statement through our usual regulatory arrangements and performance management processes, which complement quality outcomes, operational and finance performance measures.	As above
5.	As part of this yearly assessment NHSI will also seek assurance through the SOF, in which a provider's performance is monitored against five themes.	As above

6.	As part of the safe staffing review, the director of nursing and medical director must confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.	Previous annual safer staffing reviews have been conducted and overseen by the director of nursing and agreed with the medical director. Future annual staffing reviews will include this statement.
7.	Trusts must have an effective workforce plan that is updated annually and signed off by the chief executive and executive leaders. The board should discuss the workforce plan in a public meeting.	Workforce plans are updated annually and presented at open Board.
8.	Boards must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their board every month.	
9.	An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance and NHS Improvement resources. This must also be linked to professional judgement and outcomes.	This is achieved through annual and mid-year safer staffing reviews.
10.	There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.	The Hurst tool is for acute adult in-patients; further iterations of the tool are due in 2018 for older peoples and learning disability units. Currently the Trust uses the original Hurst Tool for all areas and does not manipulate the data however it is acknowledged that the outcome may not be 100% accurate.

11.	As stated in CQC's well-led framework guidance (2018) and NQB's guidance any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review.	QIAs are conducted on all CIP transactions involving staffing. Whilst quality is considered within annual safer staffing reviews and resulting recommendations, formal QIAs will be conducted for all adjustments to skill-mix and new roles moving forward.
12.	Any redesign or introduction of new roles (including but not limited to physician associate, nursing associates and advanced clinical practitioners – ACPs) would be considered a service change and must have a full QIA.	As above.
13.	Given day-to-day operational challenges, we expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments.	Safer staffing escalation SOP is followed in relation to safer staffing. This includes robust assessment of safety and quality and considers associated financial and performance related factors.
14.	Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix.	Safer staffing escalation SOP includes escalation to execs.

17.2 Appendix 2 2017 Safer Staffing Recommendations Progress

Recommendation 1: Reduce the staffing on Ward 1 from 6/6/4 to 5/5/3 once the PICU is opened and the function of the ward is fully transitioned from High Dependency Unit to general Adult Acute Ward.
Status: Complete

Recommendation 2: Due to the acuity and number of patients cared for within Ward 2 an additional HCSW is required to respond immediately to the PoS being used. When the PoS is not in use the person will be utilised to backfill any short notice shortfalls that have been unable to be backfilled across the Harplands site.
Status: Complete

Recommendation 3: The patient acuity and dependency continues to be high on Ward 5. The Ward has been working to Safer Staffing recommendations of a 6/6/4 staffing model. The establishment should be increased to allow this staffing model.
Status: Complete

Recommendation 4: Increase establishment on Ward 6 to allow for a 6/6/4 staffing model and an additional twilight due to the sustained increase in acuity and occupancy.
Status: Complete

Recommendation 5: Increase staffing on Ward 7 to 6/6/4 to meet sustained current patient dependency and occupancy.
Status: Complete

Recommendation 6: Discussions should be held with commissioners regarding the increasing number of patients with dementia requiring admission to Ward 6; in relation to the increased complexity and dependency of these patients and the impact of being on wards 5 and 7.
Status: Complete

Recommendation 7: Previous staffing reviews identified a short-fall in headroom on Summers View. Due to this, the current budgeted establishment allows for staffing of 3-3-3 however the centre requires 4-4-3.
Status: Complete

Recommendation 8: Introduce an Advanced Nurse Practitioner post to specialising in Eating Disorders (ED) to Darwin. This would address the risk associated with providing care for people with an ED by strengthening the model of care. Additionally introducing an ANP to the MDT will ensure that the trust continually moves forward in line with best practice, offering assurance to the Board that high quality care is being provided to this vulnerable group.
Status: Superseded. A Consultant Nurse in CAMHS is currently being advertised.

Recommendation 9: Increase staffing establishment on Darwin from 5/5/3 to 6/6/4 to meet sustained current patient demand and reflect the historical increase in beds.
Status: Complete

Recommendation 10: Introduce Band 2 apprenticeship roles within in-patient wards to provide a start to the potential nursing career pathway and to educate non-registered staff to a level where they are in a position to apply for trainee nursing associate or pre-reg nursing training.
Status: In progress. A model of rolling 2 year fixed term Band 2 apprenticeships has been developed and WMs and Matrons are currently taking this forward.

Recommendation 11: Improve patient care and experience, in relation to meaningful engagement, by extending Activity Worker cover across 7 days.
Status: Superseded. See 2018 Recommendation 3.

Recommendation 12: A cohort of 12 trainee nursing associates should commence in 2018. This would be funded through the apprenticeship levy (for training element) and use of existing hard-to-fill RN vacancies and funding from NHS England (for pay element). An investment of circa £5.8k per trainee per annum would be required over the 2 year period to release future savings of £6.2k per annum per qualified nursing associate.
Status: Complete. Eight Trainee Nursing Associates have commenced their training during 2018.

Recommendation 13: Workforce plans for in-patient wards should include the development of trainee advanced clinical practitioners through the apprenticeship framework to strengthen the MDT.
Status: In progress. The DoN and Deputy DoN are meeting with ADs to progress this.

Recommendations 14: Ward Clerks and Housekeepers job descriptions should be standardised and remuneration harmonised for each role.
Status: In progress. The WM T&F Group have progressed this with the support of the HoN.

Recommendation 15: The role of the Ward Clerk should be reviewed with a view to increasing support for Ward Managers in relation to workforce KPIs and administrative requirements of the MHA paperwork.
Status: This has been addressed within recommendation 14.

Recommendation 16: Integrate physiotherapists within ward teams to strengthen MDT working.
Status: Complete

Recommendation 17: Strengthen the education and training programme for in-patient staff across the MDT.
Status: Complete

Recommendation 18: Review skill mix within Access and HT in terms of the role of band 7 practitioners within the team.
Status: Complete. This has been addressed in the staffing model for the Urgent Care Centre.

Recommendation 19: The provision of a permanent rotational development post within Access and Home Treatment, similar to Mental Health Liaison, would support the development of RNs and also promote cross departmental working.
Status: Complete. This has been addressed in the staffing model for the Urgent Care Centre.

Recommendation 20: A rolling programme of rotation for Health Care Support Workers should be implemented alongside the opportunity for RNs to rotate on request.
Status: In progress. This is currently being progressed by Matrons.

Recommendation 21: Continue to strengthen rostering practices, including effective annual leave management, through increased focus on KPIs and monitor this through monthly performance reporting
Status: In progress. This has been challenging due to the number of new WMs and Matrons during 2018.

Recommendation 22: Strengthen professional and clinical supervision within Occupational Therapy by introducing a Band 7 professional lead within in-patient services
Status: Complete

Recommendation 23: Support the funding arrangements set out in this report to enhance safer staffing.
Status: Complete

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NHS Trust

REPORT TO: OPEN TRUST BOARD

Enclosure No: 10

Date of Meeting:	27th June 2019		
Title of Report:	Quality Account 2018/19		
Presented by:	Dr Buki Adeyemo, Medical Director Maria Nelligan, Director of Nursing & Quality		
Author:	Sandra Storey, Associate Director MACE		
Executive Lead Name:	Dr Buki Adeyemo, Medical Director Maria Nelligan, Director of Nursing & Quality	Approved by Exec	☒

Executive Summary:	Purpose of report	
By the 30th June 2019, all organisations are required to develop and publish a Quality Account (QA). The QA is an annual report to the public in which it provides information about the quality of services delivered, particularly ✓ what an organisation is doing well ✓ where the improvements in the quality of services are required ✓ the priorities for improvements in the coming year ✓ and how the Trust has involved service users, staff and others in determining priorities for improvement. In accordance with the agreed QA project plan, the Quality Account has been shared with key stakeholders and their feedback has influenced the content and design of the document. The Quality Committee has delegated responsibility from the Trust Board to ensure that the Trust meets its statutory obligations for publishing its QA by the 30th June 2019. The Quality Committee approved a draft of the document on the 12 June 2019. The Trust Board is asked to given final approval to the content of the 2018/19 QA noting that the final design will reflect the design of the Annual Report.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☒ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☒ • Finance & Performance Committee ☐ • Audit Committee ☐ • People, Culture & Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Primary Care Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration. ☒ 2. To provide the highest quality, safe and effective services ☒ 3. Inspire and implement innovation and research. ☒		

	4. Embed an open and learning culture that enables continual improvement. ☒ 5. Attract, develop and retain the best people. ☒ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☒
Risk / legal implications: Risk Register Reference	Legal requirement to develop and publish a Quality Account by 30 June.
Resource Implications: Funding Source:	None highlighted.
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	Diversity and Inclusion declarations highlighted in report.
STP Alignment / Implications:	N/A
Recommendations:	To receive for assurance

Version	Name/group	Date issued
V3	Quality Committee / S Storey	13.06.2019

Outstanding
Our quality journey continues

NHS
North Staffordshire
Combined Healthcare
NHS Trust

Keele
UNIVERSITY
TEACHING TRUST

Quality Account 2018/19

Contents

What is the Quality Account

PART 1

1.1 What is the Quality Account?

Quality Accounts, which are also known as quality reports, are produced annually to provide information and assurance for service users, families, carers, the public and commissioners that the Trust regularly scrutinises and reports on quality and shows improvements in the services we deliver.Quality Accounts look back on performance from the previous year explaining what the Trust has done well and where improvement is needed. They also look forward, explaining the areas that have been identified as priorities for improvement as a result of consultation with patients and the public.We hope that you find our Quality Account, which covers the financial year 2018/19 –1st April 2018 to 31st March 2019 helpful in informing you about our workto date and our priorities to improve services over the coming year.We also look forward to your feedback, which will assist us in improving the content and format of future Quality Accounts. This can be given through the Trust's website www.combined.nhs.uk.

Feedback on this Quality Account can be given through the Trust's website www.combined.nhs.uk or by email to qualityaccount@northstaffs.nhs.uk.

1.2 Our Commitment to Quality – Overview from our Chairman and Chief Executive

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

In March 2019, we were delighted and extremely proud to announce that the Care Quality Commission had awarded the Trust an overall "Outstanding" rating – the highest overall rating they can award. The news means that Combined Healthcare is 1 of only 2 specialist mental health Trusts in England with an overall 'Outstanding' rating.

The CQC rated the Trust as Outstanding in Caring and Responsive domains. It was rated Good in Safe, Effective and Well-led domains.

Everyone who is employed by or in partnership with Combined Healthcare works tirelessly to provide the best possible care. Everyone should be really proud of the CQC report which recognises the really excellent compassionate and responsive way we support service users and carers day-in and day-out.

To achieve this Outstanding rating is rare and is a real testament to our excellent staff who aspire to deliver true person-centred care in partnership with service users and carers. Our ambition is to continue to strengthen integration alongside our partners.

Amongst the comments by CQC about the Trust in its Inspection Report are the following:

- "Staff treated patients with compassion and kindness"
- "They respected patients' privacy and dignity and supported their individual needs"
- "Staff involved patients and those close to them in decisions about their care, treatment and changes to their service"
- "The Trust listened and acted on the feedback from patients their families and carers"
- "Risk assessments were completed and updated regularly"
- "Staff knew how to keep patients safe and reported incidents"
- "There was a good response to any sudden deterioration whereby patients could just walk into any location or call the duty person"
- "The Trust was actively engaged in leading, influencing and shaping local sustainability and transformation plans"
- "The Trust included and communicated effectively with patients, staff, the public and local stakeholders"

Our key achievements:

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

- ✓ The best performing Trust in England for Improving Access to Psychological Therapies (IAPT) and recovery rates
- ✓ Our dementia diagnosis rates for over-65s are the highest in the West Midlands
- ✓ Awarded Trailblazer status within Children and Young People's services, fantastic opportunity to identify and support emerging emotional concerns for children and young people
- ✓ Average length of stay for learning disability admissions cut by 60%
- ✓ 20 consecutive years of financial balance against a programme of quality improvement
- ✓ As a University of Keele Teaching Hospital we have worked in partnership to strengthen the future workforce by supporting the highest conversion rates to psychiatry training of any medical school in England
- ✓ By supporting staff health and well-being we have ensured safe staffing and have the lowest sickness rates of any Mental Health Trust in the West Midlands.

Improvement achievements have been acknowledged through a number of awards throughout the past 12 months, these include:

- ✓ Awarded the accolade "NHS Provider of the Year" by Leading Healthcare 2019
- ✓ HSJ finalist for Diabetes Initiative of the Year for the Healthy Minds Integrated Long Term Condition Service
- ✓ HSJ finalist for Emergency, Urgent and Trauma Care Efficiency Initiative of the Year for the All Age Mental Health Liaison Service
- ✓ HSJ finalist for Improving Value in the Care of Older Patients Award for the Rapid Falls Improvement project
- ✓ Shortlisted for Public Sector Team of the Year by the Partnerships Awards
- ✓ To promote a diverse and inclusive culture for service users and staff we have launched the Inclusion Council to drive our inclusion, diversity and equalities agenda, particularly focusing on taking forward BAME inclusion projects.

Our key priorities:

During 2018 we set out our plans to continue our journey of improvement towards outstanding by moving to more integrated services, based on locality, working across North Staffordshire and Stoke on Trent. We play a key part in the North Staffordshire and Stoke on Trent Alliance – bringing together health and care providers including mental health, primary care, community services, acute services, social care and the voluntary sector.

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

Our clinical services will deliver evidence based models of care that meet the needs of our service users and improve their experience of care. We will achieve this by continually engaging with our service users and carers through a variety of forums, both formal and informal.

Importantly, our Open Space Event in January 2019 brought together over 90 of our service users and carers to influence and shape how we prioritise the specific approaches we take under our core quality SPAR priorities.

In partnership with the Service User and Carer Council we also explored how we can increase opportunities for service users and carers to get involved with the Trust, building on the excellent wok undertaken so far.

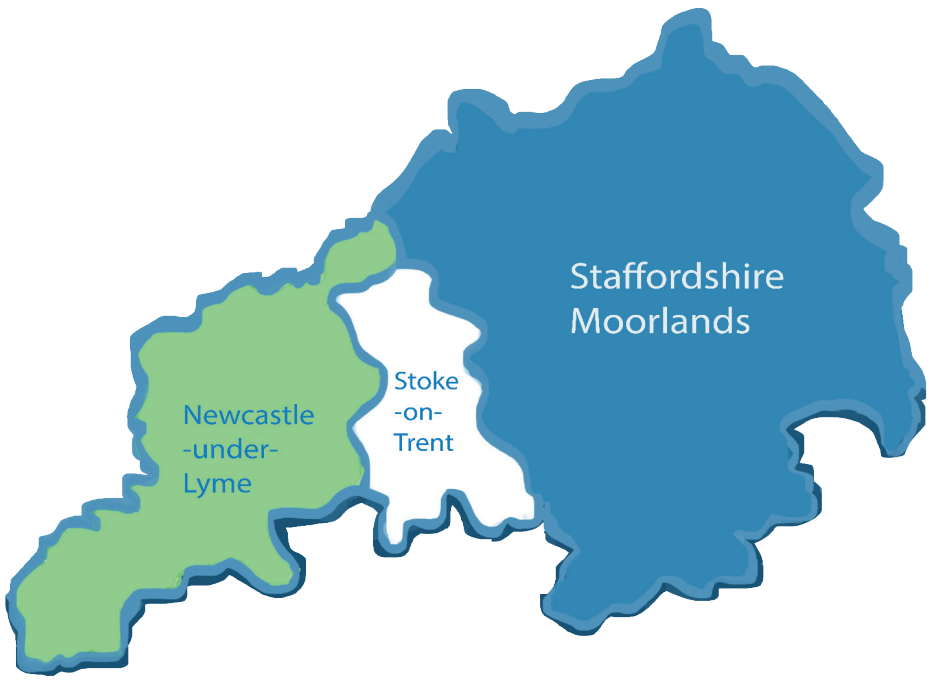
Finally, we are pleased that the Board of Directors has reviewed this 2018/19 Quality Account and confirm that this is an accurate and fair reflection of our performance. We hope that this Quality Account provides you with a clear picture of how important quality improvement, safety and service user and carer experience is to us at North Staffordshire Combined Healthcare NHS Trust. We hope you enjoy reading our Quality Account 2018/2019.

Peter Axon, Chief Executive and David Rogers, Chairman

Photos to be inserted

1.3 Introduction to North Staffordshire Combined Healthcare NHS Trust

- North Staffordshire Combined Health Care NHS Trust was established in 1994 and provides mental health and learning disability care to people predominantly living in the city of Stoke-on-Trent and in North Staffordshire. We employ approximately 1,358 staff who work from both hospital and community based premises, operating from over 30 sites. Our main site is Harplands Hospital, which opened in 2001 and provides the setting for most of our inpatient units.
- Our team of staff are committed in providing high standards of quality and safe services. We service a population of approximately 464,000 people from a variety of diverse communities across Northern Staffordshire. 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 more often, we are able to provide care in outpatients,



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

- For 2018/19, our main commissioners remained the two Clinical Commissioning Groups (CCGs); North Staffordshire (33%) and Stoke-on-Trent CCG (49%). We also work very closely with the local authorities in these areas in addition to our other NHS partners.
- We have close partnerships with agencies that support people with mental health and learning disability problems, such as Approach, ASIST, Brighter Futures, Changes, EngAGE, North Staffordshire Huntington's Disease Association, Mind, North Staffs Carers Association, Reach and the Beth Johnson Association.
- The Trust Board, comprising the Chairman and five Non-Executive Directors, the Chief Executive and six Executive Directors, lead our organisation. A General Practitioner, Staff Side Representative and the chair of our Service User and Carer Council supplement the Board.

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

1.4 Services Covered by this Quality Account

This Quality Account covers four Mental Health and Learning Disability Directorates and one Primary Care Directorate provided by the Trust. During the year we transitioned to our new locality structure which was developed in partnership with staff. We will continue our journey of further integration of services based on locality working across North Staffordshire and Stoke on Trent. During the period from 1 April 2018 to 31 March 2019, the Trust provided or sub-contracted eight relevant health services; the Trust sub-contracts out to two non-NHS bodies in respect of improving access to psychological therapies (IAPT). The services we provide are shown below under our operational structure.

Outstanding

Our journey continues...

Our Operational Structure

Stoke Community

Adult CMHT
Older People
CAMHS
IAPT

Outreach Team Older People
Care Home Liaison / Physio
Memory Services
Vascular Wellbeing
Primary Care Dementia

Adult CMHT
Older People
CAMHS
IAPT

DOLS/BIA/Stoke AMPH Team
ASD Assessment
Growthpoint
Parent & Baby
Co-operative Working

North Staffs Community

Adult CMHT
Older People
CAMHS
IAPT

Liaison & Diversion
Criminal Justice Team
IPS / Step On
Early Intervention
Dual Diagnosis

Adult CMHT
Older People
CAMHS
IAPT

CAMHS Yellow House
Schools Psychology
Eating Disorders
ASD School Age
Sustain (CAMHS)
MH Youth Offenders Team

Specialist Services

Dragon Square
Assessment and Treatment
Community L Dis
Community Learning Dis Team
Healthcare Facilitation
Intensive Support Team
Medical Services - LDs
Darwin Centre

Florence House
Summerview
Hillcrest
Ward 5 Neuro
Neuro Community Services
Neuro PSD Daycare
Neuropsychology
Out Of Area / Resettlement Team

One Recovery North
One Recovery Staffs Medical
SMIS Stoke Community
Stoke Heath Prison
SMI Business Team
SMI Inpatients (EMU)
SMI Medical

Acute and Urgent Care

Access Team
Home Treatment Team (Adult)
IOU (Adult / Subs Misuse)
Community (Street) Triage
Place of Safety
Site Managers
High Volume Users

Mental Health Liaison Team
CAMHS Central Referral Hub
Children's Psychology

Wards 1,2, 3
PICU
Acute Nurse Practitioners
Acute Therapies

Wards 4, 6, 7
Physiotherapy
ECT Team

Primary Care

Outstanding

1.5 Our Vision and Quality Priorities

Our overarching vision and quality priorities have not altered in 2018/19. Our core purpose is to improve the mental health and wellbeing of our local communities. Our strategy is to deliver an evidence-based model of care, which is appropriate to our service user needs and focuses on wellbeing and ongoing recovery.
We aim to be recognised as a centre of excellence, bringing innovative solutions to the services we deliver and embedding a culture of continuous learning across our organisation. This is reflected in our vision, values and objectives, as well as our focus on quality and safety.

Our Vision:

"To be outstanding in all we do and how we do it"
Our journey continues...

Our Quality Priorities:

Our Quality Priorities were developed with service users, carers and staff and form the framework for our annual improvement programme. The four key quality priorities are 'SPAR':

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

Our vision and quality priorities are underpinned by our values and delivered through our 7 strategic objectives.

Our Values:

Our values were developed by our staff, service users, carers and partners and are well-embedded across the Trust. They are:

Proud to CARE –

Compassionate, Approachable, Responsible and Excellent.

Our strategic objectives:

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

1.6 Quality of Services 2018/19 Key Achievements

Our Quality Strategy is underpinned by our Quality Priorities and produced in collaboration with service users, carers and staff to ensure that it reflects the needs of the local population across North Staffordshire and Stoke on Trent. Improvements during 2018/19 are summarised below:

Under Quality Priority 1 'Safe' we have:

✓ Worked towards our Zero Suicide ambition by
- Participating in the countywide Stoke-on-Trent and Staffordshire Suicide Prevention Group, working with partners to reduce death by suicide
- Hosting a multi-agency Suicide Prevention Conference in November 2018
- Continuing to invest in the environment to reduce ligature risks.

✓ Focussed on improving physical health by
- Strengthening physical health monitoring for service users through embedding the National Early Warning Score (NEWS) for in-patient services and the Lester Tool for community services
- Continuing on our journey Towards Smoke-free
- Increasing compliance with Infection Prevention and Control (IPC) audits from 85% to 90%.
- Achieving 76% uptake of Flu vaccination for patient facing staff.

✓ Provided a safe environment by
- Improving our rating for safe services from requires improvement to good across Adult Community Services and Wards for Older People
- Further refining the Falls Reduction Quality Improvement Project to reduce falls on older people's wards.
- Implementing a standardised approach to safety and quality improvement through the Community Safety Matrix.
- Maintaining safer staffing in line with the National Quality Board (NQB).
- Achieving 99.47% compliance with the Patient Led Assessment Environment (PLACE) which audits environments and cleanliness, remaining in the top performing quartile of Trusts nationally.
- Improving medicines management following the introduction of an electronic system for the daily monitoring of fridge temperatures.
- Improving compliance with Mental Health Law

following the introduction of the Inpatient Safety Matrix and provision of additional bespoke training for staff.
- Developed and implemented best practice cyber security.

✓ Acknowledged the importance of clinical leadership in maintaining safe wards by
- Developing SPAR wards accreditation framework to enhance the quality of care on in-patient wards.

Under Quality Priority 2 'Personalised' we have:

✓ Strengthened person centredness by
- Co-producing a Person Centeredness Framework with service users, carers and staff.
- Continuing to implement the Restraint Reduction Strategy, focussing on service user experience and person centred care.
- Expanding the NHS Improvement Therapeutic Observation and AQuA Trauma Informed Care Quality Improvement projects across all acute wards.

✓ Encouraged involvement by
- Collaborating with the Service User and Carer Council (SUCC) and using service user feedback (eg friends and family test) themes to influence the Trust's Quality Improvement agenda.
- Increasing the number of service users being offered the opportunity to participate in research studies through adoption of a consent to research initiative.
- Hosting an Open Space Event in January 2019, in partnership with the Service User and Carer Council to enable service users a carers to influence and agree our quality priorities for 2019/20.

Under Quality Priority 3 'Accessible' we have:

✓ Improved access to services by
- Commencing development of electronic self-referral functionality for patient and carers to the CAMHS hub.
- Strengthening our Diversity and Inclusion strategy as acknowledged by the CQC.
- Opening a Psychiatric Intensive Care Unit (PICU) to reduce the need for service users to be cared for 'out of area'.
- Working with health and social care commissioners to reduce delays in transfers of care.

✓ Worked towards improving access to records by
- Progressing the PatientAide protocol which will enable service users to control access to their own
- electronic patient record (year 1 of 3)

Under Quality Priority 4 'Recovery Focussed' we have:

✓ Promoted recovery by
- Launching a virtual and physical wellbeing academy providing people with education and learning experiences as a means of supporting personal and social recovery.
- Appointing 10 volunteer peer mentors and 5 peer support workers; supporting their knowledge and skills development through a bespoke 10 week education programme.

1.6.1 Key achievements in detail by Directorate

Stoke Community

The Directorate has successfully re-organised to provide a place based model of care from October 2018. This supports the delivery of Adult, Children's and Older People's services across the City of Stoke on Trent split geographically into North and South Stoke operational patches.

The Directorate recognises the potential challenges around ensuring robust clinical pathways are supported within the new structure and is committed to working collaboratively with clinical leads and teams to ensure that specialist areas of practice are maintained and strengthened.

In recent months the Directorate has worked hard to develop strong and effective relationships with partner organisations. Specifically there has been a refocus upon the section 75 arrangements with the City Council and a commitment to strengthen the role of social work within the Trust.

The Directorate has positive links with numerous third Sector organisations and has recently worked in partnership with the Financial Inclusion Group to deliver an enhanced offer to service users in the City in relation to debt, benefits and housing advice. This is particularly pertinent to the Stoke Locality due to high levels of deprivation and has culminated in a pilot through which a financial capability advisor (provided by the Citizen's Advice Bureau) will be working with the adult CMHT's over the next 6 months.

The Stoke Community Directorate hold the Trust lead role in relation to Older People's services and are proud to continue to have excellent diagnosis rates across North Staffordshire.

As of February 2019, the rate for people aged over 65 living in Stoke on Trent was 85.2% while in North Staffordshire it was 73.2%. This is against a national average of 66.7%. Much of this was achieved because of the excellent team working within their memory services. These services provide assessment, diagnosis and treatment for people with a number of conditions, including dementia. They also have a team that works closely with GPs to treat people living with dementia closer to home and a further team that supports people at high risk of developing the condition.

The Directorate recognises the role that it plays in terms of the broader health system requirements and works closely with The Royal Stoke University Hospital to support the needs of older people through its Outreach Service. This enables rapid access to step down services from the Acute Trust and places a focus upon community rather than bed based support options.

In relation to CAMHS services within the City, a number of exciting developments are underway to improve the experience of young people in the area. Trailblazer funding has been secured to develop services into local schools, reduce waiting times for treatment to 4 weeks and the development of a digital front door.

There is a further commitment to develop Improving Access to Psychological Therapies (IAPT) services for younger people and strengthen the pathway and processes to support a smoother transition into adult services.

There are a number of generic priority areas for taking the Directorate forward over the coming months. These include strengthening clinical pathways, developing relationships within partner organisations, and improving the integration of physical and mental health.

The overall aim of the Directorate is to ensure that residents of Stoke on Trent, regardless of age, have an accessible and recovery focussed service that is responsive to their needs.

North Staffs Community

Similarly, the overall aim of the North Staffs Community Directorate is to ensure

that the residents of North Staffordshire, regardless of age, have an accessible and recovery focussed service that is
responsive to their needs. The Directorate is proud to be part of a CQC rated Outstanding organisation, this has been achieved due to the passion, commitment and
tremendous hard work by all of their staff.

The Directorate has successfully taken the lead for the pan Staffordshire expansion of the liaison and diversion service, assuring parity of care delivery across Staffordshire. They are also leading on the award of the trailblazer pilot with their Children's and Young Person's services, mobilising teams and aligning them to designated schools to delivery early interventions to young people to support emotional well-being at an early age. This is underpinned by robust partnership working with the clinical commissioning group, local authority and local schools.

The IAPT team continues to over perform in the recovery rates for people presenting with common mental health issues.

The Directorate has also been successful in receiving funding and support from the national digital programme to develop a digital front door and web based services for Children and Young People.

Specialist Services

Setting up this brand new Directorate in October 2018 has been a significant achievement in itself. Their overarching purpose is to grow and diversify services within the Trust and it is against this yardstick they have judged the new arrangements to have been a success.

The contract for Stoke Community and Drug Alcohol Services was won just as the Directorate was being formed. The new service commenced officially on the 1 January 2019 and they have overseen the arrangements being put in place as lead provider supported by Addaction, a national 3rd sector provider and BAC O'Connor a local provider. The Trust also supported this partnership to apply for a national scheme offering Capital investment to improve services. The successful bid will see £400k in funding coming to Stoke on Trent to ensure there are excellent facilities for people with Alcohol issues to access local services.

Stoke Heath Prison Healthcare is another new contract that was won in the early days of the Directorate forming. The Trust
retained the Clinical Substance
Misuse element of healthcare at the Prison but played a lead role in forming a new integrated Healthcare team with Shropshire Community Trust leading on primary care, the new service commenced on the 1 April 2019.

Within this new service the Trust will also provide the Specialist Mental Health Services. Significantly the Mental Health Services have received a 50% increase in funding as a result of the bid for the contract. Consequently, they will have a 7 day mental health service and will be introducing new interventions for Psychological Therapies and Learning Disabilities.

Learning Disability Services have secured additional funding from commissioners to increase the level of support provided for people returning to the local area who have been sent outside Staffordshire and Stoke on Trent for their care. New funding has also been agreed to continue with a post in the service that specialises in helping people who have a LD but have also been involved with Criminal Justice Services.

Darwin Tier 4 CAMHS has been working closely with NHS England and a group of other NHS and Independent sector providers to develop a case for using the funding NHS England invest in beds around the country, being invested instead more in local services to prevent the need for hospital admission. They have positioned themselves to lead on developing the business argument for change within the partnership and will be seeking funding from NHS England to

support this work.

Neuropsychiatry Services were helped to conclude an in-depth review of their service that had been commissioned prior to the Directorate formation. The review has indicated the need to strengthen regional, if not the national, presence of their Neuropsychiatry Service, whilst at the same time modernising service element to better meet local needs and at the same time position themselves for future developments in this area.

Psychology Services hold numerous contracts with UHNM, Midlands Partnership Foundation Trust, Probation and Clinical Commissioning Groups to provide highly specialist psychology services for people outside Mental Health Services. These range from Cancer to Bariatrics, Probation and Paediatrics. They have secured all of these contracts again and have been discussing expanding into more areas with their Partners.

Adult Mental Health Rehabilitation and Resettlement Service have commenced a review of how it works internally across the community, supported housing and inpatient services. The outcomes are not yet concluded but are pointing these services to develop more forward housing solutions with support rather than housing people in wards.

The repatriation team that sits within the Resettlement element of service continue to deliver around £2m in savings each year to the local health economy through better management and return of people with complex needs who have been sent outside the NHS for specialist care.

Acute and Urgent Care

Mental Health Crisis Service and Health Based Place of Safety are proud to have achieved an Outstanding rating for their Mental Health Crisis Service and health based places of safety following the CQC most recent visit. Planning commenced in 2018 to develop a 24 hour, 365 day all age Crisis Care Centre with a planned opening during Autumn 2019. Through a programme of training and development, the Mental Health Liaison Service implemented a Children and Young Person Liaison and Assessment Service, a model that the Directorate will build on in the development of the Trust's Access Services continuing their close collaboration with the Children and Young People's Hub Specialist Team.

The High Volume Users team has been instrumental in successfully reducing the number of visits to Emergency Departments and are pleased to receive positive feedback from partnership agencies reflecting the highly responsive service delivered.

Inpatient Wards for Older People with Mental Health Problems has maintained its focus on reducing restrictive practices with significant reductions in the number of physical restraints used on the wards for older adults with mental health problems. They also highlight the successful Quality Improvement Falls Reduction initiative resulting in greater recognition of falls causation with resultant environmental improvements across their wards. They are pleased to be a shortlisted finalist in the Health Service Journal Value Award (HSJ) Improving Value in the Care of the Older Patients Award category. The service is proud to see the staff on Ward 4 developing positive initiatives around the involvement of families in the care of their relatives with family members now volunteering on the wards to support others and recognised as "outstanding" practice in the CQC inspection report.

Inpatient Wards for Working Age Adults welcome the opening of 4 operational beds in the state-of-the-art Psychiatric

Intensive Care Unit (PICU) in October 2018 following a successful recruitment campaign. They report an immediate impact

for the local community in the significant reduction of out of area admissions to specialist PICU facilities at the time of greatest need ensuring that the care is delivered close to home. They continue their assertive recruitment drive to ensure optimum staffing experience to open the remaining 2 PICU beds during the Summer 2019.

The Directorate has achieved an overall reduction in bed occupancy and length of stay across the adult inpatient wards embedding the principles and practice of the Acute Care Model working closely with carers, families and community services. They are also pleased to report commencement of a capital funded reduced ligature work programme to improve the safety of inpatient environments.

1.7 What the Care Quality Commission said about the Trust

In March 2019 the CQC published their findings from their unannounced and well led inspetions which took place within the Trust throughout January 2019. We are delighted to have received a rating of Outstanding from the CQC.

- The Trust is fully compliant with the registration requirements of the Care Quality
- Commission.

- The Trust is now one of two specialist Mental Health Trusts to be classed as Outstanding in England.

- Our Crisis services have made a significant improvement with an overall rating of Outstanding.

- We are pleased to have 3 of our 11 core services rated with an overall outstanding rating and proud that the CQC have attributed the Outstanding rating to the Caring and Responsive nature of our staff and services.

- It is particularly reassuring to note the Adult

"Overall the Trust is to be congratulated for all its work to provide an outstanding service to its patients"

Community Services and Wards for Older People have improved their rating for Safe services from Requires Improvement to Good.

Deputy Chief Inspector for hospitals, and llead for mental health, Paul Lelliott said: "The Board and staff at North Staffordshire Combined Healthcare NHS Trust can be proud of many of the services that it manages, the improvements it has made and its new Outstanding rating".

Paul Lelliott went on to report:

"We found a number of areas of outstanding practice at the Trust that were making a real difference to people's lives.
Staff treated patients with compassion and kindness, respected their privacy and dignity, and supported their individual needs.

There was good leadership across the Trust and managers had the right skills to undertake their roles, while the Board had good understanding of performance.

On our return we found the requirement notices we set out in our previous report had been met and medicines safety had improved on the wards for older adults and the community teams. Community teams now inspect emergency equipment as a matter of routine.

Patients and those close to them were involved in decisions about their care, treatment and changes to the service and staff knew how to keep patients safe. They reported incidents, including abuse, and learned from incidents".

Summary Rating Table:

Are services	
Safe?	Good
Effective?	Good
Caring?	Outstanding ☆
Responsive?	Outstanding ☆
Well led?	Good

Detailed Rating Table:

Comparison Table – 2015 to 2019:

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Long-stay or rehabilitation mental health wards for working age adults	Good Feb 2018	Good Feb 2018	Outstanding Feb 2018	Outstanding Feb 2018	Good Feb 2018	Outstanding Feb 2018
Child and adolescent mental health wards	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016
Wards for older people with mental health problems	Good ↑	Requires improvement ↓	Good →←	Good →←	Requires improvement ↓	Requires improvement ↓
Wards for people with a learning disability or autism	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good →← Feb 2018	Good Feb 2018	Good Feb 2018
Community-based mental health services for adults of working age	Good ↑	Good →←	Good →←	Good →←	Good →←	Good →←
Mental health crisis services and health-based places of safety	Good →←	Good →←	Outstanding ↑	Outstanding ↑	Good →←	Outstanding ↑
Specialist community mental health services for children and young people	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Community-based mental health services for older people	Good Sept 2016	Good Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016	Good Sept 2016	Outstanding Sept 2016
Community mental health services for people with a learning disability or autism	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016
Substance misuse services	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016
Overall	Good ↑	Good →←	Outstanding ↑	Outstanding ↑	Good →←	Outstanding ↑

Combined Healthcare CQC Service Ratings

	2015	2019
Adult Inpatient	Requires Improvement	Good
CAMHS Community	Inadequate	Good
CAMHS Wards	Requires Improvement	Good
Adult Community	Requires Improvement	Good
Crisis	Inadequate	Outstanding
Community LD	Good	Good
LD Inpatient	Good	Good
Rehab	Requires Improvement	Outstanding
OP Community	Good	Outstanding
OP Inpatient	Good	Requires Improvement
Substance Misuse	Requires Improvement	Good
Overall	Requires Improvement	Outstanding

1.8 Building Capacity and Capability

During the year, our Board membership has been refreshed and further enhanced with the appointment of a new Director of Workforce, OD, Inclusion and Communications, Director of Operations, Director of Finance, Director of Partnerships & Strategy and two Non-Executive Directors. A GP Associate Board member continues to give strength and support to the Board from a primary care perspective. The Chair of the Service User and Carer Council continues to be a full member of the Board influencing decisions made and ensuring they are service user focussed.

The Board has a wide range of experience and skills to provide effective leadership. As part of our Board Development Programme we have undertaken a Board skills assessment. Our continuous cycle of board development acts as an opportunity for ongoing organisational development and quality improvement. A core component of the development programme is to ensure that all board members have a focus of continual improvement in order to deliver the highest quality, safe services for our community, within resources available. During 2018/19, the Trust built on its approach to Board Development; participating in the Advancing Quality Alliance programme (AquA) and linking this through to leadership and quality improvement across the wider Trust through the Leadership Academy.

1.9 Our Workforce

We employ 1,358 (WTE) substantive staff, with the majority providing professional healthcare directly to our service users. We also have an active staff bank which supports our substantive workforce. We have continued to strengthen our Temporary Staffing function to allow greater provision and flexibility which is more adaptive to service needs and removes wherever possible the need for agency provision. This has resulted in our use of agency staff to fulfil 'core' operations as remaining one of the lowest rates of any NHS Trust in the country.
We recognise that our outstanding workforce are our greatest asset and continue to develop our staff and the culture within which they work, to enhance our service user's experience, improve performance and increase staff engagement and morale.

Outstanding Engagement: We have been on a journey of staff engagement for 5 years, starting with the introduction of Listening into Action (LiA) which was a Trust wide approach to engagement, creating fantastic demonstrable results. LiA was really successful at creating change through the engagement and involvement of staff, service users and carers and helping to influence staff engagement culture at an organisational level. This saw the Trust improve its staff survey engagement scores from being one of the lowest scoring Mental Health Trusts.
By developing both organisational and team engagement cultures through LiA and the introduction of Towards Outstanding Engagement, we are now priming the organisation for the next stage in our journey, which will see the development and introduction of a Trust approach to service improvement, improving team engagement and resulting in better performing teams, ultimately improving the quality of care we provide to our service users.

Health and Wellbeing: Fostering a positive culture that supports the health and wellbeing of our workforce is of great importance. Significant progress has been made this year by focusing on a variety of Health and Wellbeing initiatives for our staff including the initiation of a Health and Wellbeing Steering Group which has led a number of initiatives including healthy eating education, our winter flu fighter campaign, the continuation of a Physio fast track service and Pilates sessions which all staff are invited to attend. Our Wellbeing Wednesday and Feel Good Friday initiative has continued to be a great success. We have also offered additional support sessions for staff including Mindfulness and Bereavement & Loss. Our Wellbeing Academy is accessible by our service users and staff.

In December 2018 the Trust held their second Critical Incident Stress Management (CISM) Annual Conference which was sponsored by the RCN and provided an excellent opportunity to share good practice and to network with other colleagues from other organisations.

Schwartz Rounds commenced in April 2018 and are a confidential monthly meeting where staff from different professions and backgrounds come together to discuss the non-clinical aspects of their work. Centred on a particular case or theme, each round meeting starts with a panel of presenters talking briefly about their own experiences.

Leading with Compassion: This scheme enables staff, patients and carers to recognise someone who they believe has demonstrated leading with compassion. We have created an NHS compassion website www.nhscompassion.org incorporating a video which gives an overview of the scheme and some of the evidence behind why it is important. Staff and patients have nominated staff across all clinical and non-clinical areas resulting in 1199 nominations from across the Trust.

Diversity & Inclusion: 2018-19 has been another extremely important year for the Trust in terms of advancing equality, diversity and inclusion within the organisation and beyond. A key area of focus for us throughout this 12 month period had been on BAME inclusion; however we have also worked to progress inclusion for other equality groups, including LGBT and people with disability. Our work goes on as we continue our journey towards Outstanding Inclusion across the Trust. There is now a very well-established evidence base suggestion that organisations that put inclusion at the heart of their activities are more successful in a wide range of outcome measures, including service user and staff satisfaction and financial performance.

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

We have commissioned a cohort of accredited coaches to be a resource for the Trust. This cohort will complete during 2019–20 and will result in a register of internal coaches to support leadership and development activity.

Work commenced with AQuA (Advancing Quality Alliance) to deliver an In-Place leadership programme to support the move to locality working for all senior leaders in the organisation. The programme will be delivered over 2 cohorts of approximately 25 delegates in each, attending 6 taught sessions and 6 Action Learning sets over a 14 month period. A co-design event was held in February 2019 to introduce and launch the programme.

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

Learning Management: We launched our new Learning Management System (LMS) in 2017 and upgraded our system in 2018 to enable every staff member to be able to access both what they need for their role and extra learning opportunities. Every staff member has their own account which enables our staff to easily access and complete e learning and to book onto classes. As a consequence we have seen month on month improvements in mandatory education and staff accessing e-learning development opportunities.

Apprenticeships and New Roles: Implementation of apprentice qualifications has helped to develop new roles and pathways to enable staff to progress within their career. Examples include the development of Assistant Practitioner and Nursing Associate roles. We are also exploring the implementation of new apprenticeship routes into registered posts including physiotherapy, occupational therapy, social work and nursing. Wherever possible we work with partner organisations to maximise the learning experience for apprentices and enhance understanding and networking across the health economy.

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

Listening to Staff, including Freedom to Speak Up: Our CEO's blog is read widely and strengthens openness and honesty as part of our drive for authentic leadership. We have well-established means of listening and responding to staff, including the appointment of our Freedom to Speak up Guardian, and the Dear Caroline initiative (Dear Peter from April 2019) which provides all staff with access to our Chief Executive to anonymously raise any issues, concerns, service suggestions and compliments.

To coincide with the 2018 Freedom to Speak up month, we launched our Freedom to Speak up Champions Initiative. Working with the Freedom to Speak up Guardian, the additional Champions have promoted a positive culture to ensure staff feelcomfortable and supported to speak up about things that may concern them and in the strictest confidence. By

having Champions across the Trust's localities and diverse staff and professional groups, the aim is to give staff a wide choice of who they may be most comfortable in speaking up to.

During 2019 the plan is to spread the Freedom to Speak up message further. The aim is to ensure Champions become more visible across the Trust and that there is a variety of outlets for raising concerns over quality of care, patient safety or bullying and harassment within the Trust. Freedom to Speak up will be included on every Team and Directorate agenda to ensure that all staff have the opportunity to raise their concerns directly with their line managers.

Staff Survey: The National NHS Staff Survey provides us with an annual opportunity both to monitor changes in what it feels like to work for the Trust over time. Our Trust is benchmarked against 23 Mental Health and Learning Disability Trusts in England.

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

The results from the 2018 NHS Staff Survey benchmarked the Trust as the Best Performing Mental Health and LD Trust.

Our response rate was 58% - a 6% increase on last year and a huge 4% higher than the average rate in our benchmark group of 23 other mental health and LD Trusts in England. This year the NHS staff survey has been presented differently and aggregated into 10 themes:One of the 10 is "Safer environment – bullying and harassment".

We scored the highest nationally for all Mental Health Trusts.

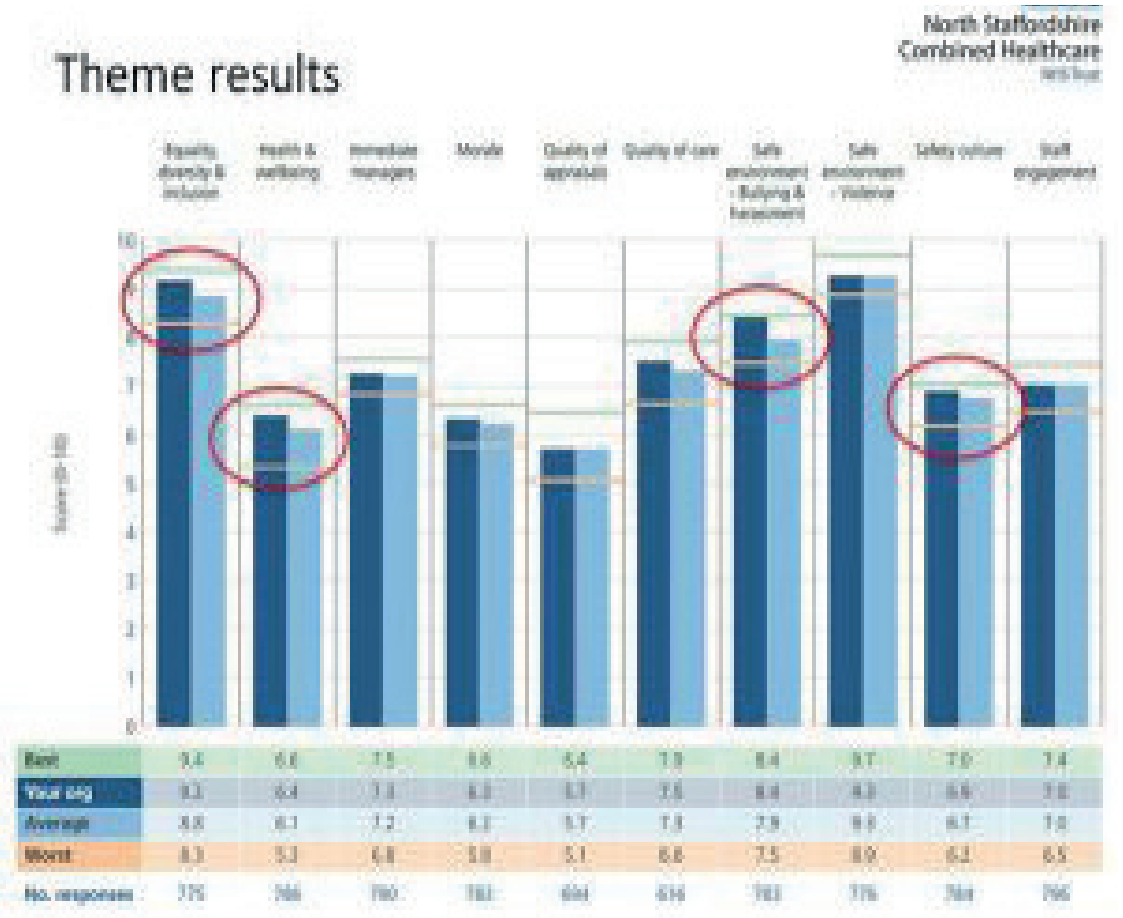
We scored above average for another 6 out of the 10 themes

- Equality, Diversity and Inclusion
- Health and Wellbeing
- Safety Culture
- Morale
- Quality of Care
- Immediate Managers

And average for 3 themes:

- Quality of Appraisals
- Staff engagement
- Safe environment from violence

Teams have action plans in place to respond to themes and trends arising from the survey.



PART 2

Priorities for improvement (looking forward) and statements of assurance from the Board

2.1 Engaging partners and stakeholders

Looking forward, we continue to be committed to providing high quality care for our service users and carers. We feel this is only achievable by maintaining our partnership with service users and carers across the communities we serve. Our clinical services will deliver evidence-based models of care and will reflect the needs of service users and their lived experience. We will achieve this by having an on-going conversation with our service users and carers and by strengthening our approach to co-production.

Following the January 2019 CQC inspection we have continued to review areas for improvement through the on-going development of comprehensive action plans and will work in partnership with the CQC, service users, carers and other key stakeholders to implement and sustain improvements. As such we have included partners in the development and publication of this Quality Account.

2.2 Quality planning, governance and quality improvement

Our Quality Strategy is underpinned by our Quality Improvement Programme recognising that strong clinical leadership and engagement is essential in successfully delivering the strategy and achieving the desired changes in our quality and safety culture. Our Workforce Strategy supports this through initiatives such as staff engagement, clinical supervision, staffing and recruitment thus ensuring staff are supported and engaged to deliver high quality care.

We have strengthened our approach to Quality Improvement (QI) and during 2018 were a pilot site for the new NHS Improvement board development programme for quality improvement. Furthermore training and project support in relation to QI has been delivered at a variety of levels within the trust and this will continue during 2019-20. As part of the restructure of our directorates we have strengthened QI by introducing Quality Improvement Leads in each Directorate who will lead QI projects.

We can demonstrate evidence that the assessment of risk helps to drive and shape our approach to quality governance by using reporting and trend analysis through identification of risks from Team to Boards.

Underpinning our approach to QI is the Board Assurance Framework (BAF). This identifies key strategic objectives against the strategic risks, the control measures in place and the required assurances. The BAF aligns the strategic objectives and risks to our SPAR quality priorities for which each has an Executive Lead and is overseen by a nominated sub-committee of the Board.

Our approach to Quality has been supported through the monthly Senior Leadership Team meeting (comprising the Executive Team and Clinical Directors) with a QI focus to the agenda. The monthly performance agenda based on quality, workforce, clinical effectiveness and finance with associated Key Performance Indicators ensures a focussed approach to continuous improvement.

Quality improvement is monitored through a number of methods overseen by the Quality Committee including:

- Delivery against our CQC Improvement Plans
- Performance Review and Quality Dashboard
- Listening into Action: Improving staff engagement and improving services
- The BAF containing a description of our quality goals
- Learning Lessons: Learning, sharing and taking action to provide safe and effective services through monthly publications and interactive learning events
- CQUIN initiatives: Identifying clear priorities on which to base the annual initiatives, national priorities
- A programme of quality assurance / improvement visits including:
  - External announced visits led by the CCG and Healthwatch
  - Internal unannounced assurance visits led by the Executive, representative from service user and carer council and Non-Executive Directors.
- Monthly Director question and answer sessions
- The Commissioner led, Clinical Quality Review Meeting (CQRM)
- This Annual Trust Quality Account
- CQC Well-Led inspections

We have further developed our capacity and capability to implement quality improvement and change through a review of services to ensure that we have the right resources in the right place at the right time to meet the needs of service users and carers. We did this by;

- Changing our directorate structure from specialities to localities to ensure that people receive services that are seamless and close to home
- Reviewing safer staffing across 24 hour services in line with National Quality Board standards
- Implementing the SafeCare module within e-Rostering to enable real time visibility of Trust wide in-patient staffing requirements
- Enabling a range of teams to undertake QI projects through training and project support from NHSI and AQuA.

We will continue to develop and refine methods to demonstrate and evidence the impact of the investment in QI by use of national benchmarking data including:

- National NHS Benchmarking Data Annual Report Measures
- National Reporting and Learning System (NRLS) six monthly organisational report
- Friends and Family Test data
- NHS Choices
- Patient Led Care Assessments (PLACE)
- Mortality Surveillance
- National Safer Staffing requirements.

Learning from the Gosport Review (June, 2018) we have taken steps to review levels of assurance against the key areas of concern highlighted, in order to ensure that such events would be highly unlikely to occur within this organisation.

The following assurance processes are embedded:

- Incident reporting is robust with weekly incident monitoring and reporting via teams, through to directorates and executive committees.
- Complaints reporting and procedures; reporting through Trust reporting structures
- Freedom to speak up and Dear Caroline; reporting through Trust reporting structures

- Serious incident monitoring and Mortality review groups; reporting through Trust reporting structures
- Medicine Organisational Governance (MOG); reporting through Trust reporting structures.'

A fully developed action plan was approved and is being monitored through our Senior
Leadership Team in March 2011

2.3 Summary of Quality Improvement Programme 2019/20

Our Quality Priorities for 2019/20 were agreed with service users and carers at the Open Space event in January 2019 and agreed by the Board as set out in the Board Assurance Framework and agreed with commissioners.

Under Quality Priority 1 'Safe' we will:

❖ Continue to work towards our Zero Suicide ambition by
- o Further developing the system wide approach to suicide prevention
- o Continuing to invest in the environment to reduce ligature risks

❖ Further develop clinical leadership to maintain safe wards by
- o Implementing the SPAR wards accreditation framework to enhance the quality of care on in-patient wards
- o Delivering a QI program to increase compliance with Mental Capacity Act and Mental Health Act

❖ Improve physical health by
- o Introducing NEWS2 as the latest evidence based early warning systems to support the sepsis programme
- o Proactively implementing the annual Flu Vaccination programme

❖ Strengthen our approach to supporting people with Dual Diagnosis by
- o Raising the profile of the dual diagnosis policy and strategy through all directorates
- o Establishing joint case review systems between substance misuse and mental health providers
- o Developing an e-learning package to increase access to training.

Under Quality Priority 2 'Personalised' we will:

❖ Strengthen person centredness by
- o Embedding the Person Centredness Framework, including a range of person centred approaches and tools in collaboration with service users, carers and staff in particular continuing to improve care planning
- o Further embedding Trauma Informed Care across acute wards
- o Further reducing restrictive practice, in collaboration with service users and carers, through the Reducing Restrictive Practice Group

❖ Encourage involvement by
- o Identifying quality priorities for 2020/21 in partnership with the SUCC and other stakeholders
- o Continuing to work in partnership with the Service User and Carer Council (SUCC) and use service user feedback (eg. friends and family test) themes to influence the Trust's Quality Improvement agenda.

Under Quality Priority 3 'Accessible' we will:

❖ Improve access to services by
- o Achieving
  - 100% compliance for referral to assessment (1st contact) in 18 weeks in general and 4 weeks in CAMHS
  - 92% compliance for referral to treatment (2nd contact) in 18 weeks
  - 100% compliance with 3 hour assessment target for service users entering the Place of Safety
- o Developing a strategy for people with Autism
- o Developing a pathway for people with complex needs particularly Emotionally Unstable Personality Disorder
- o Continuing to work with health and social care commissioners to minimise use of out-of-area beds and reduce delays in transfers of care
- o No out of area admission to inpatient units

❖ Progress digital solutions to improve accessibility by
- o Continuing to work in collaboration with Primary Care and the University Hospital of North Midlands (UHNM) to become more accessible to patients through the use of video consultation
- o Developing the protocol to give the pa-

tient control to access their own electronic patient record (year 2 of 3) and continue our work with staff around education and on-going development of the electronic patient record system (Lorenzo)

- Further developing the use of technology through the digital exemplar to improve access to CAMHS services and be more responsive.

Under Quality Priority 4 'Recovery Focussed' we will:

Promote recovery by

Continuing to embed the Wellbeing Academy to provide people with education and learning experiences as a means of supporting personal and social recovery

- Embedding and further developing peer mentoring, volunteering and employment opportunities for people with lived experience
- Undertaking transformation of community pathways to promote person centredness, recovery and underpin integration with primary care
- Scoping impact of loneliness and PTSD on service users to inform service delivery.

2.4 Statement of Assurance from the Board

How progress will be measured and monitored:

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

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

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

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

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

Measuring clinical performance:

Clinical audit, clinical excellence and research and development all contribute to measuring effectiveness (including both clinical outcomes and patient-reported outcomes) safety and patient experience through quantitative information. This includes reporting data regarding the impact of services on patients. The clinical audit programme is developed to reflect the needs and the national priorities. Further information is contained below.

Quality governance assurance framework:

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

Litigation cases for 2018/19:

The numbers have remained fairly static for non-clinical claims received for 2018/19, there was no expenditure on non-clinical claims during the year. The Trust has been able to successfully defend claims where we have been able to provide evidence that policies and procedures have been followed. We continue to work closely with NHS Resolution to use the intelligence learnt from these cases thereby ensuring quality improvements.

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

The Trusts one ECT clinic is accredited. Three wards (1, 2 and 3 at the Harplands hospital) for working age adults are accredited. Our Memory Clinic services are accredited. Our learning disability wards, the young people's wards and older person's wards have commenced the accreditation process.

Learning lessons:

This is the 8th year that the Patient Safety Team has delivered Learning Lessons sessions and bulletins. These both provide all Trust staff with the opportunity to learn lessons from both incidents and complaints. The Learning Lessons sessions have continued to be offered on a monthly basis and are well attended by clinical and non-clinical staff. The Learning Lessons brand is now well recognised both internal and external to the Trust and has assisted in supporting the just culture agenda.

2.5 Review of services

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

During the period from 1st April 2018 to the 31st of March 2019 North Staffordshire Combined Healthcare NHS Trust provided eight NHS services. The Trust has reviewed all the data available on the quality of care in all of the NHS services provided by the trust. The income generated by the NHS services reviewed in 2018/19 represents 100% of the total income generated from the provision of the NHS services by North Staffordshire Combined Healthcare NHS Trusts for 2018/19.
The Trust's main services, as referred to above, are listed in the introductory section of this Quality Account- see 'services covered by this Quality Account'.

2.6 Participation in Clinical Audit

'Clinical audit is a quality improvement process that seeks to improve patient care and outcomes against specific criteria and the implementation of change.
Where indicated, changes are implemented at an individual team, or service level and further monitoring is used to confirm improvement in healthcare delivery. As such, clinical audit is an essential part of the quality assessment framework and a key element of clinical governance.'

During 2018/19, eight national clinical audits, one national confidential inquiry and one national review programme covered relevant health services that the trust provides.

During that period the trust participated in all (100%) of the national clinical audits, both (100%) of the national confidential inquiries / national review programmes which it was eligible to participate in, as follows:

- Prescribing Observatory for Mental Health (POMH) (4 topics)
- Learning Disabilities Mortality Review
- National Clinical Audit of Anxiety and Depression (NCAAD)
- NCAAD: Spotlight on Psychological Therapies
- National Audit of Care at the End of Life (NACEL)
- National Clinical Audit of Psychosis: EIP Spotlight Audit
- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)

The national clinical audits and national confidential inquiries that the trust participated in, and for which data collection was completed during 2018/19, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or inquiry.

Title	Number of cases required to be submitted	Number of cases submitted	Percentage of cases submitted
Assessment of the side effects of depot antipsychotics (POMH Topic 6d)	No minimum number specified	91	NA
Monitoring of patients prescribed lithium (POMH Topic 7f)	No minimum number specified	70	NA
Rapid tranquilisation (POMH Topic 16b)	No minimum number specified	5 (all those meeting inclusion criteria)	NA
Prescribing clozapine (POMH Topic 17a)	No minimum number specified	35	NA
National Clinical Audit of Anxiety and Depression	100	100	100%
NCAAD: Focus on psychological therapies	146	146	100%
National Audit of Care at the End of Life	NA - Organisational data only	NA - Organisational data only	NA
National Clinical Audit of Psychosis: EIP Spotlight Audit	All those meeting eligibility criteria (100% return)	82	100%
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)	All those meeting eligibility criteria (100% return)	N/A No eligible cases in 2018/19	N/A
Learning Disability Mortality Review	All those meeting eligibility criteria (100% return)	10	100%

The reports of four national clinical audits were reviewed in 2018/19. Actions are monitored by the Trust's Clinical Effectiveness Group:

National Clinical Audit of Psychosis

Good Practice	Key Actions
A high proportion of service users were offered / provided an intervention for smoking, where appropriate. 100% of service users were offered / provided an intervention for hazardous use of alcohol, where appropriate. 99% of service users with an F20/F25 diagnosis had a current care plan	To consider the usefulness and feasibility of implementing QRISK across the Trust To cascade flowcharts detailing physical health interventions to staff. To consider the possibility of providing information leaflets relating to antipsychotic drugs online via the Trust website. To undertake a snapshot survey of consultants to determine whether they routinely offer information to patients regarding their medicines and involve them in decision making, and where they record this.

POMH 16b: Rapid tranquilisation

Good Practice	Key Actions
▯ There was evidence of debrief taking place in 4/5 cases. ▯ Debrief had taken place within 24 hours in all applicable cases.	▯ Ward staff to be advised that the individual completing the incident form should email the ward team advising that the care plan needs to be reviewed following the ward round. ▯ Staff to be advised that incident reports relating to rapid tranquilisation where haloperidol has been used should indicate whether the patient is haloperidol naïve and, if so, whether an ECG has been undertaken recently. ▯ Data relating to haloperidol prescribing and ECGs will be included in the monthly rapid tranquilisation report, together with data relating to offer of oral medication. ▯ Other trusts will be approached via POMH-UK to determine how they are implementing and recording BARS and discussions will take place internally to agree whether local implementation is appropriate and feasible.

POMH 18a: Use of clozapine

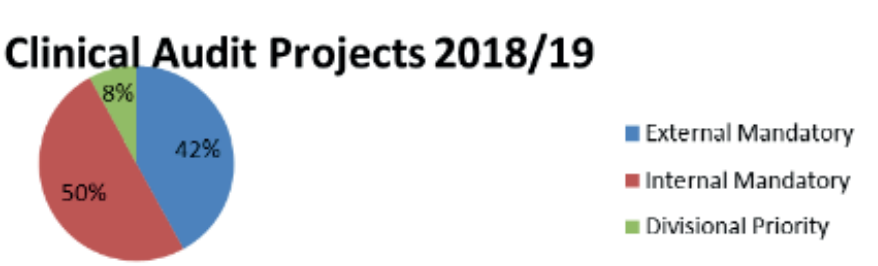
Good Practice	Key Actions
▯ Pre-Treatment screening included physical examination, with assessment of the cardiovascular system.	▯ Clinicians will be encouraged to undertake additional monitoring with the support of the Home Treatment team if the service user is not an inpatient at the time of initial prescription. ▯ When off-label prescriptions are identified by the pharmacy team they will highlight this to the prescribing consultant in order for them to complete an off-label prescribing form in accordance with Trust policy. ▯ Clinicians will be reminded of the importance of ensuring that secondary psychosis can be excluded before prescribing clozapine and that this is recorded appropriately in the electronic patient record.

National Audit of Care at the End of Life

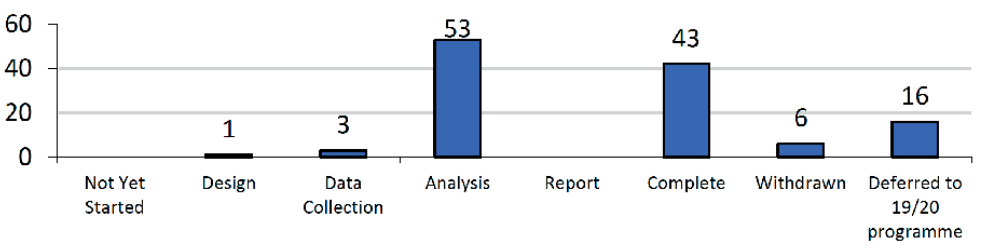
Good Practice	Key Actions
▯ All recommended policies and guidance relating to care at the end of life were in place. ▯ The trust had access to a Specialist Palliative Care Team outside of the hospital. ▯ Compliments were received by the trust in relation to end of life care in a high proportion of cases.	▯ The results of the audit will be summarised and communicated to all relevant staff and highlighted via the Senior Leadership Team.

Local clinical audit programme 2018/19

All projects on the clinical audit programme were facilitated by the Clinical Audit Team. The programme is split into four priority levels in line with national requirements/ standards, including National Institute for Health and Clinical Excellence (NICE) guidance, POMH and other national audits, and standards produced by the Royal Colleges.
The following reflects the total number of projects identified split by the four priority areas:



Of the 100 active projects undertaken by the Clinical Audit Department during 2018/19, 43 (43%) were completed. The graph below outlines project status for the 122 projects registered on the clinical audit programme for 2018/19



For all clinical audits on the formal programme of work, an action plan to improve the quality of healthcare is developed in conjunction with the project steering group. The process includes reviewing the findings and devising appropriate actions to reduce any shortfalls identified. The action plans are agreed with the audit lead and then submitted to the Clinical Effectiveness Group (chaired by the Medical

Director) for ratification. Once this process is complete, the reports are published and disseminated appropriately. Individual action plans are then entered onto the action plan-monitoring database and regular updates requested from the action 'owners' to ensure progress is being made.

The reports of 100% of completed local clinical audits were reviewed during 2018/19 with actions to further improve the quality of healthcare provided in areas of:

- Care planning
- Risk assessments
- Mental capacity act assessments
- Transitions from children's to adult's mental health services
- Tobacco and alcohol screening and interventions
- Physical health assessments and interventions
- Medicines storage and processes

Once actions have been implemented, a re-audit is undertaken to determine if the actions made have resulted in improvements to the quality of healthcare. Further details are available at https://combined.nhs.uk/about-us/quality

2.7 Participation in Research

During 2018/19 the Research and Development (R&D) team, along with our research-active clinicians, continued to contribute to national and international high-quality portfolio and commercial research. We continued to work with the Clinical Research Network West Midlands (CRN WM) supporting the High Level Objectives (HLO's) and met our obligation to report on research initiation and delivery activity to the Department of Health, via the National Institute for Health Research (NIHR).

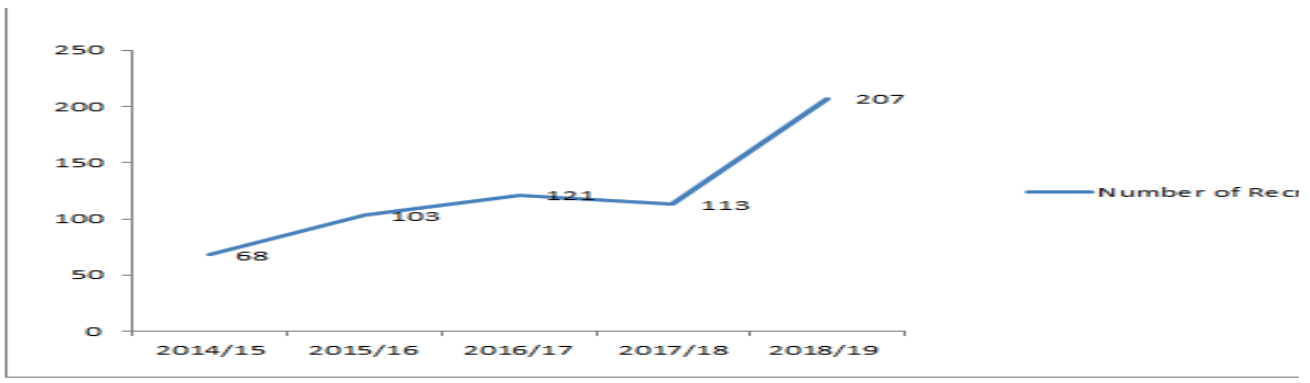
2018/19 Achievements:

- ✓ All 5 R&D objectives identified in the Trust's Board Assurance Framework (BAF) were fully achieved
- ✓ Dragons Den, co-led with the Service User and Carer Council, was re-launched with a focus on innovation and value makers
- ✓ Good practice innovations that the Trust has been shortlisted for or won have been converted into published articles
- ✓ We progressed work to increase the number of Honorary Lecturer roles for Doctors, Allied Health Professionals, Nursing and Social Work
- ✓ With input from Service Users, a 'Consent to Contact' approach was developed to aid informing service users about opportunities for participating in research.

Research Delivery

During 2018/19 research active clinicians and the R&D team worked together to recruit patients, carers and staff into 21 National Institute for Health Research (NIHR) and Commercial studies on our research portfolio, with a further educational student projects undertaken within the Trust.

The emphasis of engagement with key stakeholders saw an 83% increase in the number of participants recruited into research studies, rising from 113 in 2017/18 to 207 participants in 2018/19, the highest number of recruits in the last five years. The West Midlands Clinical Research Network has commended the Trusts efforts in helping patients participate in research.



Research Management and Governance:

Research Policy:

During 2018/19, the R&D Department continued to embed the new UK Policy Framework for Health and Social Care Research and the new EDGE research management system. The Trust were commended by the West Midlands Clinical Research Network for the high quality of their work and data submitted to the new system.

Safety Reporting: Adverse Event (AE), Serious Adverse Event (SAE), Serious Adverse Reaction (SAR) and Serious Unexpected Serious Adverse Reaction (SUSAR) are reportable to Sponsors and Regulators of research (CTIMP and Non-CTIMP studies). The Trust as a Host site for research are contracted to comply with Sponsor and Regulatory requirements. During 2018/19 there were no reported adverse events for hosted research.

Training: Legally, all Investigators involved in clinical trials are required to hold a valid Good Clinical Practice (GCP) training certificate, and refreshers should be undertaken every 24 months. During 2018/19 there were 10 active Investigators and 100% compliance with valid certification.

Innovation and Evaluation: Significant progress has been made to support Innovation across the Trust, with a number of developments and initiatives, with some due to take place in 2019/20:

- **BeAble App Development**
  In 2018/19 the Vascular Wellbeing Team and BitJam Ltd, supported by the R&D Team, began Stage 1 prototype development for the BeAble App. The BeAble concept comprises an "App on prescription", providing service users with the option of engaging collaboratively with their care, through the medium of digital technology, focussing specifically on supportive self-management. There has been positive feedback from both clinicians and service users. Stage two and three of BeAble App developments are being explored in 2019/20.

- **Innovation Nation October 2018**
  Innovation Nation was the Trust's first research and innovation conference and showcasing research, evaluation and innovation projects and practice. Supporting the Trust objective to "Encourage, implement and inspire research and innovation at all levels", this well attended by staff and key stakeholders and was considered to be a lively and forward-thinking event. Given its success, plans for a further conference for Autumn 2019 are currently underway.

2.8 Statement from the Care Quality Commission

Registration:

North Staffordshire Combined Healthcare NHS Trust is required to register with the Care Quality Commission (registration number CRT1-6179202103). The Trust is registered to carry out the following regulated activities:

- Accommodation for persons who require nursing or personal care
- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the 1983 Mental Health Act
- Diagnostic and screening procedures
- Family planning
- Maternity and Midwifery services
- Surgical procedures

At the following locations:

- Lawton House (Trust Headquarters)
- Harplands Hospital
- Darwin Centre
- Dragon Square Community Unit
- Summers View
- Florence House
- Moorcroft Medical Centre
- Moss Green Surgery

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

CQC inspection:

Following the inspection in December 2018 and January 2019, and as noted earlier in thisreport, the CQC rated the Trust as 'Outstanding'.

There have been no enforcement actions required by the Trust during 2018/19.

CQC Special Reviews and Investigations:

The CQC has not required the Trust to participate in any special reviews or investigations during 2018/19.

2.9 Statement on Data Quality

NHS Number and General Medical Practice Code Validity

The Trust submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

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

- 99.9 % for admitted patient care; and
- 100 % for outpatientcare.

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

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

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

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

Data Security and Protection Toolki

The Trust's measured their performance using the online self-assessment tool declaring compliance with the National Data Guardian's 10 data security standards.

External Clinical Coding Audit

North Staffordshire Combined Healthcare NHS Trust was subject to the annual external clinical coding audit during 2018/19 by NHS Digital approved auditors. The audit results reported in the latest published audit for that period for clinical coding (diagnosis and treatment) are:

- 92% Primary diagnosis correctly recorded (98% in 2017/18)
- 94.8% for Secondary diagnosis correctly recorded (91.3% in 2017/18)

The services reviewed in the sample were adult and older adult mental health. The Trust was commended for its high standard of coding accuracy and a high level of commitment demonstrated from the Clinical Coding Team to ensure a clinical coding provision.

Relevance of Data Quality

The availability of complete, comprehensive, accurate and timely data is an essential component in the provision of high quality mental health services and risk management. It is also required to ensure compliance with external regulatory requirements and with national and local targets, standards and contractual requirements.
Good data quality is essential to ensuring that, at all times, reliable information is available throughout the Trust to support clinical and/or managerial decisions. Poor data quality can create clinical risk, compromise effective decision making and impact on the Trust's ability to monitor standards of care and secure income for its services.
Safe and efficient patient care relies on high quality data. By taking responsibility for their clinical data, clinicians can improve its quality and help drive up standards of care.

Data Quality Metrics

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

Action to Improve Data Quality

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

Other actions include:

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

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

Data Quality Forum - Data issue management

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

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

The Forum also ensures a high standard of data quality within the clinical systems across the Trust and changes that need to be made to systems or processes to deliver improvements in data quality. The Forum also ensures that all clinical and non-clinical staff are aware of their responsibilities surrounding excellent standards of data quality through continuous communication and promotion of standards.

PART3
Review of quality performance for 2018/19 (looking back) and statement from key partners

This section is in two parts:
Section 3.1: Reviews performance and progress against the key priorities defined in last year's Quality Account.
Section 3.2: Adds to the information provided in section 3.1 and provides a summary of our performance against core quality indicators/ metrics as mandated by NHS England. Each quality indicator/metric is linked to one or more of the following three headings: patient safety, clinical effectiveness and patient experience.

3.1.1 CQUIN

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

The following table identifies the CQUIN quality improvement areas for 2018/19. Further details of the agreed goals and for the following 12-month period can be found at https://combined.nhs.uk/about-us/quality

	Safety	Effectiveness	Experience	
Staff Health and Wellbeing	✓			✓
Physical Health	✓	✓		✓
Improving Services for people who present at A&E	✓	✓		✓
Transitions from CYPMHS to AMS	✓	✓	✓	✓
Preventing Ill Health by Risky Behaviours		✓		

Staff Health and Wellbeing: Improvement of Health and Wellbeing

SPAR priority
Safe

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

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

How did we monitor and report on progress?
An action plan was developed by the working group to monitor progress in implementing initiatives across the Trust. The results of the annual Staff Survey, which is coordinated, analysed and reported on nationally, were reviewed to determine level of compliance in accordance with national requirements.

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

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

SPAR priority
Safe

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

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

also aimed to work with GP colleagues to reduce discrepancies between their patient registers and those held by the Trust, and to develop a protocol to outline physical health monitoring responsibilities across primary health care and secondary mental health services.

How did we monitor and report on progress? An improvement plan was developed by the working group to monitor progress. Quarterly reports detailing progress were shared with Commissioners, which included the results of a case note audit.

What did we achieve? As a result of this CQUIN the Trust has strengthened links with CCG and primary care colleagues and has worked to align Trust and primary care databases. Digital processes and information flows have also been reviewed over the course of the year.

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

SPAR priorities
Accessible; Personalised

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

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

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

What did we achieve? Working together, NSCHT and UHNM have been able to demonstrate a reduction in attendances by the patients supported by this CQUIN of over 30%. This is a fantastic achievement and significantly exceeded the CQUIN requirement for a 20% reduction.

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

SPAR priorities
Accessible; Personalised

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

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

How did we monitor and report on progress? Audits of case notes were undertaken which reviewed all service users who transitioned or were discharged at transition age. Surveys were produced to determine how prepared service users felt at the point of discharge / transition and whether they felt their goals had been achieved following transition.

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

Preventing Ill Health by Risky Behaviour: Alcohol and tobacco

SPAR priorities
Personalised

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

Our goal: We aimed to ensure that people who access our services are asked about their

How did we monitor and report on progress? An action plan was developed by the working group to monitor progress in implementing initiatives across the Trust. Local commissioners were provided with a quarterly report detailing progress. The Trust signed up to the national Sugar Sweetened Beverages (SSB) national data collection exercise and submitted data in relation to this on a quarterly basis.

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

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

SPAR priority
Safe

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

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

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

What did we achieve? In 2018-19, 76% of frontline clinical staff across the Trust were vaccinated against flu, contributing to patient safety.

Physical Health: Cardiometabolic assessment and treatment for people with psychoses

SPAR priority
Safe

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

Our goal: The Trust was tasked with implementing appropriate processes for assessing, documenting and acting on six cardiometabolic risk factors in 90% of a sample of inpatients, 90% of Early Intervention Team service users and 75% of a sample of community service users, who fell into the following categories (based on ICD10 codes)

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

How did we monitor and report on progress? An improvement plan was developed by the working group to monitor progress by implementing processes across the Trust.

Data relating to inpatients and community service users was submitted for central analysis by the Royal College of Psychiatrists. Data relating to EI service users was submitted as part of the National Clinical Audit of Psychosis EI Spotlight Audit for central analysis.

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

Physical Health: Collaboration with Primary Care Clinicians

SPAR priorities
Safe, Personalised

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

Our goal: In accordance with the CQUIN, we aimed to ensure that key information relating to service user's mental and physical well-being was communicated from the Trust to the service user's GP in a timely fashion. We

smoking status and alcohol intake and that where necessary they are provided with relevant advice and interventions.

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

What did we achieve? As a result of this CQUIN the Trust has continued to provide training to nursing staff so that they are aware of their responsibilities in relation to smoking cessation and alcohol interventions. Processes have been streamlined to ensure that patients are offered the support they need with smoking and alcohol consumption. This is both supported by and supportive of the Trust's move towards Smoke Free environments, which was launched on 3 April 2018. A variation of this CQUIN is being taken forward into 2019/20, which will further support a continued focus on this important topic.

3.1.2 Key Quality Priorities Achievements 2018/19

Priority: Zero Suicide Ambition
Outcome: The Trust hosted a multi-agency Suicide Prevention Conference in November 2018. This provided an opportunity for partners to sign a Suicide Charter setting out their determination to work together with an ambitious aim for nothing less than zero suicide in Staffordshire and Stoke on Trent from 2019 onwards.

Additionally we have:

- Continued to facilitate the 'living well with risk group' to embed the strategy and ensure involvement of people with lived experience.
- Received patient stories of hope in different media formats to share the recovery messages at both our Quality Committee and Board.
- Where possible we have involved family/ carers to ensure that their views are incorporated into risk management plans, highlighting any protective factors that these relationships provide.
- Developed an overarching database to develop closing the look on all lessons learnt from SI investigations
- Developed and embedded panel review methodology to improve learning from serious incidents
- Continued to invest in the environment to reduce ligature risks as per our 2016/19 plan.

Priority: Improved Physical Health Monitoring
Outcome: Continued on our Towards smoke free journey to improve the Physical Health of service users and staff. Improve Physical Health monitoring through embedding the National Early Warning Score (NEWS) for inpatient services and the Lester Tool for community services.

Additionally we have achieved the following:

- The Trust is now a smoke free organisation.
- As part of our PDSA cycle, e-cigs have been distributed and this has been closely monitored and evaluated. A vending machine was installed in October 2018 for patients and staff to use at a cost which has received positive feedback.
- A continued improvement with Flu vaccination achieving 76% uptake for patient facing staff.
- Threshold agreed with UHNM for patients transferring to Royal Stoke which has seen a reduction in transfers ensuring patients are treated in the most appropriate environment that meets their needs.
- Compliance with physical health monitoring and recording post rapid tranquilisation is monitored through monthly review of incidents and subsequent completion of physical health monitoring.

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

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

Additionally:

- Held an open Space Event in January 2019 to enable service user and carers to influence and agree our quality priorities for 2019/20 in partnership with the Service User and Carer Council who will collaborate on improvement initiatives.
- Relaunched our innovation strategy co-led with the Service User and Carer Council.
- We have used Service User feedback on Friends and Family Test (FTT) themes to help influence our quality improvement agenda.
- Launched a virtual and physical wellbeing academy to complement traditional rehabilitation approaches by providing people with education and learning experiences as a means of supporting personal and social recovery.
- Commenced introduction of a Restraint Reduction Strategy focussing on service user experience and person centred care.

Priority: Improvement in Medicines Management
Outcome: Implemented an electronic system for the daily monitoring of fridge temperatures, production of generic labels to reduce the risk of labelling issues, and improved compliance in medicine management training.

Additionally:

- In March 2019, the CQC noted in their inspection findings that medicines safety had improved on the wards for older peoples and community teams.
- Refreshed pharmacy strategy.
- Work commenced to ensure delivery of integrated working within the community teams
- Pharmacists working collaboratively with clinical leads.
- On-going monitoring of rapid tranquillisation.

Priority: Review of Models of Care and Pathways
Outcome: Continued to work with health and social care commissioners to ensure that service users are located in the most appropriate environment and reduce delays in transfers of care

Additionally:

- PICU operational from October 2018 with plans for further extension.
- Progression of the project management of major capital schemes including crisis care centre business case and crisis pathway services.
- Approval of the Lorenzo Digital Exemplar business case by the Trust Board.

Priority; Diversity and Inclusion is strengthened
Outcome: Launched the inclusion council to drive our inclusion, diversity and equalities agenda
Additionally:

- 2018-19 has been another extremely important year for the Trust in terms of advancing equality, diversity and inclusion within the organisation and beyond.
- A key area of focus for us throughout this 12 month period had been on BAME inclusion;
  However, we have also worked to progress inclusion for other equality groups, including LGBT and people with disability.
- Continued to implement the diversity and inclusion plan and Workforce Race Equality Standard (WRES), with further awareness sessions delivered with staff, Board and Leadership Academy involvement.
- Third cohort (and largest to date) of the Stepping up Programme commenced in February 2019 with participants from across our STP partners and beyond.
- Open space event in 2019 attended by service users, carers, partners and staff to provide feedback and help improve service quality and experience.
- Acknowledged by the CQC that the Trust has developed a lot of initiatives around the Workforce Race Equality Standards since their last inspection.

3.1.3 Other Quality Achievements

Quality Improvement

During 2018/19 an increasing number of staff completed Quality Improvement (QI) training and implemented projects within their teams including Patient Safety, Restraint Reduction and Access & Waiting times. Successful projects include the Ward 4 Falls Improvement Initiative shortlisted for the Health Service Journal Value Awards.

Additionally, four senior staff were supported to complete the Advanced Improvement Practitioner Programme which provided them with increased QI knowledge and skills, which is being used to support the plan for clinical teams to be equipped with quality improvement methodology knowledge and skills to take forward QI projects.

Safeguarding

The protection of our most vulnerable children and adults is a fundamental responsibility of all public agencies. The Trust is committed to ensuring that people who come into contact with our services are safeguarded from abuse in line with local and national policy. In support of this, the Safeguarding Team works with staff to support best practice and decision making around safeguarding issues. This support is delivered through a variety of mediums including training, supervision and individual case guidance. The Trust also has a suite of policies covering all areas of safeguarding. Safeguarding has been strengthened in the past 12 months by:

- Increased participation in safeguarding supervision and individual and team level across the Trust.

- The development of an adult safeguarding level 3 training package in order to enhance staff knowledge and skills in line with the latest Adult Safeguarding Intercollegiate Guidelines (2018).
- The development of a sexual safety and responding to sexual violence policy, with enhanced training provision around sexual violence delivered by a specialist service.
- Specialist domestic abuse training commissioned in order to continue to deliver enhanced awareness of domestic abuse to frontline staff.
- Membership of both the Staffordshire and Stoke on Trent Channel Panels for local authorities and the Stoke-on-Trent Prevent Board (part of the governments counter-terrorism strategy).

Infection Prevention Control (IPC)

We have continued our extensive efforts to prevent all avoidable infections and minimise the risk of resistant organisms across our Health & Social Care footprint. Additionally we have:

- Continued to implement the IPC work programme approved by Board, including the sepsis action plan.
- Had zero healthcare acquired infections in 2018/19

Service User and Carer Feedback

We view all feedback, as valuable information about how trust services and facilities are received and perceived. We continue to develop a culture that sees feedback and the learning from complaints as opportunities to improve and develop services. Therefore to improve our services we proactively gather feedback from Service Users and Carers through a number of routes including:

- Patient Advice and Liaison Service (PALS) - we recognise the importance of our PALS service in being a key source of information and feedback for the Trust and an early warning system for emerging issues and concerns.
-
- Compliments - Each year our staff receive compliments and praise from people they have cared for. We are pleased to report that compliments and

Friends and Family Test Feedback have increased from 244 in 2016/17 to 2063 in 2017/18 and 2,434 in 2018/19.

- Complaints - Overall the Trust receives a very low number of complaints compared to NHS benchmarking data. The Trust received 33 complaints for 2018/19 (43 2017/18), with continued focus on early resolution and addressing of concerns via PALS and front-line teams where possible. This year we have continued to strengthen our complaints procedure to enhance the experience of those using the service alongside ensuring timely and quality investigation and responses. We have also introduced centralised monitoring of actions arising from complaints.

- Friends and Family Test (FFT) - FFT is an important national feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. We are pleased to report a continued significant increase in FFT returns across the Trust with a high level of satisfaction; the FFT responses during 2018/19 evidence that 91% of people using our services would recommend us as a place to receive care.

Service User and Carer Council

The Chair of the Council is a member of the Board. The Council continues to meet on a monthly basis, with an active and forward looking agenda. These meetings alternate between business meeting and an educational workshop. The educational workshops are continuing with the aim of supporting the building of the knowledge and skills of the Council and increasing representation from other service users, carers and volunteers. These have been positively received with the Council identifying the educational topics, therefore meeting the development needs of the members. Furthermore the Council are developing an induction programme for all volunteers including encouragement to join the Council. We continue to seek wider involvement to support the Council, on increasing service user and carer involvement across a range of trust business and activities.

This has included building relationships with members from other faiths and communities and we also have a BAME strategy to increase inclusivity and representation across diverse communities.

Peer Mentors

- The Volunteer Peer Mentor role has been developed during 2018/19 and ten peer mentors have been recruited and have commenced their bespoke training programme. Once completed peer mentors will commence their placements. The programme will run twice a year to capture new recruits.

Supporting Carers

- In preparation for the implementation of the Triangle of Care each team or ward has identified 2 carer's links. These links have attended training and are in the process of developing team specific carer's pathways across their service in order to ensure parity for carers.

We are pleased to have received many expressions of interest from service users and carers with a willingness to be a part of the engagement agenda of the Trust.

Patient Led Assessment Care Environment (PLACE)

The PLACE programme, led by the Head of Facilities, continues to deliver excellent outcomes. Each PLACE inspection team included 50% patient representation and there was an independent validator on each assessment.

The Trust's overall score for cleanliness was 99.47% which continues to be a fantastic achievement. Our programme of work will continue during 2019/2020.

PLACE 2018	Cleanliness %	Food and Hydration			Privacy, Dignity and Well Being %	Condition, Appearance and Maintenance %	Dementia %	Disability %
		Food and Hydration %	Organisation Food %	Ward Food %				
Harplands Hospital	99.30	96.36	93.39	98.04	97.19	98.79	91.99	97.95
Dragon Square	100	N/A	N/A	N/A	93.10	97.80	N/A	92.31
A&T Unit	100	94.43	89.22	100	100	98.75	N/A	100
Darwin Centre	100	96.98	93.79	100	96.77	99.46	N/A	100
Florence House	100	95.26	91.22	100	97.22	100	N/A	100
Summers View	100	95.71	91.40	100	96.30	99.46	N/A	100
NSCHT Organisation Average score	99.47	96.26	93.08	98.47	97.07	98.90	91.99	98.28
National Average Score	**98.47**	**90.17**	**89.97**	**90.52**	**84.16**	**94.33**	**78.89**	**84.19**
National Average score per MH/LD site	**98.40**	**90.60**	**88.80**	**92.20**	**91.00**	**95.40**	**88.30**	**87.70**

3.2 Reporting against Core Indicators

The following section describes how we have performed against core indicators required by NHS England and indicators of interest to key stakeholders. The indicators are grouped in tables as per the three quality dimensions of patient safety, clinical effectiveness and patient experience.

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

3.2.1 Patient Safety Incidents

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

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

All patient safety incidents are reported on the Trust incident reporting system, they then go through a verification process before being uploaded to NRLS. This results in data altering over time, therefore the table below represents the position at year end, in relation to the number of patient safety incidents within Ulysses and the harm impact in comparison to previous years.

Area of Performance	Incidents (clinical and non-clinical)		
Impact	2016/17	2017/18	2018/19
General Incidents	4,553	4,330	5,164
Moderate	75	80	75
Major	3	9	6
Catastrophic	76	65	91
Total	4,707	4,484	5,336
*Major and Catastrophic incidents as a % of total (i.e. those resulting in harm or death)	1.7%	1.7%	1.8%

*impact on service provision/environment/person

The table above illustrates an increase in the number of incidents reported across the Trust for 2018/19. The rationale for this increase has been explored and is in relation to a number of factors. These include a small number of people with complex needs being responsible for a large number of incidents, better awareness and reporting of incidents in the community and increasing services (eg opening of additional wards). In the last 3 years there has been increased staff understanding of the need for incidents to be reported and an indication of a learning and improving culture. All incidents are subject to weekly review and analysis, in order to ensure that issues / trends are quickly identified and actions implemented enabling improved delivery of care services.

The table below relates to the number of patient safety incidents that were reported to the NRLS prior to year-end. This differs slightly from the figures above as these are only patient safety incidents and are not uploaded onto NRLS until the verification process is complete.

Area of performance	Incidents reported to the National Patient Safety Agency (NPSA)
Performance:	There were 2,527 NRLS incidents reported during 2018/19, a slight increase in the number of incidents reported from the previous year. The reasons for this increase are included above. Of these, the number of incidents resulting in severe harm or death of service users (82) as a percentage of the total was 3.2%.

Our culture of incident reporting has continued to improve during 2018/19 as demonstrated through benchmarked data from the NRLS. The latest data illustrates our higher reporting rate per 1000 beds than the national reporting median for mental health trusts. During the reporting timeframe (April 2018-September 2018) 96% of incidents reported to NRLS were either no harm or low harm incidents (72% and 24% respectively).

Never events:

A never event is a serious, largely preventable, patient safety incident that should not occur if the available preventable measures have been implemented. An example would be an inpatient suicide using curtain or shower rails. The table below details the Trust performance in 2018/19.

Area of performance	'Never events'
Performance:	One near miss – The Trust reported one near miss never event which did not result in harm. The required actions were in place to prevent the incident occurring i.e. the failure of a shower curtain rail to fall when pressure applied and therefore the Trust took action to alert the wider NHS of the potential for patient harm.

Serious incidents:

The Serious Incident framework (NHS England, 2015) definition for reportable incidents is as follows:
"Acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services".
In 2018/19 we have:

- ✓ Maintained a strong performance in respect of the timely investigation and quality of completed investigations and the approaches taken to learning from serious incident investigation.
- ✓ Monitored and identified learning and trends, reporting and sharing learning from these through Trust governance structures from 'Team to Board'
- ✓ Share learning in an open, transparent and compassionate manner with families and carers through our Being Open and Statutory Duty of Candour Policy Framework.
- ✓ Continued to raise staff awareness and embedded statutory requirements relating to patient safety through a series of initiatives which form part of the on-going programme of patient safety education
- ✓ Complied with statutory duties and monitored this through Trust governance structures.
- ✓ Shared data and reports externally through the Clinical Quality Review Meeting chaired by Commissioners.
- ✓ Been audited by the Trust auditors to assess the Trust process in terms of the management of unexpected deaths. This determined that the Board should take 'substantial assurance' that the process was robust, thorough and met the key standards in line with 'National Guidance on Learning from Deaths' (2017).

Area of performance	Serious incidents (SIs) (clinical and non-clinical)
Performance	During 2018/19 there have been 105 serious incidents reported by the Trust

Learning from incidents and strengthening our quality governance arrangements:

The Trust has taken forward the following safety improvement initiatives to improve its incident reporting and management framework:

- ✓ Continued membership of the Advancing Quality Alliance (AQuA) to strengthen the Trust's approach to Quality Improvement (QI).
- ✓ Our commitment to quality improvement has led to an increasing number of staff completed QI training and projects implemented within their teams including Patient Safety, Restraint Reduction and Access.
- ✓ Senior staff have been supported to complete the Advanced Improvement Practitioner Programme which provided them with increased QI knowledge and skills, which will be used to support clinical teams in learning quality improvement methodology and to take forward more QI projects.
- ✓ Advancement of the Learning Lessons framework. Bi-monthly bulletin and a monthly Learning Lessons workshop where staff listen to the learning outcomes of investigations and share their stories.
- ✓ Partnership working with our key stakeholders to promote good mental health and the reduction of stigma by participating in national events such as 'Brew Monday' with the Samaritans and the Parkinson's 'Get it on Time' campaign.
- ✓ All incidents continue to be subject to weekly review and analysis, in order to ensure that issues and trends are quickly identified and improvement actions implemented.
- ✓ Inclusion of Duty of Candour awareness within the Trusts' mandatory training curriculum.

Training sessions have been facilitated for senior managers to support their quality and safety roles within clinical directorates.

3.2.2 Readmission Rates

This has been a key area of work and focus particularly around embedding person centred framework including a range of person centred approaches and tools in collaboration with service users and carers. The table below details the rate of unplanned readmissions for patients (adults and older adults) within 30 days. The target for this metric is 7.5%

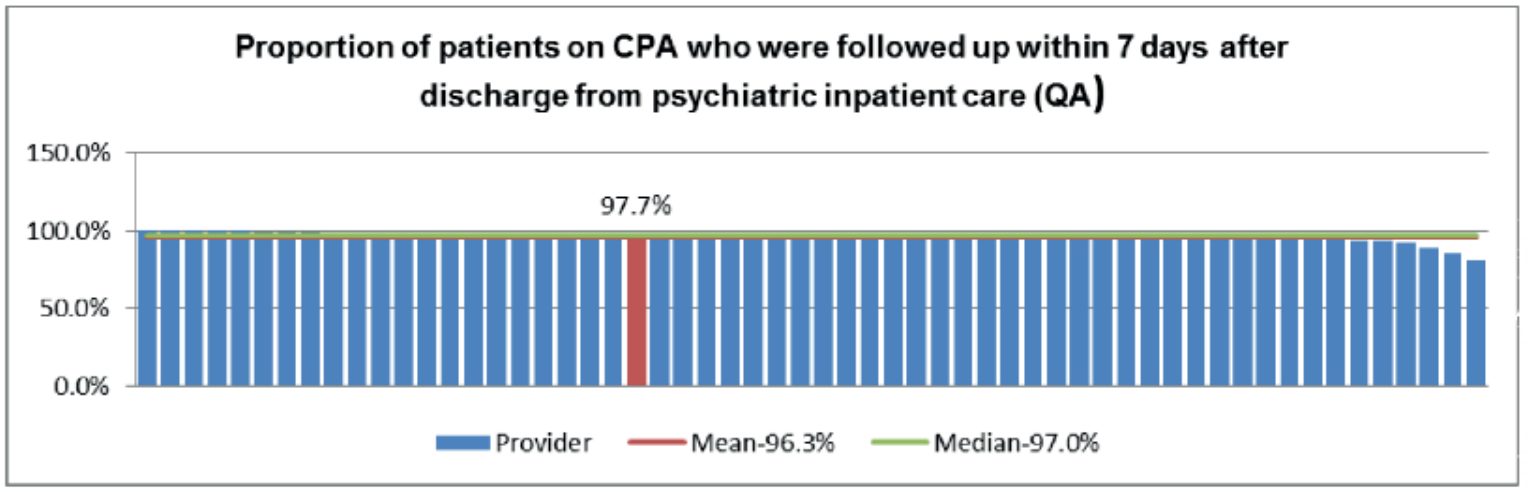
Area of performance	Patients re-admitted within 30 days of discharge
Performance:	For 2018/19 the readmission rate was 5.4% for the year against the 7.5% target. For 2017/18 this was 5.2%

3.2.3 Patients on Care Programme Approach (CPA) followed up 7 days after discharge from in-patient care

This is a key focus for the Trust and from February 2019 commenced a pilot to ensure 48 hour follow up from all adult acute wards. The standard operating procedure has been to ensure that the standard is achieved in all settings in 2019/20. Reports are provided for every patient who was not followed up within 48 hours and/or 7 days to provide further scrutiny and remedial action. The table below details the results of follow up of CPA patients within seven days of discharge against a target of 95%

Area of performance	7 day follow up of Care Programme Approach (CPA) patients
Performance:	There is strong national evidence that the period following discharge has shown to be a high risk period for service users at risk of suicide and self-harm. To mitigate these risks and provide appropriate support to service users, the Trust aims to ensure that every adult is followed up within 7 days of discharge. Our average level of performance for the year was 97.7%.

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	100.0%	96.9%	94.1%	93.1%	86.7%	97.4%	97.9%	97.4%	90.9%	95.7%	93.9%	96.1%
2018/19	100.0%	97.9%	98.7%	96.3%	96.4%	98.0%	97.1%	100.0%	96.2%	97.3%	97.1%	97.0%



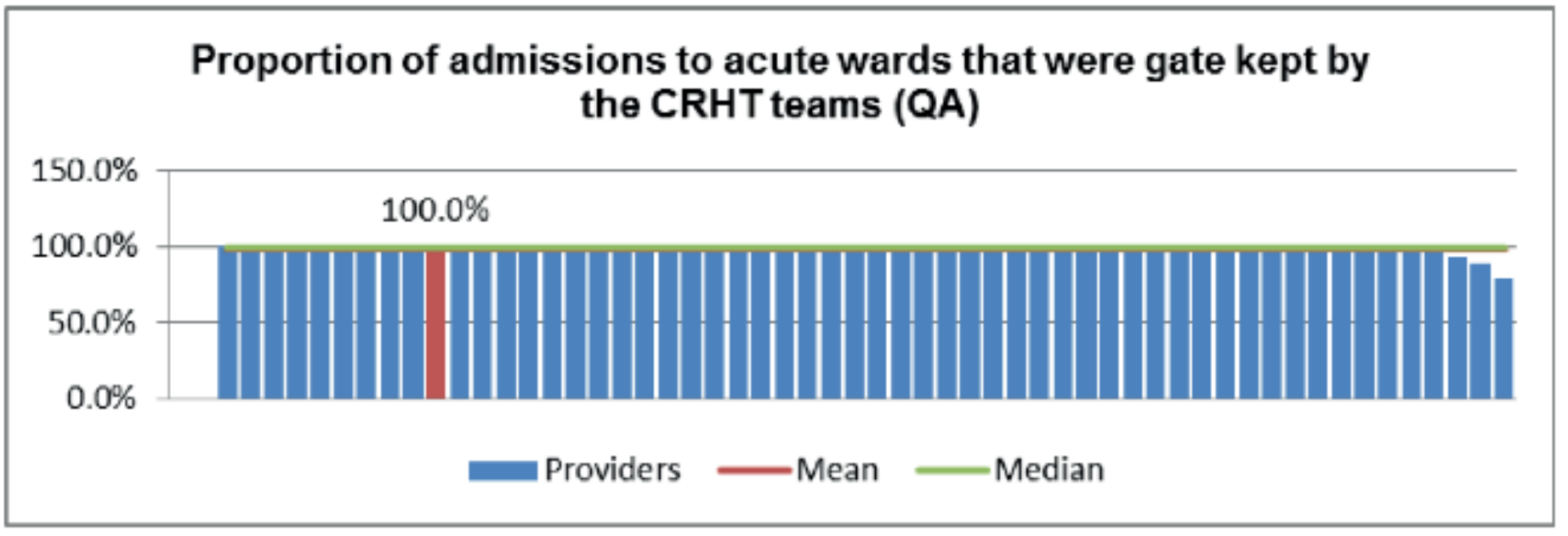
Source: NHS England

3.2.4 Admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper

The table below details the acute admissions gate kept by Crisis Resolution teams against a national target of 95%

Area of performance	Crisis resolution gate kept admissions – acute
Performance:	100% of patients admitted to acute inpatient wards were gate kept by the CRHTs at the end of 2018/19.

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	100%	100%	96.6%	100%	100%	98.9%	92.3%	97.7%	100%	100%	100%	100%
2017/18	100%	98.5%	95.9%	97.2%	97.8%	98.6%	97.5%	100%	100%	100%	100%	100%
2018/19	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100%



Source: NHS England

3.2.5 Patient Experience of Community Mental Health Services – The Annual Mental Health Community Survey 2018

The CQC use a survey to find out the experiences of people who receive care and treatment. This data has been taken from the national survey data published by the CQC November 2018.

The CQC ask people to answer questions about different aspects of their care and treatment. Based on their responses, the CQC will give an NHS Trust a score out of 10 for each question (the higher the score the better). Each NHS Trust will also receive a rating of 'about the same', 'better' or 'worse'.

Responses were received from 225 people who use our Trust services.
No questions received a worse score, in all questions the Trust performed either better or about the same in comparison to other Trusts that took part in the survey.

A summary of performance is provided against key metrics is provided below:

Area of Performance	Trust Score	How we compare
Health and Social Care - Giving enough time to discuss needs and treatment	7.0/10	About the same
- Understanding how mental health needs affect other areas of patient's life	6.8/10	About the same
Organising Care - Knowing how to contact this person if concerned about their care	9.9/10	Better
Medicine review - For those receiving medicines for 12 months or more, checks on how patients are getting on with their medicines.	7.7/10	About the same
Reviewing care - Feeling that decisions were made together by them and the person seen	7.1/10	About the same
Overall views Respect and Dignity - For feeling that they were treated with respect and dignity by NHS mental health services	8.2/10	About the same

Community Teams have action plans in place to help further improve performance over the year. In particular, the Trust has strengthened the approach to care planning, designed to evidence holistic assessment, recovery focussed care planning and service user participation. A Community Safety Matrix (CSM) Audit tool has been launched to monitor quality of face to face interactions with service users. Assurance is gained and actions agreed for improvement on a monthly basis.

PART 4
Annexe
4.1 Engagement and Statements from Key Partners

Engaging our partners and stakeholders

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

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

Development Stage

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

Agreeing priorities

We asked our Service User and Carer Council what priorities they would like to see reported in this Quality Account. In addition we have held a number of engagement meetings including dedicated 'drop in' sessions, attended events and communications from our partners to agree our key quality priorities

Sharing the draft Quality Account

In line with a Department of Health Guidance, we also produced a draft Quality Account and shared this with key partners as follows:Local commissioners, Local Health watch organisations, Local Authority Overview and Scrutiny Committees.

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

Comments from key partners

Staffordshire and Stoke on Trent Clinical Commissioning Groups (CCGS)

Staffordshire & Stoke-on-Trent Clinical Commissioning Groups (CCGs) are pleased to comment on this Quality Account 2018/2019.

The quality assurance framework that Commissioners use reviews information on quality, safety, patient experience, outcomes and performance, in line with national and local contractual requirements. The CCG Quality representatives meet with the Trust on a monthly basis to seek assurance on the quality of services provided. The CCGs work closely with the Trust and undertake continuous dialogue as issues arise, attend relevant Trust internal meetings and conduct quality visits to clinical areas to experience the clinical environment and listen to the views of patients and front line staff.

The CCGs were pleased to note the improvements made on the 2018/19 quality priorities; achievements include:

- The CCGs wish to congratulate the Trust on achieving an overall 'Outstanding' CQC rating (CQC inspection during December 2018 and January 2019) and recognise the considerable amount of work undertaken by staff at all levels to achieve this.
- In November 2018 the Trust hosted a multi-agency Suicide Prevention Conference where partners signed a Suicide Charter setting out their commitment to reducing suicides.
- The Trust actively involve family/carers to ensure that their views are incorporated into any future development and listen to feedback from the Service User and Carer Council (SUCC).
- Throughout 2018/19 the CCGs, in partnership with the Trust and Staffordshire and Stoke-on-Trent Health watch have undertaken a programme of announced quality visits which have provided 'real time' assurance on the quality of services provided by the Trust. The CCGs would like to thank staff for their continued support and open approach to these visits. The 2019/20 quality visits programme has been agreed with the Trust.
- The CCGs welcomed the opening of the new purpose built Psychiatric Intensive Care Unit in October 2018.
- It is pleasing that the Trust is continuing to participate in the Advancing Quality Alliance programme (AQuA) as part of their everyday business.
- The appointment of a Restraint Reduction Lead to progress the implementation of the Trusts Restraint Reduction Strategy is a positive move towards reducing the number of restraints used.
- The Trust has continued to participate in the delivery of the five national CQUIN schemes throughout the year and have provided reports detailing the successes and the substantial improvements made for service users as a result of these schemes.

2018/19 has not been without its challenges and we look forward to further improvements in respect of:

- Recruitment and retention continues to be a major priority for the Trust due to a national workforce shortage, Nursing and Medical recruitment remains an ongoing challenge.
- The CCGs actively support the collaboration between the Trust and other stakeholders to reduce death by suicide as part of the Zero Suicide ambition and as part of the Suicide Awareness Strategy for Staffordshire and Stoke on Trent.
- The CCGs recognises the ongoing work to embed the new Organisational structure and will continue to monitor through quality assurance processes.

The CCGs are pleased to see the Trusts ongoing commitment to provide the highest quality mental health services through their four on-going priorities, known as SPAR.
Commissioners are pleased that the Trust continues to be an active partner within the Staffordshire Sustainability and Transformation Partnership. Overall the CCGs recognise that significant improvements in quality and safety have been seen at the Trust during a challenging period locally but also in the wider NHS. We look forward to working together with the Trust to ensure continued improvement over the coming year.
The CCGs wish to state that to the best of their knowledge, the data and information contained within the quality account is accurate

Heather Johnstone Marcus Warnes
Director of Nursing and Quality Accountable Officer
Staffordshire CCGS Staffordshire CCGs

Healthwatch Stoke-On-Trent

Healthwatch Stoke-on-Trent congratulates the Trust on being awarded an overall Outstanding rating and achieving Outstanding in Caring and Responsive domains as well as being rated Good in Safe, Effective and Well led domains from their recent CQC inspection.
Healthwatch Stoke-on-Trent Mental Health Group also congratulates the Trust in the progress they have made in a number of services over the last 12 months and the new developments they have implemented in particular the no smoking policy implemented across the Trust and the development of the PICU Unit in difficult times for the NHS.
The Trust came to present their Draft Quality Account at our Mental Health Group meeting on 15th May 2019 and asked our opinions on the content and readability of the document and we are pleased that they have incorporated these into the second draft.
We do still have some concerns around care planning and although the Trust have made progress over the last 12 months there is still more work to be done and we requested that this is identified clearly in the Quality Accounts. We are pleased to see that this has been done in their summary of Quality improvement programme 2019/20 under Quality priority 2 'personalised'.
The Trust have been very supportive in the work of our Mental Health Group over the last 12 months providing information we have needed to do our work.
We look forward to their continued support in the work the Mental Health Group will be doing in the coming 12 months around Adult Community Mental Health Services.

Healthwatch Staffordshire

The report is very well laid out, easy to read and understand which is helpful in terms of the public being able to read and understand it. It reflects well the work that has taken place to enable the organisation to achieve an 'outstanding' CQC rating and the pride in the work that has been done shines through in the report. Clearly a great deal of progress has been made in the past 12 months but it is encouraging to note that the trust has robust plans to improve even further.
it is good to see that the trust continues to strive for improvement in the quality of the service based on locality working and particularly the level of commitment to partnership working with other local providers including the 3rd sector to offer a holistic service to the population of North Staffordshire.
The report demonstrates staff are involved in the development of the new locality structure and are also central to the improvement plans put in place by the trust and that both staff and service users are active in the co-production of various improvement plans.
The report provides a clear framework for the organisation to work towards achieving improvement in all aspects of the service. There is a lot of mention in the report about co-production with service users carers and staff and this engagement is weaved throughout the report.
It is mentioned in the report that the repatriation team has delivered £2million in savings by the better management and repatriation of people with complex needs back into the county, it would be useful to know how many residents were returned to county in the past 12 months and how many new placements have been made outside of county due to lack of appropriate services within county

It would also have been interesting to have details on numbers relating to 'The high volume users team' which has been instrumental in reducing the number of visits to ED's. The detail would really highlight the improvements made
It is really pleasing to see that the trust has received an outstanding rating from CQC and the improvement over a 4 year period is very heartening to see. The commitment to continuous improvement is heartening and knowing the trust is not planning to become complacent and not see room for further improvement.
The Health and Wellbeing service offered to staff indicates a trust that values its staff and this in turn is clearly having a positive impact upon the delivery of the service and most certainly is reflected in your staff survey figures which clearly indicate the impact of the services in place for staff. It would be interesting to know what the staff turnover rates are and whether these initiatives have resulted in a lower than average national staff turnover?
Accepting that there is an increase in reporting of incidents/ never events. It would have been good to know what the catastrophic incidents were and what learning came from these. Increased reporting is good but what is being done to reduce the number of incidents?
You also mention the work done on reducing suicide rates but I could not gauge whether you had met your target for reducing suicides to zero as this was not clear but if met is certainly something to 'shout about.'
Overall this is a clear and concise report of what the trust has done to achieve such a good improvement all round and a clear plan for continuous improvement over the next 12 months.
I look forward to reading of the further improvements that will ensure the trust retains its 'outstanding' rating for the foreseeable future.

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

The Adult and Neighbourhoods Overview and Scrutiny Committee have asked the Trust to record the following in the Quality Account.
Unfortunately due to the timing of the 2019 Local Elections and the election of new Councillors and committee it has not been possible on this occasion to comment on the Trust's Quality Account.

Staffordshire Council Health Scrutiny Committee

We are directed to consider whether a Trust's Quality Account is representative and gives comprehensive coverage of their services and whether we believe that there are significant omissions or issues of concern.

There are some sections of information that the Trust must include and some sections where they can choose what to include, which is expected to be locally determined and produced through engagement with stakeholders.

We focused on what we might expect to see in the Quality Account, based on the guidance that Trusts are given and what we have learned about the Trust's services through health scrutiny activity in the last year.

We also considered how clearly the Trust's draft Account explains for a public audience (with evidence and examples) what they are doing well, where improvement is needed and what will be the priorities for the coming year.

Our approach has been to review the Trust's draft Account and make comments for them to consider in finalising the publication. Our comments are as follows:

Introduction, the Vision and key achievements are well articulated, and the explanation of the Quality Account process is present. A list of services provided by the Trust is included. The statement from the Board is signed by both the Chair and CEO.

Priorities, we note how and why they were chosen. The means intended to monitor, measure and report to board level is described. The CQC report is well presented. However, the priorities for 2019/20 don't seem to address issues raised in the CQC report. We would have liked to see a clear link between the two.

Statements of Assurance, Evidence of participation in local and national clinical audits and subsequent outcomes are explained. The importance research is acknowledged and there is detail of research undertaken reasons and subsequent results. We are of the opinion that more statistical information would be useful.

Registration with the CQC is present in the report.

Review of quality performance, CQUIN income, it is noted that the 2.5% of potential income was conditional to on achieving quality improvement and innovation goals agreed with the Commissioners through the CQUIN Framework. The achievements on 2018/19 priorities are noted but some statistical

information would make the information more useful. We are not clear that what has been achieved is what the Trust was contracted to achieve through the CQUIN.

We are pleased to note that each of the quality/metric indicators is linked or more of the three headings of Patient Safety, Clinical Effectiveness and Patient experience. An explanation of how, by whom and the rational for choice of the indicators is present. Some comparison to national indicators and definitions of some terms used, for example under patient safety incidents - “catastrophic” would have been helpful.

Information is present in relation to specific services and what the patients and public have to say about them.

Indicators and evidence in respect complaints, staff and patient surveys, inspection and benchmarking together with detail of performance against national priorities is available to the reader.

We again commend the Trust for the commitment to provide communication and support for service users and carers whose first language is not English and to those who need other formats. A glossary of terms is also present.

4.2 Amendments made to initial draft Quality Account following feedback from Stakeholders

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

You said:

We note how and why priorities were chosen. The CQC report is well presented however, the priorities for 2019/20 do not seem to address issues raised in the CQC report. We would like to see a clear link between the two.

Our response:

Our Open Space Event in January 2019 brought together service users and carers to help shape our 2019/20 priorities. The CQC published their Inspection report on the 28 March 2019. We have linked the two, the focus of which is to continue our journey to a more improvement led organisation. The Quality Account sets out how we will do this by engaging our partners and stakeholders alongside strengthening our quality planning and governance arrangements.

You said:

CQUIN income, we are not clear what has been achieved is what the Trust was contracted to achieve through CQUIN.

Our response:

In previous years we have included a table detailing the % of CQUIN achieved. CQUIN is being presented differently this year in part because of the total number of metrics measured and how payment is calculated throughout the course of the year. Once CQUIN performance against agreed goals has been finalised a table will be uploaded on to the Trust's website at https://combined.nhs.uk/about-us/quality

You said:

The importance of research is acknowledged and there is detail of research undertaken, reasons and subsequent results. We are of the opinion that more statistical information would be useful.

Our response:

Our report highlights that the Trust has achieved its highest number of recruits in the last 5 years, including statistical details of training provided. We have taken the opportunity to strengthen the data further.

You said:

We are pleased that each of the quality / metric indicators is linked to the three headings of Patient Safety, Clinical Effectiveness and Patient Experience. Some comparison to national indicators and definitions of some terms used would have been helpful.

Our response:

The report highlights that we have a higher reporting rate than the national reporting median for mental health trusts. While the terminology used in the Quality Account is the terminology used by the National Reporting and Learning System (NRLS), we have taken the opportunity to further explain some of the terminology used.

Y
ou said:
We do still have some concerns about care planning and although the Trust have made progress over the last 12 months there is still more work to be done and we requested that this is identified clearly in the

Quality Accounts. We are pleased to see that this has been done their summary of Quality Improvement Programme 2019/20 under Quality priority 2 'personalised'.

Our Response:
Our Quality Improvement Programme 2019/20 highlights that we will continue to improve care planning by embedding the Person Centredness Framework.

You said:

It would be useful to know more detail about the repatriation team regarding how many patients were returned to county and how many new placements made outside of the county in the last 12 months. It would also be interesting to have details on the High Volume User's Team' which has been instrumental in reducing visits to Emergency Departments.

Our Response:

The data with commissioners is that 13 patients have been repatriated during 2018/19. The data regarding the small number of outside placements will be formally reported when confirmed with commissioners. We are receiving positive feedback from the Emergency Departments regarding our High Volume User's Team. We are collaborating with UHNM to develop our data sharing processes which will enable us to articulate this information in more detail.

You Said:

It would be interesting to know what the staff turnover rates are and whether these initiatives have resulted in a lower than average national staff turnover

Our Response:

National turnover rates for MH & LD Trusts for 2018 is 12.56%, the Trust's rate for 2017/18 is 12.60%. National figures for 2019 have not yet been released. We are aiming for improvement following initiatives such as the Health and Wellbeing Service.
Good to know more detail regarding catastrophic incidents and learning including what is being done to reduce the number of incidents.

Our response:

While the terminology used in the Quality Account is the terminology used by the National Reporting and Learning System (NRLS), we have taken the opportunity to further explain some of the terminology used. Under the section serious incidents safety learning initiatives are highlighted including learning from incidents.

You Said:

Has the Trust met its target for reducing suicides to zero?

Our response:

The Quality Account set outs how we are working with partners across Staffordshire and Stoke on Trent with regards to suicide prevention. Under key achievements we highlighted that we hosted a multi-agency Suicide Prevention Conference in November 2018. This provided the opportunity for the partners across the area to sign a Suicide Charter setting out a commitment to work together with an ambitious aim for less than zero suicide from 2019 onwards. Under the Section Quality Improvement Programme 2019/20 we have set out our commitment to continue working towards the zero suicide ambition by further developing the system wide approach to suicide prevention.

4.3 Auditor Statement of Assurance

To be added.

4.4 Trust Statement

We are pleased to publish this quality account for the financial year 2018/19, 1 April 2018 to 31 March 2019.
It re-confirms our commitment to continually drive improvements in services and to remain transparent and accountable to the general public, patients, commissioners, key stake holders and those that regulate our services.
To ensure our Quality Account covers the priority areas important to local people we have consulted with our key stakeholders in the voluntary and statutory sectors, with local authorities and with our staff.
Their valuable comments have been listened to and, where appropriate, have been incorporated into this document to help strengthen involvement in our services going forwards.
In line with the recommendation of the Francis inquiry, this Quality Account is signed by all Trust Board members to provide assurance that this is a true and accurate account of the quality of services provided by North Staffordshire Combined Healthcare NHS trust.
We can confirm that we have seen the Quality Account, that we are happy with the accuracy of the data reported, are aware of the quality of the NHS services provided and understand where the trust needs to improve the services it delivers.

Table of signatories to be added.

4.4.1 Statement of Director's Responsibilities in respect of the Quality Account

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

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

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

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

David and Peter signatures to be included

David Rogers — Peter Axon

Chair — Chief Executive

4.5 Glossary

AIMS- Accreditation for inpatient rehabilitation units.
ASD- Autistic spectrum disorder
ADHD- Attention deficit hyperactivity disorder
ASIST- Advocacy services in Staffordshire
CAMHS- Child & Adolescent mental health services
CCG- Clinical commissioning group (made up of local GPs, these groups replaced primary care Trusts (PCTs) as commissioners of NHS services from 2013/14)
CLRN- Comprehensive local research network
CPA- Care programme approach
CPD- Continuing professional development
CPN- Community Psychiatric nurse
CQC- Care quality commission
CQUIN – Commissioning for Quality and Innovation
DOH- Department of health
ECT- Electroconvulsive therapy
EngAGE- Stoke-on-Trent forum for people over 50 to give their views
Health watch- Local independent consumer champions, represents the views of the public.
HRG4- Health resource group (standard groupings of clinically similar treatments)
IAPT- Improving access to psychological therapies team
IM&T- information management and technology
IT- information technology
KPI- key performance indicator
Metric- method of calculating performance
Mind- Mental health charity network
MRSA- Methicillin-resistant staphylococcus Aureus
NDTI- National Development team for inclusion
NEWS – National Early Warning Score
NHSLA - NHS Litigation Authority
NICE - National Institute for health and clinical excellence
NIHR - National institute for health research
NPSA - National patient safety agency
NSCHT- North Staffordshire Combined Health Care NHS Trust
PALS- Patient advice and liaison service
PBR- Payments by results
PIP- Productivity improvement pathway programme.
POMH- Prescribing Observatory for mental health
QIPPP- Quality, innovation, productivity, partnership and prevention.
LPS - Liaison Psychiatry Service
R&D- Research and development
REACH - Local advocacy project supporting people with learning disabilities
RETHINK- Mental health membership charity
SPA - Single point of access (to mental health services)
STOMP - Stopping Over Medication of People
STP – Staffordshire Transformation Programme
SUS- Secondary user's service
TDA - Trust development Authority

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

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

Enclosure No:

Date of Meeting:	11th July 2019		
Title of Report:	Serious Incidents Annual Report 2018-2019		
Presented by:	Dr O Adeyemo. Executive Medical Director		
Author:	Jackie Wilshaw. Head of Patient and Organisational Safety		
Executive Lead Name:	Dr O Adeyemo. Executive Medical Director	Approved by Exec	☐

Executive Summary:		Purpose of report	
The purpose of this report is to provide an overview and analysis of all Serious Incidents that have been reported and investigated by the Trust during the timeframe April 2018 to March 2019.		Approval	☐
		Information	☐
		Discussion	☐
		Assurance	☐
Seen at:	SLT √☒ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☒√ • Finance & Performance Committee ☐ • Audit Committee ☐ • People, Culture & Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Primary Care Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration.☐ 2. To provide the highest quality, safe and effective services ☐√ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☐√ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. ☐√ 7. Take a lead role in partnership working and integration. ☐		
Risk / legal implications: Risk Register Reference	Nil		
Resource Implications: Funding Source:	Nil		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	All issues related to D&I are considered for each individual investigation		
STP Alignment / Implications:	Alignment with the suicide prevention agenda		
Recommendations:	To be read by the Trust Board. To continue with the current governance process.		
Version	Name/group	Date issued	

1. Purpose of the report

This report provides assurance to the Quality Committee of the Trust processes relating to Serious Incidents (SIs). The report covers the period from 1st April 2018 to 31st March 2019 and details the following:

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

2. Serious Incidents 2018/19

Serious Incident investigations are undertaken following incidents involving people in receipt of services or who have been in receipt of services in the previous 12 months. This does not include those service users whose deaths are determined by HM Coroner to be as a result of natural causes. For comparison purposes, the table below illustrates the total number of SIs reported by quarter for the last two years, April 2017 to March 2019.

Table 1.

StEIS Incident category	Q1	Q2	Q3	Q4	Total 2017/18	Q1	Q2	Q3	Q4	Total 2018/19
Apparent/actual abuse	0	1	2	2	5	2	0	0	1	3
Unexpected potentially avoidable injury causing serious harm: this is subdivided as shown below										
Apparent/actual/suspected self-harm criteria meeting SI criteria	1	0	2	2	5	2	2	3	2	9
Slip, trip, fall	2	6	3	3	14	1	6	1	2	10
Unexpected/Potentially avoidable injury causing serious harm	0	0	0	0	0	3**	0	0	0	3
Disruptive, aggressive behaviour meeting SI criteria	0	0	0	0	0	1	1	1	0	3
Unexpected/Potentially avoidable serious assault	0	0	0	0	0	0	0	1	0	1
Under 18 admission	0	0	0	0	0	0	0	1	0	1
Incident demonstrating existing risk	0	0	0	0	0	0	0	1	0	1
Unexpected potentially avoidable death: This is subdivided as shown below										
Pending review	4	10	8	11	33	5	13	8	20	46
Apparent/actual/suspected self-harm criteria meeting SI criteria (suspected suicide)	3	6	2	5	16	10	3	4	11	28
Total	10	23	17	23	73	24	25	20	36	105

**one incident was reported on to StEIS which was not an exact category match but which was believed to meet the criteria for a SI review.

The annual figures are updated to reflect incidents that are downgraded from the SI process and thereby removed from StEIS post incident reporting.

In 2018/19, a total of 114 incidents were reported onto the national database StEIS (Strategic Executive Information System). However after discussions with our commissioners, 9 incidents were downgraded: 8 of the SIs were downgraded due to being natural cause deaths and therefore investigated as part of the Trust mortality surveillance process and 1 incident was downgraded as the death occurred as a non-mental health related accident.

The reporting period 2018/19 shows an increase of 31% in SIs in comparison to 2017/18. Quarter 4 showed the biggest increase in SIs reported with an increase of 37% on quarter 4 in 2017/18. This is examined further in the main body of the report.

3. SI Breakdown by Category

3.1 SI's relating to deaths

During 2018/19 there were 74 deaths reported in the primary category of unexpected/potentially avoidable death. In comparison, there were 49 deaths reported in the category in 2017/18. This is an increase of 38% within this reporting timeframe. The incidents of unexpected/potentially avoidable death are then divided into two further subcategories of which there were 46 deaths in the subcategory of 'pending review' and 28 deaths in the subcategory 'apparent/ actual/ self-inflicted harm meeting SI criteria'.

The category showing the largest increase was that of 'pending review', this category is used when the circumstance around the death do not immediately give rise to a reasonable suspicion of death by suicide. The majority of deaths reported in this category relate to the deaths of people known to substance misuse services. As a result of the increase in deaths in the Substance Misuse service, the Medical Director has commissioned a review of the deaths..

Suicide prevention remains at the forefront of the Trust agenda and is one of the five priority areas for the Staffordshire and Stoke-on-Trent STP partnership. In the previous reporting period (2017/18), there was a 33% reduction in the number of deaths where suicide was suspected however there has been an increase of 43% in the number of suspected deaths by suicide in 2018/19. These deaths do not relate to any specific area or team although, as can be expected, the areas of highest reporting are the adult community teams.

The Trust has continued to implement and develop our suicide prevention strategy. The suicide prevention action plan is regularly reviewed and updated, through the internal Trust Suicide Prevention Group, as actions are completed and new actions are added. In addition to the Suicide Awareness training developed by the Trust in 2017/18, we have introduced Suicide Prevention training for staff in the form of the 'Connecting with People' model during 2018/19. In 2019/20, this will be complemented by a follow up course in suicide response training for up to 8 Trust staff. This will utilise a 'train the trainer' approach therefore developing trust staff as cascade trainers and increasing the training provision accordingly. In November 2018, the Trust produced and delivered a national suicide prevention conference in conjunction with our partner agencies across Stoke-on-Trent and Staffordshire. The event was oversubscribed and applauded as a great success by all those who attended. During the day, the Trust and our partners signed a charter, pledging to introduce a zero suicide ambition across the region. As a result of the success of the conference the Trust and our partners were invited to be part of a bid for additional funding for raising awareness around suicide prevention. The outcome of this 'Wave 2' bid is still unknown at the time of this report. The Trust is also participating in a national zero suicide ambition programme for mental health inpatient areas led by NHS England. Whilst much of the environmental work recommended by the national programme has already been completed, or is the process of completion, the Trust does have areas for action. For example, a 2 day face-to-face follow-up appointment post discharge from the adult wards has been implemented and the next action is the review of risk assessments and care plans, specifically relating to ward leave, with a view to strengthening these.

As previously stated the Trust continues to work in partnership across the local health and social care economy. The Trust representatives contribute to the Staffordshire and Stoke-on-Trent Suicide Prevention group and action plan where the aim is to reduce suicides across the whole of the county. The latest Public Health Data (2015-17) is shown below and demonstrates an improvement in the suicide rates with Stoke-on-Trent showing fewer deaths by suicide. However it must be noted that it is not possible to separate data for Staffordshire into North and South Staffs.

2015-17	Suicide rate per 100,000
Stoke-on-Trent	9.1
Staffordshire (North and South)	9.7
West Midlands	9.5
England	9.6

3.2 Slips, trips and falls

The number of serious incidents as result of patient slip, trips and falls reduced by 29% in 2018/19. As in previous reports, the majority of falls were reported from the Older Person's wards. Ward 4 remains the ward with the highest number of falls with the most significant harm (6 fractures). The continued implementation of falls reduction quality improvement (QI) initiatives have resulted in an overall reduction of falls on Ward 4 and across other wards. The reduction in Ward 4 falls was achieved following numerous PDSA cycles (Plan-Do-Study-Act) and therefore the greatest impact was seen towards the end of the year. The sharing of the learning from this QI project had immediate impact when Ward 7 experienced an increase in falls and rapidly implemented the learning from the project. The number of no harm and no harm falls reported reduced as well as the number of falls which met the SI criteria during 2018/19. In addition to a reduction in the number of overall falls, the SI investigations showed that the completion of the falls risk assessment and the multifactorial risk assessment had improved and care plans were in place to mitigate against the risk of falls.

3.3 Apparent/actual abuse

The category of apparent/actual abuse was used by the Trust for the first time in 2017/18, when 5 incidents were reported under this category. This category was used to record instances where the Mental Health Act process was incorrectly implemented resulting in a person being illegally detained in hospital. There has been an improvement in 2018/19 with a reduction to 2 incidents in this category, which also related to admissions involving the Mental Health Act. The incidents related to LD in-patient services. One incident occurred after a miscommunication among staff lead to a person being prematurely admitted to the unit before the documentation had been completed. This investigation is currently ongoing, however the early learning regarding the miscommunication has been shared with the staff. The other incident related to the use of an adult LD bed for a 17 year old. The care team were unable to locate a tier 4 specialist CAMHS LD bed for the young person and the use of the Darwin Centre was considered to be inappropriate to meet his needs. Therefore after discussion it was felt to be in the best interests of the person to admit into an adult LD bed, with considerations for age appropriate needs.

3.4 Violence and Aggression

The Trust analysis of reports relating to violence and aggression are reviewed within the bimonthly Learning from Experience report. The category of violence and aggression is the highest reported category of incidents however due to the skilled interventions of staff, these are typically no harm or low harm incidents. It is noted that during this reporting timeframe there has been an increase in the number of incidents SIs which relate to violence and aggression towards others. These incidents are those where the

level of harm sustained by individuals is rated as moderate or above. It is noted that these incidents are distributed between inpatient and community patients with no common factors identified during the investigation processes.

3.5 Under 18 admissions to adult wards

The admission of people under the age of 18 years do not always require full SIs investigations. Investigations are commissioned following the initial review process, in cases where the admission of the person is considered inappropriate, a SI investigation will commence. During this reporting timeframe, there have been 2 cases where the age of the individual could either not be verified (and it was suspected that the person was older than 18 years) or was verified by the Home Office to be over 18 prior to admission to an adult ward.

The initial investigations are required to consider whether the placement was reviewed and determined to be appropriate prior to admission i.e. whether the person and their clinical presentation/behaviour could be managed within CAMH services and also to take into account the actual age of the person. A discussion with the Trust commissioners is then held in order that a decision to complete a full SI investigation is explored and agreed by the Trust and our commissioner colleagues.

4. SI Breakdown by Team

Tables 2-4 below illustrate Serious Incidents by location/team for the period April 2018 to March 2019. The tables show incidents in the inpatient areas, the community teams and in substance misuse services. Where the names of two teams are listed, the team listed first were the lead area for investigation purposes.

Table 2: Inpatient teams

Area	Number
Ward 1	1
Ward 2	3
Ward 2/CDAS	1
Ward 2/HTT	1
Ward 3	2
Ward 4	7
Ward 5	1
Ward 7	2
PICU Harplands Hospital	1
Assessment & Treatment	2
Darwin Centre	2
Darwin Centre/Ward 1	1
Florence House	1
Total	**25**

Table 3: Community Teams

Area/Team	Number

Access Team	1
Acute Home Treatment	4
Ashcombe Centre	2
CAMHS Blurton	1
CJMHT/HVU	1
CJMHT/CDAS	1
Early Intervention	2
ECT Suite	1
Greenfield Centre	6
Healthy Minds	1
Lymebrook	5
Lymebrook/One Recovery	1
MH Liaison Team	2
MH Liaison Team/IAPT NS	1
Neuropsychiatry com	1
NS Memory Clinic	1
Parent & Baby Unit	1
Recovery & Resettlement	2
Sutherland Centre	10
Sutherland Centre/CDAS	1
Total	**45**

Table 4: Substance Misuse Services

Area/Team	**Number**
One Recovery (Burton)	5
One Recovery (Leek)	5
One Recovery (Newcastle)	5
One Recovery (Stafford)	5
One Recovery/EI team	1
One Recovery/Greenfield	1
One Recovery/Lymebrook	2
CDAS	8
CDAS/Greenfield Centre	1
CDAS/HV Users	1
CDAS/Sutherland Centre	1
Total	**35**

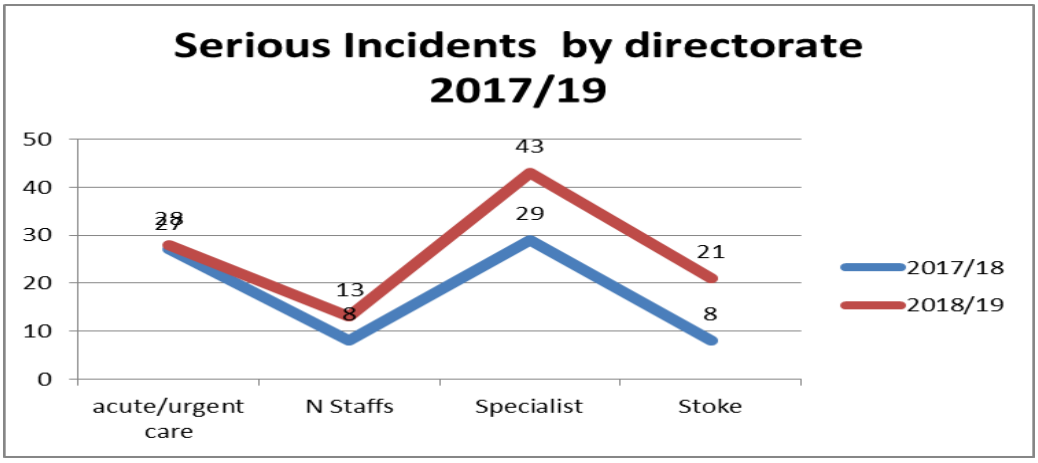
In total there were 13 SI incidents involving clients from Stoke Community Drug and Alcohol services (CDAS). This is composed of 11 deaths reported by CDAS and 2 incidents which were jointly owned by mental health and substance misuse services. This is an increase on the previous reporting period but a comparison of the number of incidents reported is not possible as the previously reported figure was not a full year figure as this service did not commence until June 2017.

There were 25 incidents related to clients known the Staffordshire One Recovery Service. This includes one incident jointly owned with mental health services. There were 13 deaths reported in 2016/17 and 14

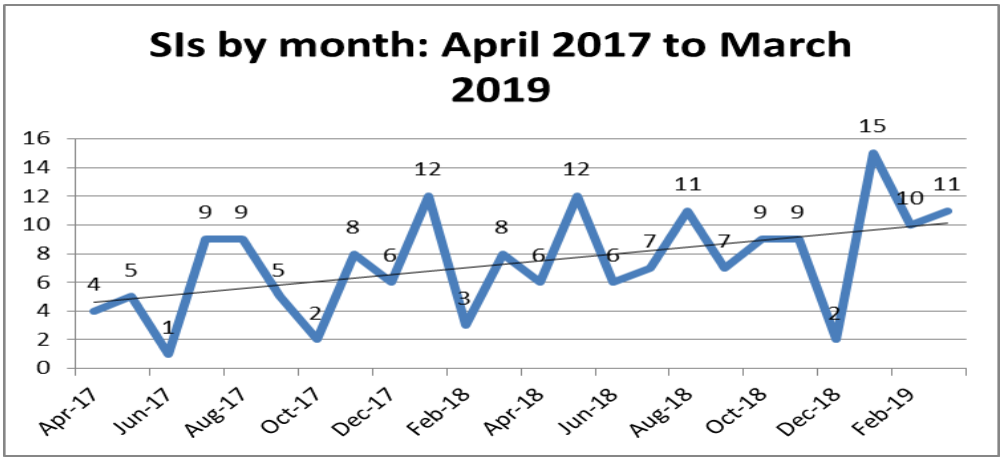
deaths reported in 2017/18. Therefore this is a 40% increase on the number of incidents reported in the previous years. The rationale for this increase is not yet known although the impact of reductions in commissioned services must be of future consideration. The Substance Misuse teams are currently engaged in a review of the SIs reported in 2018/19, the results of which will be discussed at the service away day in June 2019.

4.1 SI Trends by Directorate

Following the restructure of the Trust directorates in October 2018, the serious incidents for the reporting period April 2017 to March 2019 have been reallocated to the new structure for comparison purposes. The graphs demonstrate the increase in incidents across all directorates. The figures for the Specialist Directorate reflect the increase in incidents reported by Substance Misuse Services. In 2017/18, 22 SIs were reported in Substance Misuse Services compared with2018/19, where 35 Serious Incidents were reported and investigated.



The graph below shows SIs per quarter for the period April 2017 to March 2019 with the trend line showing an increasing trend line. This is due to an increase in SIs across all areas in 2018/19 which cannot be explained by the introduction of new services i.e. PICU or the full year effect of CDAS being operational.



5. SI Investigations

Following the occurrence of any SI, the Trust commissions and implements an investigation into the incident. In these cases the Trust uses staff trained in Root, Cause, Analysis (RCA) methodology to investigate. Investigations will follow one of the 3 methods outlined in the sections below.

5.1 Standard SI investigation

Each SI is allocated one Investigating Officer (IO). Investigating Officers are allocated from outside of the directorate in which the incident occurred in order to ensure transparency and impartiality towards the investigations. In 2018-19, 103 of the SI investigations followed this methodology.

5.2 Review Panel Investigation

In recognition of need to learn from incidents, Medical Director introduced Panel review methodology particularly following feedback from staff regarding their experience of the traditional route cause analysis approach. The one-on-one interview process can be very intimidating to staff who may already be distressed at the circumstances of a Serious Incident. The panel review is based on the 'Just Culture' approach of Sydney Decker, whereby a multidisciplinary panel of staff is utilised to investigate those incidents which are considered to be of increased sensitivity for staff. During 2018/19 there have been 2 Serious Incidents where the Review Panel methodology has been used to facilitate investigations. These related to the death of a young person who was receiving care from community Child and Adolescent Mental Health Services and the death of an adult within acute in-patient services.

These investigations may or may not include the input of an external investigator, depending upon the complexity of the incident and following discussion between the Trust and our commissioners. There are currently 2 investigations ongoing at the time of this report. Early review of the care provided included an unannounced Board visit to the PICU and the early learning from these incidents has been identified and an intermediate action plan written, with regards to the PICU incident.

During 2018/19 the Trust received the review panel report following the serious self-harm attempt and subsequent death of a person admitted to Ward 3 during 2017/18. This investigation did include input from a clinician external to the Trust. The action plan remains in place and the implementation and embedding of change is being monitored through the Directorate governance processes and the Trust Clinical Safety Improvement Group.

5.3 External Independent Investigations

Independent investigations are required where the integrity of the internal investigation and its findings are likely to be challenged or where it will be difficult for an organisation to conduct a proportionate and objective investigation internally due to the size of organisation or the individuals or number of organisations involved. Independent investigations avoid conflicts of interest and should be considered if such conflicts exist or are perceived to exist. An independent investigation can be used as a means of assessing whether a provider's account of an incident has been fairly presented to give credit to the findings and assurance that lessons will be learnt to prevent recurrence, or it can be used to obtain an objective assessment of the nature and causes of an incident irrespective of whether or not any investigative work has been or is to be undertaken by the service provider. There have not been any investigation undertaken using this approach during 2018/19.

Following the completion of each investigation all recommendations and subsequent actions are retained by the relevant directorate and to an identified role within the directorate i.e. service manager. Each action is monitored by the directorates for completion and review. Following this the Head of the Patient and Organisational Safety Team reviews the actions plans for evidence of changes being embedded into

practice. All embedded changes or delays to implementation are reported monthly to the Clinical Safety Improvement Group and quarterly to Quality Committee.

6. Learning from Serious Incidents

The Patient and Organisational Safety Team and the Directorates ensure that any learning identified from SIs that requires immediate attention is shared with teams immediately. Recommendations and learning from SI investigations are then disseminated on completion of the SI investigation. Throughout 2018/19 there have been a number of reports where no recommendations for practice were identified. Examples of learning and actions taken in response to outcomes of SI investigations are outlined below:

- There were a number of recommendations around the theme of improving communication, areas for improvement included internal team-to-team communication and externally to other agencies. Actions taken included:
    - Improving information provided to the Access Team or the Community Mental Health Teams post discharge from inpatient care. A new template was devised in order to support the information transfer between teams.
    - A review of the triage process in the CMHTs; actions were taken to strengthen the process in order to ensure that all team members understood and were able to implement the necessary actions to escalate concerns on receipt of referrals.
    - Improved letters to GPs following service user non-engagement with services. A new Standard Operating Policy was implemented by the Access Team to ensure that practitioners complete a detailed contact note, including the reason for discharge and a review of risks (historical and current) when the person is discharged.
    - Information provided to patients was strengthened, with inpatient staff ensuring that people are provided with written information with regards to post discharge reviews and the Access team.
    - Teams were also tasked with improving the documentation in respect of people being discharged from services including the rationale for decisions made/discussions with service users.
- As stated in previous reports improvements in recording information featured in several investigations. Clinicians were challenged around improving the recording of information in relation to risk assessments, care plans and mental capacity assessments. Staff were reminded through training and supervision that care plans should be SMART (specific, measurable, achievable, realistic and timely) and person centred. The outcomes of the training and supervision sessions are being monitored through the safety matrix audits, case supervision and management processes. Following on from this, the focus for the next year is on the strengthening of the person centred narrative used by clinicians in the clinical notes.
- In CAMHS, an out-of-hours referral pathway was developed and shared across all ‘front-door’ portals in order to ensure that the pathway is followed by non-CAMHS clinicians. This document was also used as a reminder tool for existing CAMHS staff regarding the use of ‘leave beds’.
- The CMHTs reviewed the practice regarding “depot clinics" and how these clinics fit as part of the wider MDT care package. This review recognised the need to ensure that:
    - Clinical need and capacity as well as performance target discussions are reflected in caseload supervision. It was agreed that there would be a mechanism for recording this and the actions taken.
    - Improved quality of clinical note entries which should reflect the interaction and appraisal by a specialist mental health professional.

Substance Misuse teams were reminded that clinical notes should also include engagement strategies to support hard to engage patients. The teams were also asked to ensure that where necessary they should request access to records from partner agencies in order to fully explore the care delivered. As in previous reports, issues relating to the care of people with a dual diagnosis featured in a number of SI investigation reports. The reports into these incidents concluded that in these cases substance misuse tended not to be a problem of addiction but of binge and occasional use, which resulted in unpredictable and chaotic behaviours, including self-harm. Earlier reports showed that there was a need for improved communication between mental health and substance misuse services and this action was incorporated into several of the action plans. In 2017/18 there were two incidents were the person was known to both mental health and substance misuse services. However improved recognition of this need and the implementation of dual diagnosis awareness training during 2018/19 appear to have had positive results, as during this reporting timeframe, 11 incidents were reported where the person was known to both services. Action plans remain in place to strengthen joint working between mental health and substance misuse teams.

7. Conclusion

- The Trust continues to monitor all incidents on a weekly basis, Serious Incidents monthly at Clinical Safety Improvement group and Trust Board and this report demonstrates compliance with Trust policies and processes.
- Serious Incidents are also reviewed monthly at the commissioner led SI-Subgroup and bimonthly at the Clinical Quality Review Meeting
- There has been an increase in incidents relating to drug-related deaths in the Substance Misuse Services. The link between the reduction in commissioning for substance misuse services across Stoke-on-Trent and Staffordshire and the increase in drug-related deaths is currently under review by the service.
- The number of harm falls related SIs has reduced during 2018/19. The introduction to quality improvement and actions in relation to falls prevention remains ongoing, with new teams being introduced to the methodology during this timeframe. The number and impact of all falls continues to be monitored by the NOAP senior clinicians and the patient safety team.

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REPORT TO OPEN TRUST BOARD

Enclosure No: 12

Date of Meeting:	27th June 2019		
Title of Report:	Learning Disability Mortality Review (LeDeR): Trust update		
Presented by:	Dr O Adeyemo. Executive Medical Director		
Author:	Jackie Wilshaw. Head of Patient and Organisational Safety		
Executive Lead Name:	Dr O Adeyemo. Executive Medical Director	Approved by Exec	☒

Executive Summary:		Purpose of report	
In May 2019, 2 papers were published outlining the latest update of the LeDeR programme. The University of Bristol published the third annual Learning Disability Mortality Review report and NHS England and NHS Improvement published LeDeR: Action from Learning. This report provides an overview of the published updates and a Trust position statement.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT √ Execs ☐ Date: 11th June 2019	Document Version No.	
Committee Approval / Review	• Quality Committee √ • Finance & Performance Committee ☐ • Audit Committee ☐ • People, Culture & Development Committee • Charitable Funds Committee ☐ • Business Development Committee ☐ • Primary Care Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration.☐ 2. To provide the highest quality, safe and effective services. √ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. √ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. ☐ 7. Take a lead role in partnership working and integration. ☐		
Risk / legal implications: Risk Register Reference	Nil		
Resource Implications: Funding Source:	Release of staff to complete mortality reviews		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	There is a need to ensure that people with learning disabilities are not discriminated against and as a result potentially receiving less robust physical heath care		
STP Alignment / Implications:	Nil		
Recommendations:	To receive for assurance		

Version	Name/group	Date issued
1	Dr Adeyemo	05/06/2019

1. Introduction

The Learning Disability Mortality Review (LeDeR) programme was commissioned to improve the standard and quality of care for people with a learning disability. There was also an aim to support local areas across England to review the deaths of people with a learning disability, to learn from those deaths and to put that learning into practice.

In May 2019 the University of Bristol published the third annual Learning Disability Mortality Review report, which presents information about the deaths of people with learning disabilities and puts forward recommendations for action at a national level.

Separately, NHS England and NHS Improvement also published LeDeR: Action from Learning, which provides an overview of actions taken in response to recommendations made in the second annual LeDeR report and action going forwards.

2. Key points from the reports

The third annual **Learning Disability Mortality Review** (LeDeR) report highlights a number of concerns about the deaths of people with learning disabilities. These include:

- system level issues
- staff training
- care coordination and communication
- Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) orders recognising signs of deterioration

The report makes twelve recommendations at a national level that cover:

- availability of data
- identification of people with learning disabilities
- listening to families
- priority programmes of work needed
- service and care coordination
- transition from children's to adults' services'
- addressing bias

The report states there is much that can and should be done at local level to reflect on the learning coming from the reviews of deaths, and to translate that into actions for improvement.

NHS England and NHS Improvement's **LeDeR: Action from Learning** report states that CCGs, working with their local authority and NHS partners, have made significant progress towards completing LeDeR reviews in a timely way but there is still a long way to go. The national bodies have committed to invest an additional £5 million to address the backlog of unreviewed cases and increase the pace with which reviews are allocated and completed. Data on CCGs' progress of completing reviews will also be published on their website moving forward.

They have also committed to national action to tackle the major conditions that cause death among people with a learning disability based on lessons learned from reviews.

In 2019/20 the University of Bristol will be reporting more regularly about themed learning, and the learning into action collaborative will continue to co-ordinate national responses to the learning emerging from the LeDeR programme.

3. Trust progress

Trusts are required to notify the LeDeR team at the University of Bristol of all deaths of people with learning disabilities. From this central point, the local area is informed of the deaths and a local reviewer appointed to review the death. For people known to the Trust, the local reviewer should be appointed from a nearby locality, outside of Staffordshire, in the Midlands and East region. Since the introduction of the LeDeR programme, the Trust has reported the deaths of 17 people with learning disabilities. However the allocation of reviewers has proved problematic for the system, with a lack of trained reviewers being available to complete the reviews. The reasons given for this are that reviewers are not given sufficient time away from their other responsibilities to be able to complete reviews, and that the process is not formally mandated.

The Midlands and East region has the highest proportion of deaths reported that were still waiting allocation to a reviewer (49%). Therefore although the Trust has a number of LeDeR trained reviewers, there have only been two reviews completed for people known to the Trust due to the lack of available reviewers across the region. One report indicated that the standard of care was good and that there was no learning for the Trust and the other report was stopped at the initial review stage after it was determined that there was no value in continuing into the Multi-Agency Learning Review stage.

In order to mitigate against the regional lack of reviewers and to provide a timely review of the deaths of people with learning disabilities, the Trust initiated a process, in November 2018, to complete our own mortality surveillance processes on learning disability deaths whist the external LeDeR reviews are awaited. The aim of these mortality surveillance reviews is to ensure that any learning from the deaths of people with learning disabilities is shared and actions taken in a timely manner rather than waiting for a prolonged period of time before the regional LeDeR review takes place.

The table below shows the number of deaths reported by the Trust since the commencement of the LeDeR process (April 2017).

INC NO	LeDeR id*	INC DATE	Updates	MS review completed by NSCHT
18918		13/11/2017		
19227		29/11/2017		
20011		25/01/2018		
20501		03/03/2018		
20704		28/03/2018		
18013		01/09/2017		
21314		04/05/2018		
21425		12/04/2018		
21492		17/05/2018		

22542		14/07/2018		
24214	**25302465**	**07/11/2018**	**Good Care/Physical/EN1**	**Yes**
24217	**25302479**	**11/11/2018**	**Good Care/Physical/EN1**	**Yes**
24354	25303312	15/11/2018	Reviewed – extra info required	No
24772	**25307526**	**16/12/2018**	**Good Care/Physical/EN1**	**Yes**
25589	25316416	06/02/2019	Awaiting CoD	No
26144	25322282	15/03/2019	To be reviewed 4.6.19	No
26650	25325761	15/04/2019	Awaiting MS review form	No

*The Trust was not initially provided with LeDeR identification numbers

The highlighted section shows the reviews requested by the Trust Mortality Surveillance Group. There have been 7 reviews requested and 3 completed to date. In each case reviewed, the mortality surveillance group judged the care to have been of a good standard (records/documentation indicated that care had been appropriately provided by learning disability services), the predominant area of care related to the person's physical health and of the 3 completed reviews, the deaths were determined to be Expected and Natural deaths (EN1).

The attendance of all organisations at the multi-agency health and social care, Staffordshire wide steering group has not been consistent; this is reported to be due to the relatively few number of reports available to be reviewed. Nonetheless the terms of reference for the group have been agreed and the stakeholders support the need for a group which provides analysis and oversight of the deaths of all people with a learning disability across the locality.

4. Conclusion and next steps

People with learning disabilities continue to die at an earlier age than the general population. During 2015-2018, the average age at death, of a person with a learning disability was 60 years compared with 83 years for the general population. There is a need to review and understand the care needs of people with a learning disability and to ensure that the right adjustments are in place to ensure that their needs are picked up early in every care setting. NHS England and Improvement stated that the LeDeR programme is making progress but acknowledged that there is still a long way to go to ensure that the reviews are completed in a timely way. During 2019/20, the University of Bristol will be reporting more regularly about themed learning, which is possible as increased numbers of reviews is completed and the learning into action collaborative will continue to coordinate national responses to all learning emerging from LeDeR.

At Combined Healthcare, the ongoing national recognition on improving the care of people with learning disabilities is welcomed. The Trust continues to internally monitor the care received by people with learning disabilities in order to ensure that any learning from these deaths is noted and actions taken as appropriate.

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REPORT TO OPEN TRUST BOARD

Enclosure No: 13

Date of Meeting:	27th June 2019		
Title of Report:	Performance & Quality Management Framework [PQMF] Month 01		
Presented by:	Victoria Boswell, Associate Director of Performance		
Author:	Victoria Boswell, Associate Director of Performance		
Executive Lead Name:	Lorraine Hooper, Director of Finance, Performance & Estates	Approved by Exec	☐

Executive Summary:	Purpose of report	
The report provides an overview of performance for April 2019 covering Contracted Key Performance Indicators (KPIs) and Reporting Requirements. In addition to the performance dashboards a full database (Divisional Drill-Down) has been made available to Directorate Heads of Service and Clinical Directors to enable them to interrogate the supporting data and drive directorate improvement. This is summarised in the supporting PQMF dashboard.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☒ Execs ☐ Performance Review Date: 28 May 2019	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance, Performance and Estates Committee ☒ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Primary Care Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration. ☐ 2. To provide the highest quality, safe and effective services ☒ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☒ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☐		
Risk / legal implications: Risk Register Reference	In Month 1 there is 1 target related metric rated as Red: all other indicators are within expected tolerances. All areas of underperformance are separately risk assessed and a rectification plan is developed, overseen by the relevant sub-committee of the Trust Board.		
Resource Implications: Funding Source:	A Data Quality Improvement Plan is agreed with commissioners to address data quality issues that may impact on performance.		

Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	The PQMF includes monitoring of ethnicity as a key national requirement. The Trust is seeking to ensure that all Directorates are recording in a timely way the protected characteristics of all service users to enable monitoring of service access and utilisation by all groups in relation to the local population.	
STP Alignment / Implications:		
Recommendations:	The Board is asked to • Receive the report as outlined • Note the Management action	
Version	Name/group	Date issued
1.2	Public Board	18/06/19

PERFORMANCE & QUALITY MANAGEMENT FRAMEWORK
REPORT TO TRUST BOARD MEETING

Date of meeting:	27 June 2019
Report title:	**Performance & Quality Management Framework** **Performance Report – Month 01 2019/20**
Executive Lead:	Lorraine Hooper, Director of Finance, Performance & Estates
Prepared by:	Victoria Boswell, Associate Director of Performance
Presented by:	Lorraine Hooper, Director of Finance, Performance & Estates

1 Introduction to Performance Management Report

The report provides an overview of performance for March 2019 covering Contracted Key Performance Indicators (KPIs) and Reporting Requirements. In addition to the performance dashboards a full database (Divisional Drill-Down) has been made available to Directorate Heads of Service and Clinical Directors to enable them to interrogate the supporting data and drive directorate improvement. This is summarised in Appendix 1.

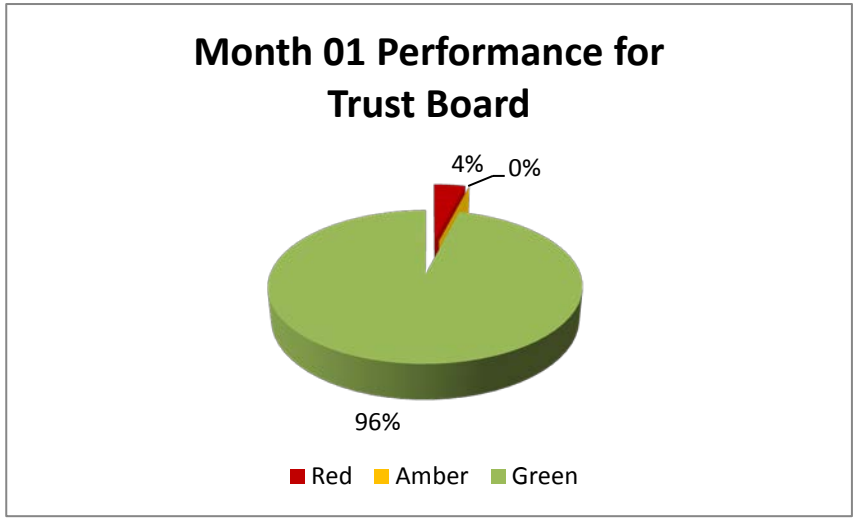
2 Executive Summary

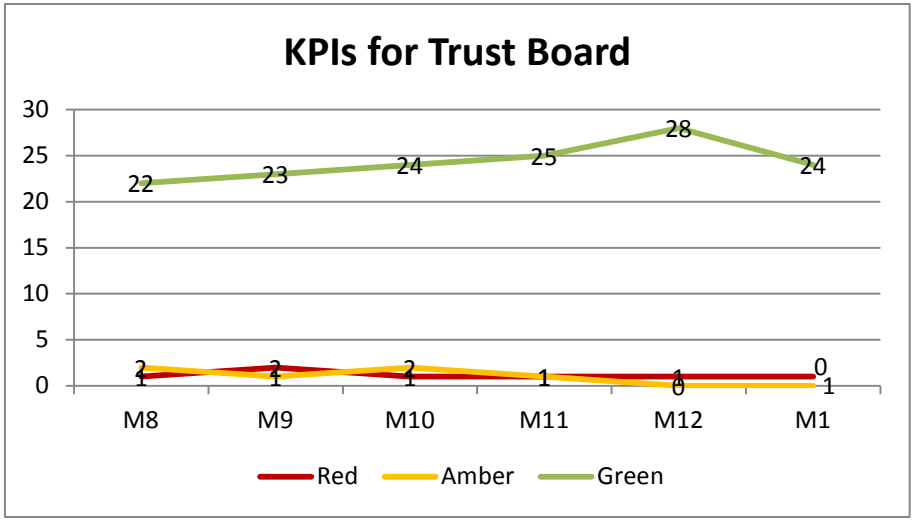
The following performance highlights should be noted:

- Mental health delayed transfers of care 3.5% in M1 (target 7.5%)
- 61.8% of IAPT service users are moving to recovery (target 50%).
- 7.1% of IAPT service users wait no longer than 90 days between 1st and 2nd treatment (target <10%)
- 96% of service users on Care Programme Approach (CPA) for at least 12 months have a formal review within 12 months (target 95%)

Exception Reporting

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





3 Updated metrics and targets

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

- PALS & Complaints figures for March confirmed, provisional data received for April 2019
- Sickness absence percentage figures for M1 are provisional. Year to date sickness absence figures have been refreshed to reflect the updated 12 months rolling position.

4 Exceptions – Month 01

KPI Classification	Metric	Exec/Op Lead	Target	M12	M01	Trend	Commentary
National	**Agency Spend:** % Year to Date Agency Spend compared to Year to Date Agency Ceiling	Dir of Workforce	**0%**	**GREEN** **0.0%**	**RED** **2.0%**	↗	**2.0% at M01 from 0.0% at M12** Agency is predominately over the ceiling due to Primary Care agency being higher than the approved increase in the ceiling.

5. Recommendations

Board are asked to:

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

Month: **April**
1
Key:-

PQMF Report

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

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

	Metric	Frequency	Standard	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
NHSI	Early Intervention in Psychosis - A maximum of 2 week waits for referral to treatment (Target 17/18-50%, 18/19-53%, 19/20-57%, 20/21-60%)	Monthly	56%	90.0%											
	Early Intervention in Psychosis - A maximum of 2 week waits for referral to treatment (North Staffordshire CCG) (Target 17/18-50%, 18/19-53%, 19/20-57%, 20/21-60%)	Monthly	56%	100.0%											
	Number of completed EIP pathways (North Staffordshire CCG)	Monthly	No Target	1.0											
	Number of incomplete EIP pathways (North Staffordshire CCG)	Monthly	No Target	0.0											
	Early Intervention in Psychosis - A maximum of 2 week waits for referral to treatment (Stoke-on-Trent CCG) (Target 17/18-50%, 18/19-53%, 19/20-57%, 20/21-60%)	Monthly	56%	88.9%											
	Number of completed EIP pathways (Stoke-on-Trent CCG)	Monthly	No Target	8.0											
	Number of incomplete EIP pathways (Stoke-on-Trent CCG)	Monthly	No Target	4.0											
NHSI	CAMHS - % of CYP with ED (Routine Cases) referred with a suspected ED that start treatment within 4 weeks of referral (North Staffs and Stoke CCG)	Monthly/Quarterly	95%												
	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%												
	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%												
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%												
	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%												
	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%												
CCG	Compliance with 18 week waits (Referral to Treatment or Intervention)	Monthly	92%	92.1%											
CCG	Zero tolerance RTT waits over 52 weeks for incomplete pathways	Monthly	0	0											
CCG	MH Liaison Team response to A&E referrals within 1 hour	Monthly	95%	95.0%											
CCG	Patients will be assessed within 12 weeks of referral to the Memory Assessment service	Monthly	95%	100.0%											
CCG	Number of people seen for crisis assessment within 4 hours of referral	Monthly	95%	100.0%											
National	Percentage of inpatient admissions that have been gatekept by crisis resolution/ home treatment team	Monthly	95%	100.0%											
National/CCG	Overall safe staffing fill rate	Monthly	No Target	91.2%											
National	Mental health delayed transfers of care (target NHSI)	Monthly	7.5%	3.5%											
CCG	Emergency Readmission rate (30 days). Percentage of patients readmitted within 30 days of discharge.	Monthly	7.5%	4.8%											
NHSI	Total **bed days** patients have been Out of Area - In Month figures rather than Bed days for patients returning in month	Monthly	No target	4.0											
Trust Measure	Adult	Monthly	No target	4.0											
Trust Measure	Older Adult	Monthly	No target												
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%	2.6%											
Trust Measure	Total patients Out of Area - In Month figures rather than Bed days for patients returning in month	Monthly	No target	1.0											
Trust Measure	Adult	Monthly	No target	1.0											

	Metric	Frequency	Standard	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Trust Measure	Older Adult	Monthly	No target	0.0											
Trust Measure	Total bed days - PICU	Monthly	No target	60.0											
Trust Measure	Total patients - PICU	Monthly	No target	2.0											
SAFE															
CCG	Number of patients 16/17 years old admitted to Adult Psychiatric wards	Monthly	0.0	0.0											
NHSI	Admission to adult facilities of U16s	Monthly	0.0	0.0											
CCG	Bed Occupancy (incl home leave) - Trust	Monthly	85%	94.5%											
CCG	Bed Occupancy (incl home leave) - Acute Services & Urgent Care - Adult Inpatient	Monthly	90%	92.4%											
CCG	Bed Occupancy (Including Home Leave)-Trust excluding Adult Inpatient	Monthly	85%	95.6%											
CCG	LD & CAMHS Inpatient - LD	Monthly	85%	92.2%											
CCG	Neuro & Rehab - Neuro	Monthly	85%	101.3%											
CCG	Acute Services & Urgent Care - Older Adult Inpatient	Monthly	85%	95.1%											
CCG	LD & CAMHS Inpatient - C&YP	Monthly	85%	90.3%											
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)	1.50%											
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%	61.8%											
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%	99.5%											
NHSI / CCG	Improving Access to Psychological Therapies (IAPT) Programme: the percentage of service users referred to an IAPT programme who are treated within 18 weeks of referral	Monthly	95%	100.0%											
CCG	IAPT: Patients wait no longer than 90 days between 1st and 2nd treatment	Monthly	<10%	7.1%											
CCG	Place of Safety Assessments	Monthly	No Target	27.0											
National	The proportion of those on Care Programme Approach (CPA) for at least 12mnths having formal review within 12mnths *NHSI*	Monthly	95%	96.0%											
NHSI	The proportion of those on Care Programme Approach (CPA) receiving follow-up contact within 7 days of discharge	Monthly	95%	97.0%											
Trust Measure/CCG	(ALL PATIENTS) The proportion of those receiving follow up within 7 days of discharge	Monthly	Internal-No Target CCG -90%	95.5%											
NHSI/CCG	Never Events	Monthly	0	0.0											
National	Patient Safety Alerts not completed by deadline	Monthly	0	0.0											
CCG	Mixed Sex Accommodation Breach	Monthly	0	0											
CARING															
National	Inpatient Scores from Friends and Family Test – % positive	Monthly	No Target	85.0%											
National	Staff Friends and Family Test - % recommended - care	Quarterly	No Target												
National	Percentage of complaints responded to in line with timescale agreed with complainant	Monthly	95%	100.0%											
National	Written complaints rate	Quarterly	No Target	3.1											
CCG	Duty of Candour Each failure to notify the Relevant Person of a suspected or actual Reportable Patient Safety Incident	Monthly	0	0.0											
ORGANISATIONAL HEALTH															
National	% Year to Date Agency Spend compared to Year to Date Agency Ceiling	Monthly	0%	2.0%											
National	Sickness Absence Percentage: Days lost	Monthly	4.95%	4.3%											
National	Staff Turnover (% FTE)	Monthly	>10%	0.5%											

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REPORT TO OPEN TRUST BOARD

Enclosure No: 14

Date of Meeting:	27/06/2019		
Title of Report:	Finance Position M1		
Presented by:	M Newton – Deputy Director of Finance		
Author:	L Dodds – Assistant Director of Finance		
Executive Lead Name:	Lorraine Hooper – Executive Director of Finance, Performance & Estates	Approved by Exec	☒

Executive Summary:	Purpose of report	
This report summarises the finance position at month 1 (April 2019)	Approval	☒
	Information	☐
	Discussion	☐
	Assurance	☒

Seen at:	SLT X Execs Date: 11/6/19	Document Version No.	

Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☒ • Audit Committee ☐ • People, Culture & Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Primary Care Committee ☐
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration. ☐ 2. To provide the highest quality, safe and effective services ☐ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☐ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☐
Risk / legal implications: Risk Register Reference	Ref 1035: Trust top 3 risks around delivery of cost improvement target and delivery of trust financial position.
Resource Implications: Funding Source:	If the trust does not deliver recurrent CIP, it impacts on future sustainability, Not 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:	The Trust Board are asked to: Note:

	The reported year to date deficit of £305k against a planned deficit of £293k. This is an adverse variance to plan of £12k. The M1 CIP achievement of £0k; an adverse variance of £158k to plan The cash position of the Trust as at 30th April 2019 with a balance of £10,216k; £1,224k better than plan. Total Agency expenditure of £219k against the agency cap of £205k; an adverse variance of £14k to plan Capital expenditure at £92k compared to planned capital expenditure of £179k. Use of resource rating of 3 against a plan of 3.

Version	Name/group	Date issued
1	N/A	28/05/2019

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Financial Overview as at 30th April 2019

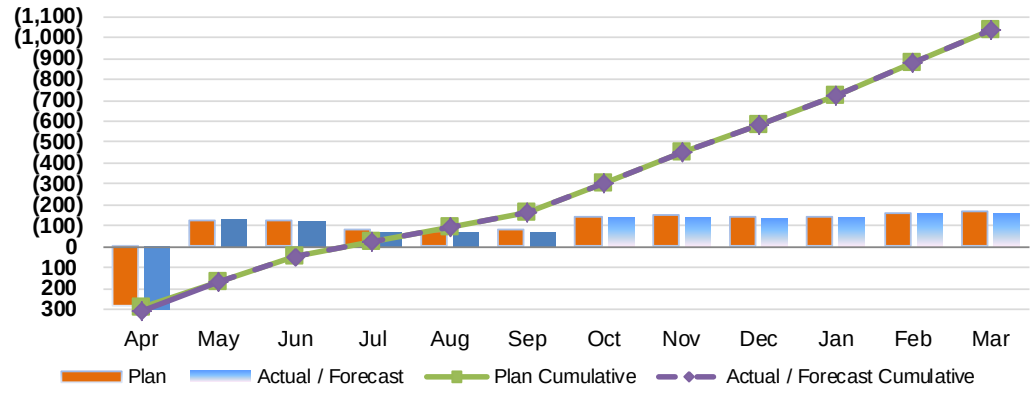
Income & Expenditure - Control Total (Surplus) / Deficit

£000	Plan	Actual	Var	%	RAG
YTD	293	305	12	(4)	G
FOT	(1,038)	(1,038)	0	0	G

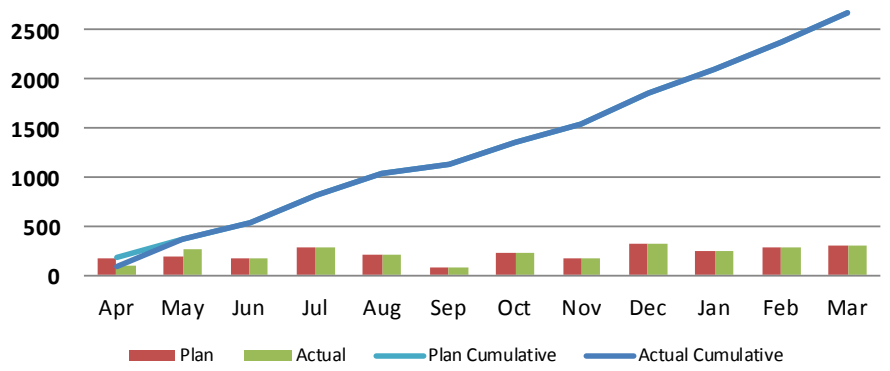
Charge to CRL

£000	Plan	Actual	Var	%	RAG
YTD	179	92	(87)	(49)	R
FOT	2,676	2,676	0	0	G

Retained (Surplus) / Deficit Run Rate 2019/20



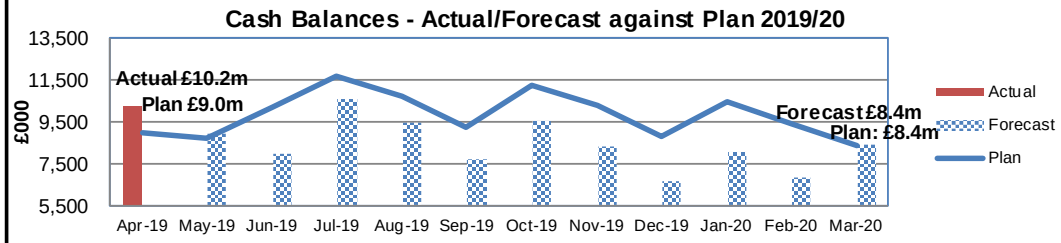
Net Capital Expenditure - Plan / Forecast 2019/20



Cash Balances

£000	Plan	Actual	Var	%	RAG
YTD	8,992	10,216	1,224	14	G
FOT	8,354	8,355	1	0	G

Cash Balances - Actual/Forecast against Plan 2019/20



Cost Improvement

£000	Plan	Actual	Var	%	Rec Var	RAG
Clinical	147	0	(147)	(100)	(689)	R
Corporate	11	0	(11)	(100)	(262)	R
Total	158	0	(158)	(100)	(951)	R

Use of Resource	Plan	Actual
Overall Risk Rating	3	3
Liquidity Ratio	1	1
Capital Servicing Capacity	4	4
I& E Margin	4	4
I&E Margin Variance to Plan	1	2
Agency Spend	1	2

Introduction:

The Trust's 2019/20 financial plan is to deliver a trading position of £338k surplus. The trust has accepted the Control Total from NHS Improvement (NHSI) of £1,038k surplus which includes £700k from the Provider Sustainability Funding (PSF).

1. Income & Expenditure (I&E) Performance

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

- During month 1, the trust had an in month trading position of £340k deficit against a plan of £328k deficit; **giving an adverse variance of £12k**. Although the Trust has not achieved the plan of £328k deficit in month 1, Provider Sustainability Funding (PSF) has been assumed at £35k based on the assumption that the trust will be delivering in line with plan by the end of quarter 1. The Trust therefore has a deficit at month 1 of £305k; **giving an adverse variance of £12k**.

- The Trust has not produced a detailed forecast at month 1, but expects to deliver in line with plan to give a trading surplus of £338k. Sustainability and Transformation funding (PSF) is expected to be £700k in line with plan giving an overall Control Surplus of £1,038k.

		Month 1			Year to Date		
Table 1: Summary Performance	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
Income	(92,745)	(7,703)	(7,675)	28	(7,703)	(7,675)	28
Pay	68,346	5,923	5,672	(252)	5,923	5,672	(252)
Non Pay	21,185	1,869	2,107	239	1,869	2,107	239
EBITDA	**(3,215)**	**88**	**104**	**15**	**88**	**104**	**15**
Other Non-Op Costs	2,877	240	236	(3)	240	236	(3)
Trading Surplus	**(338)**	**328**	**340**	**12**	**328**	**340**	**12**
Provider Sustainability Funding	(700)	(35)	(35)	0	(35)	(35)	0
(Surplus)/Deficit for the year	**(1,038)**	**293**	**305**	**12**	**293**	**305**	**12**

2. Income

Table 2 below shows the Trust income position by the annual plan:

- The NHS Stoke-on-Trent CCG and NHS North Staffordshire CCG contracts are set on a block basis. The figures currently assume
  - £2.6m CCG underwriting agreement is assumed to be paid through income (see section 2.1.)
  - £1m STP efficiency savings are currently assumed to be paid through main CCG contract. From month 2, this will be split out from the main block and monitored separately.

- Associates over-performance relates entirely to 2018/19 over-performance, raised in month 1.

- Other income has under-performed in month 1 due to lower than planned GP GMS income.

		Month 1			Year to Date		
Table 2: Income	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
NHS Stoke-on-Trent CCG	(40,145)	(3,325)	(3,325)	0	(3,325)	(3,325)	0
NHS North Staffordshire CCG	(27,508)	(2,248)	(2,248)	0	(2,248)	(2,248)	0
Staffordshire Associates	(552)	(51)	(63)	(12)	(51)	(63)	(12)
Other Associates	(289)	(24)	(25)	(1)	(24)	(25)	(1)
Specialised Services	(3,496)	(312)	(317)	(5)	(312)	(317)	(5)
Stoke-on-Trent CC s75	(3,999)	(333)	(333)	0	(333)	(333)	0
Stoke-on-Trent Public Health	(3,968)	(331)	(331)	0	(331)	(331)	0
Staffordshire Public Health	(450)	(38)	(38)	0	(38)	(38)	0
ADS/One Recovery	(1,466)	(122)	(122)	(0)	(122)	(122)	(0)
OATS	(838)	(70)	(57)	13	(70)	(57)	13
Private Patients	0	0	0	0	0	0	0
Total Clinical Income	**(82,712)**	**(6,853)**	**(6,858)**	**(5)**	**(6,853)**	**(6,858)**	**(5)**
Other Income	(10,033)	(851)	(817)	33	(851)	(817)	33
Total Income	**(92,745)**	**(7,703)**	**(7,675)**	**28**	**(7,703)**	**(7,675)**	**28**
Provider Sustainability Funding	(700)	(35)	(35)	0	(35)	(35)	0
Total Income Incl. PSF	**(93,445)**	**(7,738)**	**(7,710)**	**28**	**(7,738)**	**(7,710)**	**28**

2.1 CCG Underwrite Agreement

The contract with Staffordshire CCGs was signed on 31st May 2019, which enables the Trust to receive maximum block contract income from Staffordshire CCGs of £67.102m. This includes:

- an opening contract value of £64.49m
- a contractual commitment for the CCG to underwrite the Trust delivery of a £338k control surplus, through payment of a maximum further £2.6m in month 12.

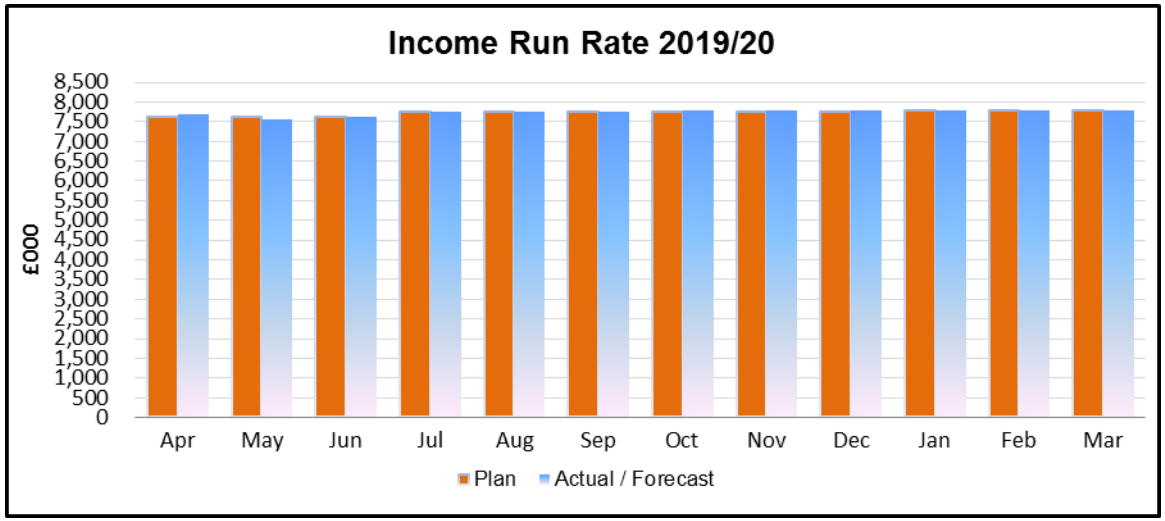
In order to receive the payment of £2.6m, the Trust is required to work with the CCG to identify contract efficiencies. The mitigations being explored by CCG colleagues alongside Trust colleagues are a service line review (30th September 2019) and any over delivery against internal Trust CIP should this be possible. The £2.6m payment will be made to the extent that cost efficiencies cannot be released from the contract.

The table below shows the current progress:

CCG Underwriting £338k Surplus	Income	Expenditure	Total
Contract Efficiency Requirement	**(£2.6m)**		**(£2.6m)**
Identified Solutions			
Service line review		£0m	£0m
Over-delivery of Trust Internal CIP	£0m	£0m	£0m
Expected M12 Contract Variation	**£2.6m**	**£0m**	**£2.6m**

2.2 Income Run Rates

Actual, Plan and Forecast income run rates are shown below.



3. Expenditure

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

- Underspend of £252k on pay is due to vacancies across the trust, partially covered by temporary staffing.
  - Agency costs at £219k are slightly above the month 1 agency cap of £205k.

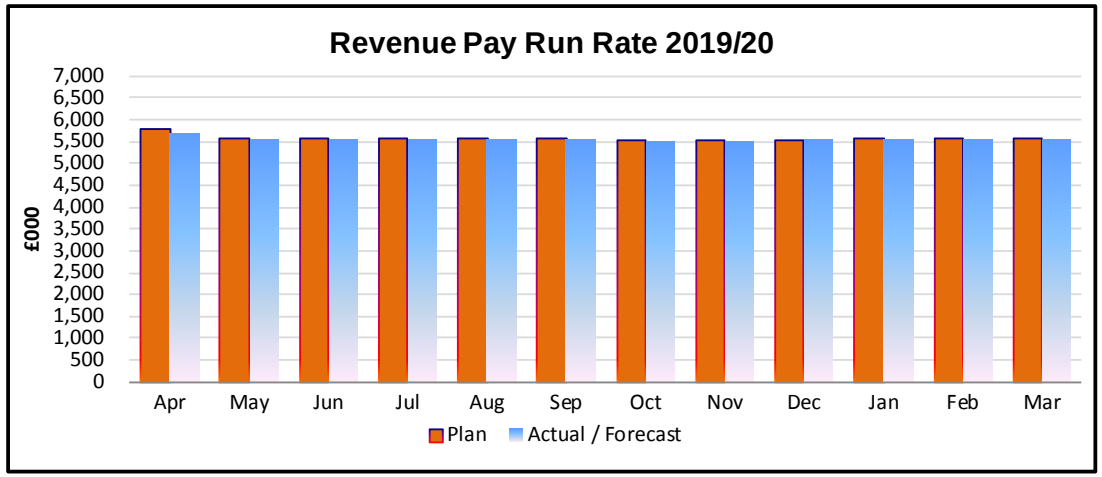
- Non-Pay over spend of 239k is mainly due to unachieved CIP, residential payments, IT costs.

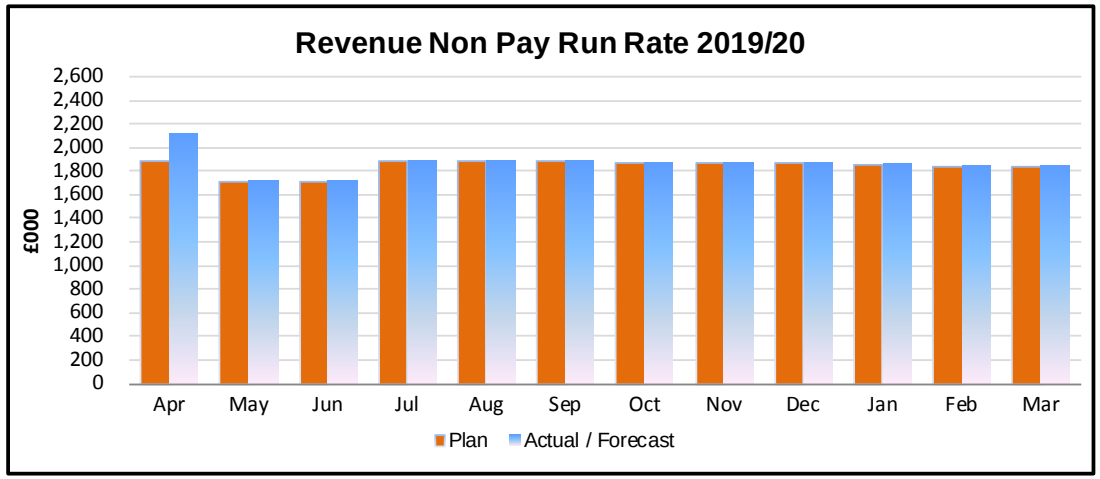
		Month 1			Year to Date		
Table 3: Expenditure	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
Medical	8,586	718	525	(194)	718	525	(194)
Nursing	32,605	2,837	2,761	(75)	2,837	2,761	(75)
Other Clinical	14,857	1,288	1,152	(136)	1,288	1,152	(136)
Non-Clinical	12,074	1,062	994	(68)	1,062	994	(68)
Apprenticeship Levy	223	19	21	2	19	21	2
Agency	0	0	219	219	0	219	219
Total Pay	**68,346**	**5,923**	**5,672**	**(252)**	**5,923**	**5,672**	**(252)**
Drugs & Clinical Supplies	2,942	245	234	(11)	245	234	(11)
Establishment Costs	1,840	156	122	(34)	156	122	(34)
Information Technology	704	59	113	54	59	113	54
Premises Costs	2,605	218	188	(30)	218	188	(30)
Private Finance Initiative	4,445	370	376	6	370	376	6
Services Received	5,499	458	452	(6)	458	452	(6)
Residential Payments	1,760	147	202	55	147	202	55
Consultancy & Prof Fees	28	2	21	19	2	21	19
External Audit Fees	65	5	5	(0)	5	5	(0)
Unacheived CIP	(2,505)	(158)	0	158	(158)	0	158
Other	3,801	366	394	28	366	394	28
Total Non-Pay	**21,185**	**1,869**	**2,107**	**239**	**1,869**	**2,107**	**239**
Finance Costs	1,172	98	98	(0)	98	98	(0)
Dividends Payable on PDC	635	53	53	0	53	53	0
Investment Revenue	(54)	(5)	(6)	(1)	(5)	(6)	(1)
Depreciation (excludes IFRIC 12)	1,124	94	92	(2)	94	92	(2)
Total Non-op. Costs	**2,877**	**240**	**236**	**(3)**	**240**	**236**	**(3)**
Total Expenditure	**92,407**	**8,031**	**8,015**	**(16)**	**8,031**	**8,015**	**(16)**

Agency Breakdown		
Agency Type	**YTD (£000)**	**%**
Medical	127	58%
Nursing	41	19%
Other Clinical	(4)	-2%
Non Clinical	3	1%
Sub Total	**167**	**76%**
Primary Care	52	24%
Total Agency	**219**	**100%**
Agency Ceiling	**205**	
(Surplus)/Deficit	**14**	

3.1 Run Rates

Actual, plan and forecast run rates for pay and non-pay are shown below.





4. Cost Improvement Programme

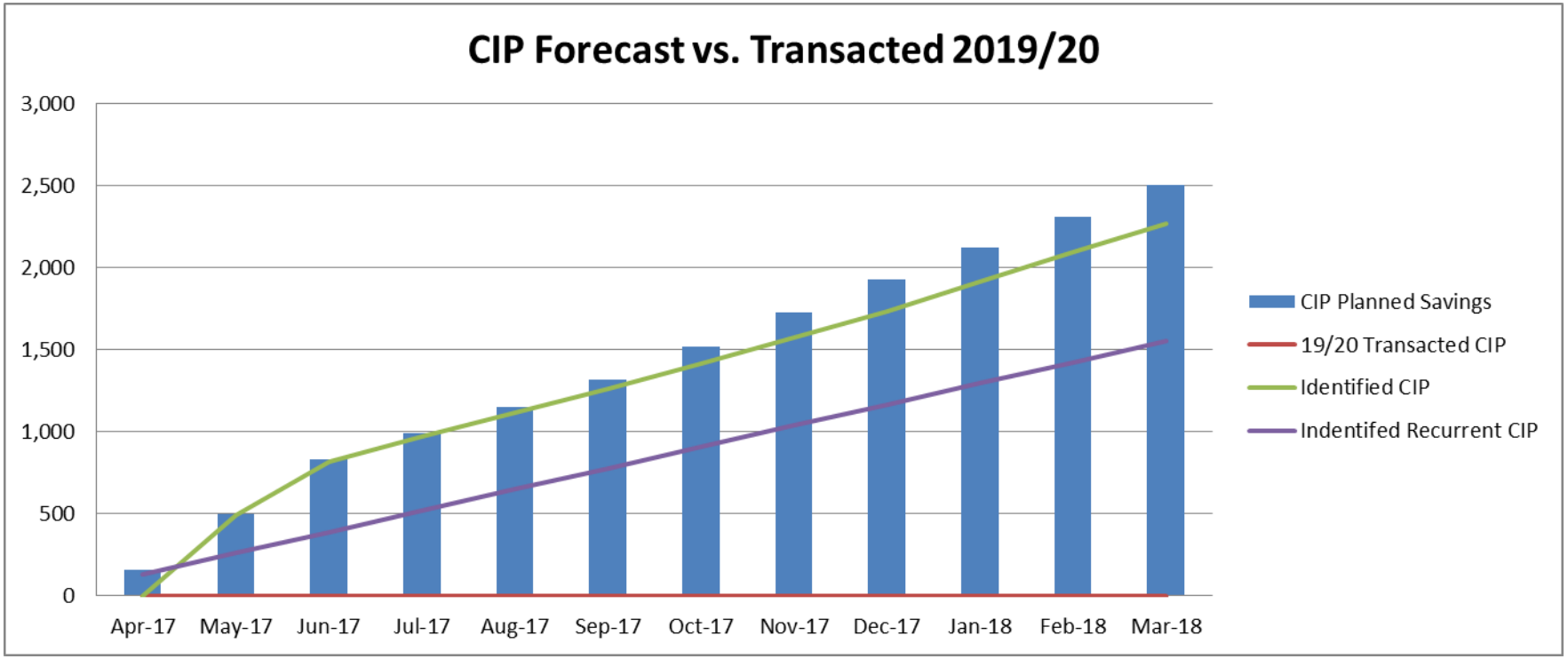
The Trust target for the year is £3.505m, made up of £2.505m Internal and £1.000m system efficiency requirement. This takes into account the requirement to deliver a £0.338m trading control surplus for 2019/20:

- For the Trust Internal Target (£2.505m)
  - The trust has identified schemes to deliver £2,272k against the target; a £233k shortfall
  - On a recurrent basis, the trust has identified schemes to deliver £1,554k against the target, which represents a £951k shortfall.

- The Trust share of the mental health system savings is £1,000k. The savings forecast are based on the Trust's share (33%) of the total savings identified in the initial PIDs, which have been approved by the STP. It is currently assumed to be 100% delivered.

		YTD 2019/20			Forecast 2019/20			Recurrent Forecast			
Cost Improvement Programme	**Target (£000)**	**Plan (£000)**	**Actual (£000)**	**Under / (Over) Delivery (£000)**	**Plan (£000)**	**Forecast (£000)**	**Under / (Over) Delivery (£000)**	**Plan (£000)**	**Forecast (£000)**	**Under / (Over) Delivery (£000)**	**Recurrent Transacted as at Month 1**
Clinical	1,987	147	0	147	1,987	1,833	154	1,987	1,298	689	0
Corporate	518	11	0	11	518	439	79	518	256	262	0
Internal CIP	**2,505**	**158**	**0**	**158**	**2,505**	**2,272**	**233**	**2,505**	**1,554**	**951**	**0**
System CIP	1,000	0	0	0	1,000	1,000	0	1,000	1,000	0	0
Total Trust Cost Improvement	**3,505**	**158**	**0**	**158**	**3,505**	**3,272**	**233**	**3,505**	**2,554**	**951**	**0**

3.1 CIP Forecast & Transacted 2019/20



- Identified CIP reflects the best case scenario and has not been risk assessed for deliverability.
- The trust had a £982k recurrent shortfall against the CIP target in 2018/19, which has been rolled forward into 2019/20 targets in line with the principles agreed in the Cost Improvement Framework.
- The graph above excludes system led CIP schemes.

5. Statement of Financial Position

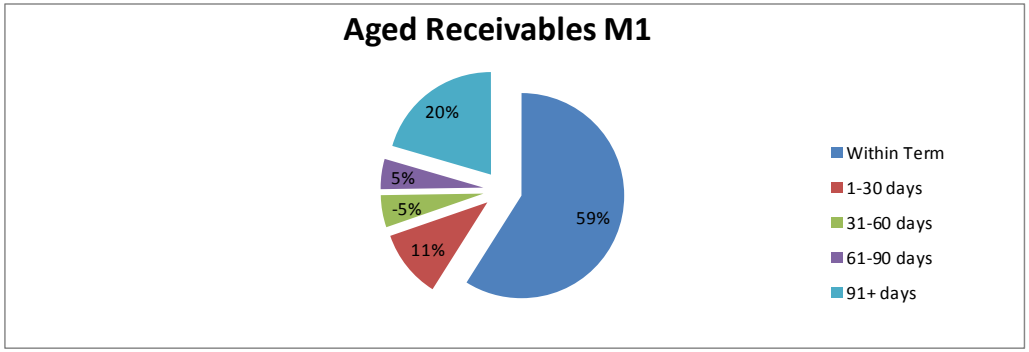
Table 6 below shows the Statement Financial Position of the Trust.

Table 6: SOFP	31/01/2019 £'000	28/02/2019 £'000	31/03/2019 £'000	30/04/2019 £'000
Non-Current Assets				
Property, Plant and Equipment - PFI	16,203	16,177	16,736	16,775
Property, Plant and Equipment	14,633	14,775	15,142	15,111
Intangible Assets	256	250	255	247
NCA Trade and Other Receivables	0	0	0	0
Other Financial Assets	1,089	1,089	321	321
Total Non-Current Assets	**32,181**	**32,291**	**32,454**	**32,454**
Current Assets				
Inventories	71	105	89	83
Trade and Other Receivables	7,136	7,287	8,787	7,952
Cash and Cash Equivalents	9,801	9,912	9,132	10,216
Non-Current Assets Held For Sale	0	0	0	0
Total Current Assets	**17,007**	**17,304**	**18,008**	**18,251**
Current Liabilities				
Trade and Other Payables	(8,388)	(8,407)	(8,294)	(8,910)
Provisions	(482)	(602)	(386)	(372)
Borrowings	(635)	(635)	(635)	(628)
Total Current Liabilities	**(9,504)**	**(9,644)**	**(9,316)**	**(9,910)**
Net Current Assets / (Liabilities)	**7,503**	**7,660**	**8,693**	**8,342**
Total Assets less Current Liabilities	**39,684**	**39,951**	**41,146**	**40,795**
Non Current Liabilities				
Provisions	(458)	(458)	(555)	(555)
Borrowings	(11,027)	(10,974)	(10,921)	(10,875)
Total Non-Current Liabilities	**(11,485)**	**(11,432)**	**(11,476)**	**(11,430)**
Total Assets Employed	**28,200**	**28,520**	**29,670**	**29,365**
Financed by Taxpayers' Equity				
Public Dividend Capital	7,775	7,775	7,787	7,787
Retained Earnings reserve	9,392	9,712	11,440	11,135
Other Reserves (LGPS)	1,089	1,089	321	321
Revaluation Reserve	9,944	9,944	10,122	10,122
Total Taxpayers' Equity	**28,200**	**28,520**	**29,670**	**29,365**

Current receivables are £7,952k, of which:

- £4,260k is based on accruals (not yet invoiced) relating to income accruals for services invoiced retrospectively at the end of every quarter, and £2.2m PSF (quarter 4 core funding, incentive and general bonus distribution.
- £3,692k is trade receivables; based on invoices raised and awaiting payment of invoice. (£2,422k within terms).
- Invoices overdue by more than 31 days are subject to routine credit control processes.

		Days Overdue				
Table 6.1 Aged Receivables/Payables	Within Term £'000	1-30 Days £'000	31-60 Days £'000	61-90 Days £'000	91+ Days £'000	Total £'000
Receivables Non NHS	1,600	450	(1)	101	345	2,495
Receivables NHS	822	(9)	(207)	94	497	1,197
Payables Non NHS	266	268	6	0	5	545
Payables NHS	145	217	98	95	101	656



6. Cash Flow Statement

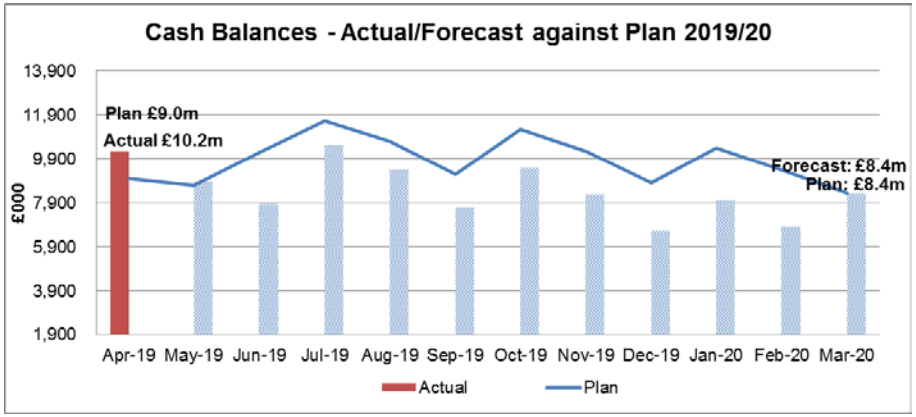
- The Trust cash position at 30th April 2019 is £10,216k, **£1,224k higher than planned.** This is as a result of slippage on capital spend and higher than planned receipts due to earlier than expected settlement of outstanding invoices.

- The notified 2018/19 PSF bonus of £1,521k is included in the cash plan in June but the expected settlement date has now been confirmed as July or August (exact date still to be confirmed).

- The variance from plan that builds up through the year is the reduction on the CCG contracts, with the final settlement of £2.6m expected in March 2020.

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

Table 7: Statement of Cash Flows	Apr-19 £'000	May-19 £'000	Jun-19 £'000	Jul-19 £'000	Aug-19 £'000	Sep-19 £'000	Oct-19 £'000	Nov-19 £'000	Dec-19 £'000	Jan-20 £'000	Feb-20 £'000	Mar-20 £'000	Annual £'000
Net Inflows/(Outflow) from Operating Activities	722	(920)	525	1,908	(774)	(1,200)	1,724	(887)	(1,203)	1,776	(771)	2,287	**3,186**
Net Inflows/(Outflow) from Investing Activities	522	(266)	(176)	(275)	(212)	(82)	276	(173)	(320)	(233)	(279)	(294)	**(1,512)**
Net Inflows/(Outflow) from Financing Activities	(151)	(151)	(150)	(151)	(151)	(468)	(151)	(151)	(150)	(151)	(151)	(468)	**(2,443)**
Net Increase/(Decrease)	**1,093**	**(1,337)**	**199**	**1,482**	**(1,137)**	**(1,750)**	**1,849**	**(1,211)**	**(1,673)**	**1,392**	**(1,201)**	**1,526**	**(769)**
Opening Cash & Cash Equivalents	**9,123**	**10,216**	**8,879**	**9,078**	**10,560**	**9,423**	**7,673**	**9,522**	**8,311**	**6,638**	**8,029**	**6,828**	**9,123**
Closing Cash & Cash Equivalents	**10,216**	**8,879**	**9,078**	**10,560**	**9,423**	**7,673**	**9,522**	**8,311**	**6,638**	**8,029**	**6,828**	**8,354**	**8,354**
Plan	8,992	8,705	10,209	11,641	10,704	9,202	11,248	10,235	8,811	10,401	9,398	8,354	8,354
Variance	**(1,224)**	**(174)**	**1,131**	**1,081**	**1,281**	**1,529**	**1,726**	**1,924**	**2,173**	**2,372**	**2,570**	**0**	**(0)**



7. Capital Expenditure

The Trust's gross capital expenditure agreed within the 2019/20 plan is £2,676k. The Trust's plan includes the sale of the Ashcombe Centre at £500k, resulting in a total capital plan of £2,176k. Table 7 below shows the planned capital expenditure for 2019/20 as submitted to NHSI.

		Year to Date			Forecast		
Capital Expenditure	**Annual Plan £'000**	**YTD Plan £'000**	**Actual £'000**	**Variance £'000**	**Plan £'000**	**Forecast £'000**	**Variance £'000**
Learning Disability Facilities	400	0	0	0	400	200	200
Mental Health Crisis Care Centre	766	146	(3)	(149)	766	766	0
Detoxification Suites and Crisis Café	200	0	0	0	200	100	100
Strategic Schemes	0	0	0	0	0	0	0
Environmental Improvements (Backlog Maintenance)	120	0	0	0	120	120	0
Environmental Improvements (Reduced Ligature Risks)	400	33	59	26	400	400	0
Energy Efficiency Programme	90	0	0	0	90	90	0
Equipment	200	0	32	32	200	200	0
IT Replacement	200	0	4	4	200	200	0
Digital Innovations	50	0	0	0	50	50	0
Business Intelligence	150	0	0	0	150	150	0
Contingency	100	0	(0)	(0)	100	0	100
Sub Total Gross Capital Expenditure	**2,676**	**179**	**92**	**(87)**	**2,676**	**2,276**	**400**
Sale of Ashcombe Centre	(500)	0	0	0	(500)	(500)	0
Total Gross Capital Expenditure	**2,176**	**179**	**92**	**(87)**	**2,176**	**1,776**	**400**

- Actual Capital Expenditure at month 1 is £92k, against the plan of £179k, **£87k lower than plan.**
- The internal forecast shows is risk adjusted, showing a best estimate of the scheme delivery. Including the assumption that contingency is not utilised, the Capital programme is forecast to be **£400k lower than plan.** Specific assumptions include:
  - Anticipated Slippage on Learning Disability Facilities
  - Risk of slippage on the Detoxification Suites and Crisis Café as a result of the NHSI timetable
  - No plans in place against Contingency

8. Use of Resource Metrics

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

Table 9: Use of Resource	Year to Date Plan	Year to Date Actual	RAG Rating
Liquidity Ratio (days)			
Working Capital Balance (£000)		8,604	
Annual Operating Expenses (£000)		7,779	
Liquidity Ratio days		33	
Liquidity Ratio Metric	**1**	**1**	
Capital Servicing Capacity (times)			
Revenue Available for Debt Service (£000)		(63)	
Annual Debt Service (£000)		204	
Capital Servicing Capacity (times)		(0.31)	
Capital Servicing Capacity Metric	**4**	**4**	
I&E Margin			
Normalised Surplus/(Deficit) (£000)		(305)	
Total Income (£000)		7,710	
I&E Margin		-4.0%	
I&E Margin Rating	**4**	**4**	
I&E Margin Variance from Plan			
I&E Margin Variance		-0.2%	
I&E Margin Variance From Plan	**1**	**2**	
Agency Spend			
Providers Cap (£000)		205	
Agency Spend (£000)		219	
Agency %		7%	
Agency Spend Metric	**1**	**2**	
Use of Resource	**3**	**3**	

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

9. Better Payment Practice Code

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

During month 1, the Trust has over-achieved the 95% target in terms of the total value of invoices paid, but has slightly under-achieved against the 95% target for the total number of invoices paid. Table 10 below shows the Trust's BPPC performance split between NHS and non-NHS suppliers.

	2018/19			2019/20 Month 1			2019/20 Total		
Table 10: Better Payment Practice Code	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**
Number of Invoices									
Total Paid	625	10,935	11,560	42	895	937	42	895	937
Total Paid within Target	581	9,914	10,495	38	837	875	38	837	875
% Number of Invoices Paid	93%	91%	91%	90%	94%	93%	90%	94%	93%
% Target	95%	95%	95%	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**-2%**	**-4%**	**-4%**	**-5%**	**-1%**	**-2%**	**-5%**	**-1%**	**-2%**
Value of Invoices									
Total Value Paid (£000s)	6,449	35,113	41,562	302	3,686	3,988	302	3,686	3,988
Total Value Paid within Target (£000s)	6,100	33,819	39,919	270	3,645	3,915	270	3,645	3,915
% Value of Invoices Paid	95%	96%	96%	89%	99%	98%	89%	99%	98%
% Target	95%	95%	95%	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**0%**	**1%**	**1%**	**-6%**	**4%**	**3%**	**-6%**	**4%**	**3%**

- NHS Invoices missed the target by 4 invoices due to late authorisation and retrospective raising of orders.
- Non NHS missed the target by 58 invoices, of which 23 relate to Clarity invoices late authorisation. Other invoices missed due to late GRNs and retrospective raising of orders.

The finance team will continue to review performance and take action where necessary to improve timely authorisation of invoices and avoid retrospective raising of purchase orders.

10. Risks

There is risk within the 2019/20 financial position, which will need to be closely monitored in order to deliver the Trust control surplus of £338k. The risks are summarised within the table below.

1. **System wide programme savings -** Risk = £1m
   Mitigations
   - Monthly tracking of savings through STP Finance Committee
   - Leading on developments of PIDs with the STP

2. **2019/20 Cost Improvement –** Risk = £233k in year and £951k recurrently.
   Mitigations
   - Recruitment to transformation team underway
   - Ongoing development of schemes with divisional and corporate teams
   - Monthly review of CIP progress through Finance, Performance and Estates Committee. This includes 2 x annual presentations by each directorate.
   - Plan is based on full recruitment to posts, which is unlikely from 1st April therefore contributing non recurrently to CIP.

3. **Management of in year cost pressures –** No funding held to offset
   Mitigations
   - In year management of budgets and forecasting to enable early sight of areas of pressure to enable early action.

11. Recommendations

The Finance, Performance & Estates Committee are asked to:

Receive the Month 1 position noting:

- The reported year to date deficit of £305k against a planned deficit of £293k. **This is an adverse variance to plan of £12k.**
- The M1 CIP achievement of £0k; **an adverse variance of £158k to plan**
- The cash position of the Trust as at 30th April 2019 with a balance of £10,216k; **£1,224k better than plan.**
- Total Agency expenditure of £219k against the agency cap of £205k; **an adverse variance of £14k to plan**
- Capital expenditure at £92k compared to planned capital expenditure of £179k.
- Use of resource rating of **3** against a plan of 3.

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO OPEN TRUST BOARD

Enclosure No: 15

Date of Meeting:	27/6/2019		
Title of Report:	Finance, Performance and Estates Committee Assurance Report		
Presented by:	Tony Gadsby Chair/Non-Executive Director		
Author:	Mike Newton – Deputy Director of Finance		
Executive Lead Name:	Lorraine Hooper – Executive Director of Finance, Performance and Estates	Approved by Exec	☒

Executive Summary:		Purpose of report	
This paper details the items discussed at the Finance, Performance and Estates Committee meeting on the 17th June 2019. The meeting was quorate with minutes approved from the previous meeting on the 10th May 2019. Progress was reviewed and actions confirmed from previous meetings.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee X • Audit Committee ☐ • People, Culture & Development Committee ☒ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Primary Care Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration. ☐ 2. To provide the highest quality, safe and effective services X 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☐ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. X 7. Take a lead role in partnership working and integration. ☐		
Risk / legal implications: Risk Register Reference	Oversees the risk relevant to the Finance, Performance and Estates Committee		
Resource Implications: Funding Source:	None applicable directly from this report		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	There are no direct impact of this report on the 10 protected characteristic of the Equality Act		
STP Alignment / Implications:	The Trust Financial performance feed into the overall STP Financial Position.		
Recommendations:	The Trust Board is asked to note the contents of this report and take		

	assurance from the review and challenge evidenced in the Committee.	
Version	Name/group	Date issued

Assurance Report to the Trust Board
27th June 2019

Finance, Performance and Estates Committee Report to the Trust Board – 17th June 2019.

This paper details the items discussed at the Finance, Performance and Estates Committee meeting on the 17th June 2019. The meeting was quorate with minutes approved from the previous meeting on the 10th May 2019. Progress was reviewed and actions confirmed from previous meetings.

Executive Director of Finance, Performance and Estates Update

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

- **Update on the 2019/20 Contract –** The contract was signed with Staffordshire CCG on the 31st May 2019. This gives an opening contract value of £64.49m with a contractual commitment for payment of a maximum further £2.6m in month 12 to deliver the Trust control total, should mitigations not be identified in year to reduce the gap.

- **2019/20 STP Financial Plan –** The original submission reported a planned £114.6m trading deficit against a £88.1m control; a £26.5m variance. This was updated on the 15th May 2019 to a planned £108.1m trading deficit against a £92.1m control; a £16m variance to plan.

  Overall, the system planned deficit before PSF, has reduced by £6.6m and variance to control has reduced by £10.6m.

- **5 Year Financial Plan** – The Trust has been involved in the preparation of the STP 5 year financial plan. Guidance is still to be published but high level planning assumptions have been agreed, including that the Mental Health Investment Standard (MHIS) will be factored into the "do nothing" financial position.

- **National Capital Funding –** For 2018/19, the national capital position was oversubscribed against its allocation, along with the plan for 2019/20. As a result, early indications are that the provider sector could be asked to reduce Capital plans by 25%. The Trust requires permission, in addition to the approved plan submission, to use its own cash to fund Capital (£1.6m forecast in 2019/20) which it will submit in the next month.

Finance

- **Cost Improvement Programme (CIP)**

The Committee received an update for Cost Improvement for 2019/20. The Trust has identified £2.272m against the £2.505m internal target; a £233k variance to plan. The recurrent value of these schemes is £1.554m, representing a shortfall of £951k.

Currently the mental health workstream has identified £1.160m for 2019/20 and £2.822m recurrently against the £3,000k system savings target, which the Trust contractually has first call on the first £1,000k delivered. The Trust is assuming to deliver 100% against the £1,000k system target, both in year and on a recurrent basis. .

The Committee were assured that there was sufficient focus being placed on Cost Improvement, they were not assured around delivery of 2019/20 programme. The committee noted that an annual timetable has been agreed from July, where directorates would attend to present progress against CIP delivery for both 2019/20 and 2020/21.

- **Agency Report**

The committee received an update on the expenditure on agency for M1 2019/20 which was £14k over the ceiling. The committee noted that this was predominantly due to expenditure in primary care, which was £24k over the ceiling, with the Trust agency £10k under the ceiling. Assuming the same run rate as month 1, the Trust would be £441k overspent against the ceiling by the end of the year.

The committee outlined a need for further application of Trust agency controls in primary care that are consistent with those exercised in other areas of the trust, to be addressed through the Primary Care Committee. The committee were concerned that should the Trust not deliver a use of resources level 1 for agency, it would be unable to achieve an overall level 1 in the use of resources framework, should all other metrics be delivered as planned.

- **Capital Report and Capital Affordability**

The committee received an update on the Trust Capital position for 2019/20. It was noted that the Trust expects to fund its £2.7m Capital programme in 2019/20 through internally generated depreciation of £1.1m and its own cash reserves of £1.6m. Any cash reserves used over depreciation to fund capital, needs to be approved by the Treasury, which is consistent with previous years.

The committee were concerned that given the national oversubscription of Capital, there is risk around approvals of funding and requested that a number of funding scenarios be modelled which prioritise capital schemes.

Activity and Performance

- **Performance Report**

The committee were assured around performance reported in the traditional method with all clinical metrics being reported as green. The committee noted that the 3 exceptions all related to workforce supply shortages, which is consistent with the national picture and were concerned that the level of vacancies after known recruitment activity has increased compared to 2018/19.

The committee received a draft performance report, presented using the new performance

framework. The committee noted the usefulness of the Statistical Process Control (SPC) in comparing related metrics to draw meaningful conclusions.

Other:

- **Reference Costs 2018/19 Pre Submission:**

The committee reviewed the process around preparation of reference cost return and were assured that the systems and controls are in place and in line with the costing standards.

The committee were concerned around the level of cluster 99 activity, which was 43% for 2018/19 and noted that the Trust relative costing index (RCI) may be materially impacted as a result. The committee urged for a Trust wide review of cluster compliance to ensure that the activity data is accurate for the 2019/20 cost collection exercise.

- **Additional Assurance Reports:**

The Committee received additional assurance reports as follows:

- Finance Position M1
- Estates Update
- Activity Report M1
- Finance, Performance and Digital Risk Register
- Cycle of Business 2019/20
- Finance, Performance and Estates Monitoring Schedule

Recommendation

The Board is asked to receive the contents of this report and take assurance from the review and challenge evidenced in the Committee.

On Behalf of Tony Gadsby
Chair of Finance, Performance and Digital Committee

NHS
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Combined Healthcare
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REPORT TO OPEN TRUST BOARD

Enclosure No: 16

Date of Meeting:	27TH June 2019		
Title of Report:	Summary of the Audit Committee held on 24th May 2019		
Presented by:	Tony Gadsby, Chair / Non Executive		
Author:	Laurie Wrench, Associate Director of Governance		
Executive Lead Name:	Lorraine Hooper, Director of Finance, Performance and Estates	Approved by Exec	☒

Executive Summary:		Purpose of report	
This report provides a summary of the key headlines from the Audit Committee held on the 24th May 2019. The full papers are available as required to members.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☒ • People, Culture & Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Primary Care Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration. ☐ 2. To provide the highest quality, safe and effective services ☐ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☐ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. ☐ 7. Take a lead role in partnership working and integration. ☐		
Risk / legal implications: Risk Register Reference	To ensure that the committee meets its terms of reference by receiving reports of the work of its sub groups		
Resource Implications: Funding Source:	N/A N/A		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). 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:	N/A		
Recommendations:	Receive the report for assurance		

Version	Name/group	Date issued

Assurance Report of the Audit Committee
24th May 2019

Going Concern Assessment

The Committee received the Going Concern Assessment, which is an annual requirement. The Committee noted one area of concern with regard to the Contract which is currently not signed but noted there was a clear agreement in place.

Understanding Management Processes and Arrangements

The Committee received the 'Letter of Understanding of Management Processes and Arrangements' that was submitted to External Audit who confirmed that that they were happy with the response.

Letter of Representation

The Committee approved the Letter of Representation

Annual Governance Statement

The Committee approved the Annual Governance Statement

Year End Local Counter Fraud Report

KPMG – Internal Auditors are required annually to submit on behalf of the Trust, their Year End Report. The Committee noted that there had been some areas of improvement identified but discussed that the Fraud Training during the Induction Day was minimal and asked for consideration to be given with regard to a more detailed module being offered.

2018/19 Internal Audit Annual Report

The Committee received the Internal Audit Annual Report which encompasses the Internal Audit Opinion to be approved by the Committee. The report described the work completed by KPMG including 9 Internal Reviews. L Hooper reported the overall opinion is 'significant assurance with minor improvement.'

The Committee discussed performance with Internal Audit and the timetable for management responses which was reported at 75% and discussed what the Trust could do to improve this to 100%. The Committee learnt that there had been a number of Internal Reports that had proved challenging and therefore, lengthy discussions had taken place with KPMG regarding recommendations being made which had meant that reports had not be submitted in a timely manner to go through Trust internal governance processes for approval.

The Committee requested assurance as to what actions are being taken to improve timelines.

2018/19 External Audit Opinion and ISA 260 Report

H Rohimun, External Audit, summarised the report to the Committee as follows:

Risks Identified:

- Fraud Revenue
- Management Override
- PFI in relation to extension
- Property Plan Equipment
- New Accounting Standards

Audit Differences - Two amendments were identified; one regarding the impact on classification issues. The other regarding the Trust receiving an updated valuation report

Financial Resilience was reported as good for 2018/19 cost improvement.

2019/20 was noted as challenging with regards to contracts. The Contract is due to be signed at the end of this month. H Rohimun stated the Trust is operating within a financially challenging health economy which poses a risk to the Trust.

2018/19 Annual Report and Assurance

The Committee approved the 2018/19 Annual Reports and Accounts. The committee noted the document was very refreshing and accessible and that limited copies should be printed to reduce physical production.

Freedom of Information Quarterly Report

The Committee received the Q4 report and reported there had been a significant increase in FOI's during 2018/19 with the highest themes relating to digital, procurement and structures; the structures relating to the new Directorate configuration. There had also been an increase with regard to requests for HR and OD in the last quarter, but no common theme had been identified. There had been a reduction within the number of breaches recorded and no exemptions applied in Quarter 4.

Risk Management Policy

The Committee chair was requested to take Chair's Action to extend this policy until September 2019. This was approved.

Progress Reports Received:

- Risk by Level and Committee
- Board Assurance Framework 2019/20
- Audit Recommendations
- Waivers Report – 1st February to 30th April 2019
- Review of Losses and Special Payments

On behalf of the Committee Chair

Tony Gadsby

18th June 2019

NHS
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REPORT TO OPEN TRUST BOARD

Enclosure No: 18

Date of Meeting:	27th June 2019		
Title of Report:	Assurance Report from Business Development Committee		
Presented by:	Joan Walley, Chair – Business Development Committee		
Author:	Chris Bird, Director of Partnerships & Strategy		
Executive Lead Name:	Chris Bird, Director of Partnerships & Strategy	Approved by Exec	☒

Executive Summary:		Purpose of report	
To receive an update from the meeting of the Business Development Committee on 6th June 2019		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☐ Date: N/a	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People, Culture & Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☒ • Primary Care Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration.☐ 2. To provide the highest quality, safe and effective services ☒ 3. Inspire and implement innovation and research. ☒ 4. Embed an open and learning culture that enables continual improvement. ☒ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☒		
Risk / legal implications: Risk Register Reference	N/A		
Resource Implications: Funding Source:	N/A		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). 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:	N/A		
Recommendations:	The Board is asked to: 1) Note the contents of this report 2)		

Version	Name/group	Date issued

Assurance Report to the Trust Board
Business Development Committee
6th June 2019

Introduction

This paper details the issues discussed at the Business Development Committee on 6th June 2019. The meeting was quorate with minutes approved from the previous meeting on 11th April 2019. Progress was reviewed and actions confirmed from previous meeting.

Action Items

The meeting received updates against the two outstanding actions that had been carried forward previous meetings.

It was agreed that the refresh of the Partnerships Strategy originally due for presenting at the June meeting would now be reframed as a Partnering Strategy and shared at the next BDC meeting.

There remains one item for action relating to a review of the Darwin Centre. The Director of Partnerships & Strategy explained that a regional meeting had been arranged via Birmingham & Solihull Mental Health Trust for 7th and 14th June which would feed a paper to be shared at Executive Team on 18th June – the DoPS agreed to share this report with members of the Committee ahead of their next meeting. This has since been done.

Director of Partnerships & Strategy Update

The meeting received an update report from the Director of Partnerships & Strategy.

The report included updates (not referenced elsewhere in this report) in relation to:

- Operational and system planning – confirmation that the DoPS will be bringing forward a process to coordinate the development of a 5 Year Plan for NSCHT. This will be a standalone document for the Trust but will also provide a platform to contribute towards the development of the 5 Year system plan
- Commercial updates – including reflections on a visit by the Chair of BDC & DoPS to the new urgent care crisis centre. The work to repurpose the centre is at an early stage but is on track to be completed in Autumn 2019.
- Partnership Working – constructive meetings with key partners including BAC O'Connor, Addaction, North Staffordshire MIND and Changes, all of whom the Trust partner with in the delivery of services. The DoPS also attended the inaugural meeting of the Cooperate Working Group, a new forum which brings together a wide range of public and third sector organisations to share learning on common issues.

Business Developments

The Committee received an update on the numerous business development opportunities that are currently being pursued. Confirmation was given that the Trust would not be submitting proposals to provide Children & Young People's Emotional Wellbeing on behalf of Stoke-on-Trent City Council, this was supported by a thorough review of the factors which influenced this decision.

The Trust continues to progress a bid for Drug & Alcohol Services for Staffordshire which, if successful, would be delivered in partnership with Addaction and BAC O'Connor. The Committee also received an update on the development of other opportunities including New Care Models and IAPT.

Digital

The Committee received an update from the Chief Information Officer on the key digital projects which are currently live across the Trust, this includes:

- Integrated Care Record – procurement and mobilisation
- Lorenzo Digital Exemplar
- HIS Service Review
- Electronic Document Transfer
- Cyber Security.

There was a thorough discussion on the refresh of the Digital Strategy which is currently underway, the linkages to primary care digitisation and the options for accelerating the expansion of digital solutions across the Trust workforce to support more efficient and effective modes of working.

Progress with North Staffordshire and Stoke-on-Trent Alliance

The Committee received an update on the development of the Northern Alliance Board as it commences its planning to evolve into an Integrated Care Partnership (ICP) for Northern Staffordshire.

This is being supported by a series of workshops coordinated by PwC who have been contracted nationally to provide ICS development support to emergent ICS's.

The DoPS advised that the deadline for Primary Care Networks to be established had now passed and there would be 13 PCNs across the Northern Staffordshire economy. Each of the PCNs has an nominated PCN Clinical Director and will be progressing their governance structures and operational arrangements throughout June prior to the Network DES Contract going live in July 2019. Each PCN will then be progressing the recruitment of the new posts set out in The Long Term Plan and GP Contract with Clinical Pharmacists and Social Prescribers being the first of the five new posts.

Local Authority Financial Plans 2019/20

The Committee considered the 2019/20 financial plans for both Stoke-on-Trent City Council and Staffordshire County Council which have been published via their respective websites and considered the implications for the Trust.

It was noted that Stoke-on-Trent City Council has a new Director of Children's services and agreed that an invitation would be extended to a meeting with the DoPS and other members of the Trusts Executive Team in the near future. The purpose of this meeting is to review areas of common interest, understand respective priorities and assess any impact of those priorities on our organisation.

In a similar vein, the Committee also agreed to receive a summary report at their next meeting on the headlines emerging from the Local Authority Directors of Public Health annual reports.

Risks

The Committee agreed to include a new risk in relation to Drug & Alcohol Services. All other risks were discussed, reviewed and remained unchanged.

Recommendation

The Board is asked to:

1) Note the contents of this report

Chris Bird, Director of Partnerships & Strategy

On behalf of Joan Whalley, Chair

19th June 2019

NHS
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REPORT TO OPEN TRUST BOARD

Enclosure No: 19

Date of Meeting:	27th June 2019		
Title of Report:	High Potential Scheme		
Presented by:	Linda Holland – Director of Workforce, OD and Inclusion		
Author:	Michèle Wilcox – OD Practitioner		
Executive Lead Name:	Linda Holland - Director of Workforce, OD and Inclusion	Approved by Exec	☒

Executive Summary:	Purpose of report	
This paper provides an overview of the High Potential Scheme. Staffordshire and Stoke-on-Trent STP are leading on the first national pilot for the scheme in partnership with the National Leadership Academy. Our implementation commenced in April 2019.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People, Culture & Development Committee ☒ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Primary Care Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration. ☐ 2. To provide the highest quality, safe and effective services ☒ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☒ 5. Attract, develop and retain the best people. ☒ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☒		
Risk / legal implications: Risk Register Reference	Nationally recognised lack of a clear, visible pipeline of leaders, ready to take up more senior leadership roles within our new and evolving health and social care system environment (Smith and Rose Reviews 2015)		
Resource Implications: Funding Source:	0.5 WTE (Band 7) Project Manager appointed. Funding has been received from the National Leadership Academy.		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	Failure to address inclusion and diversity at senior level means that Boards are not representative of the staff populations they serve. Through monitoring and review throughout the scheme, it hopes to identify and begin to address barriers to progression for some groups.		
STP Alignment / Implications:	Aligns to OD and Systems Leadership Work stream		
Recommendations:	For information and assurance.		
Version	Name/group	Date issued	

High Potential Scheme (HPS)

1.0 Introduction and Context

The HPS is a ground breaking new National Leadership Academy programme that will offer bespoke development to a diverse cohort of participants within our Staffordshire and Stoke-on-Trent STP footprint to help them fulfil their potential and progress into more senior roles at a faster pace.

The creation, pilot and establishment of an NHS High Potential Scheme is a nationally mandated piece of work that arose primarily from the recommendations of the Smith and Rose Reviews (2015). Both reviews identified a lack of a clear, visible pipeline of leaders, ready to take up more senior leadership roles within our new and evolving health and social care system environment. Compassionate and inclusive leadership styles are also highlighted as a vital development needs to be addressed by the scheme.

Inclusion and diversity are central to this scheme, as it sets out to directly address identified gaps, at Board level, for under-represented groups.

To support the delivery of the NHS Long Term Plan, talent management remains at the heart of the People Plan and Workforce Implementation Plan. This will establish a clear link to the emergent Regional Talent Boards, helping us to retain talent within our system.

2.0 Scheme Overview

The scheme forms an important part of the development pathway for future pools of talent/ aspiring senior leaders with HPS graduates ready to access the Aspiring Chief Executive Programme and regional talent pool. There are two entry points to the scheme:

- HPS1 - aimed at Agenda for Change Bands 8a + and equivalent grades in other pay structures, including medical leadership.
- HPS2 - aimed at Agenda for Change Bands 8c + and equivalent grades in other pay structures, including medical leadership.

We are delighted to be the first National pilot site to launch the High Potential Scheme for our STP.

The application process will require individuals to complete:

- An on-line application form
- On-line psychometric tests
- Face-to-face assessment process

The scheme has an open application philosophy but applications will require support either from the applicant's line manager or alternative senior organisational sponsor.

The 'HPS' is a two year bespoke development programme (2019-2021), specifically designed to meet the unique needs of each individual participant by accessing tailored development to support the acceleration of their careers. Feedback from the scheme

selection and assessment process will help inform personal development plans along with a self-assessment against a career transitions framework and 360 degree feedback.

To maximise their personal development, each participant will be assigned a careers coach for the duration of their time on the scheme. Each participant will also need to identify a scheme sponsor from their organisation within the first three months.

The HPS is not a classroom based traditional programme. It is challenging, practical and stretching; immersing successful participants in real time projects and exposing them to complexity within our system. The programme follows the 70:20:10 model which is made up of three core elements:

- Experience based learning (70%)
- Developmental relationships (20%)
- Formal Learning (10%)

The scheme will be evaluated from day one, and action research will be undertaken during the testing year to enable us to develop the best solution. Through joining the scheme there will be an expectation on individuals to provide feedback on their learning and development during the scheme.

END.

The NHS
High Potential Scheme

First national pilot:

Staffordshire
&
Stoke-on-Trent
STP

Delivered in partnership with the National Leadership Academy

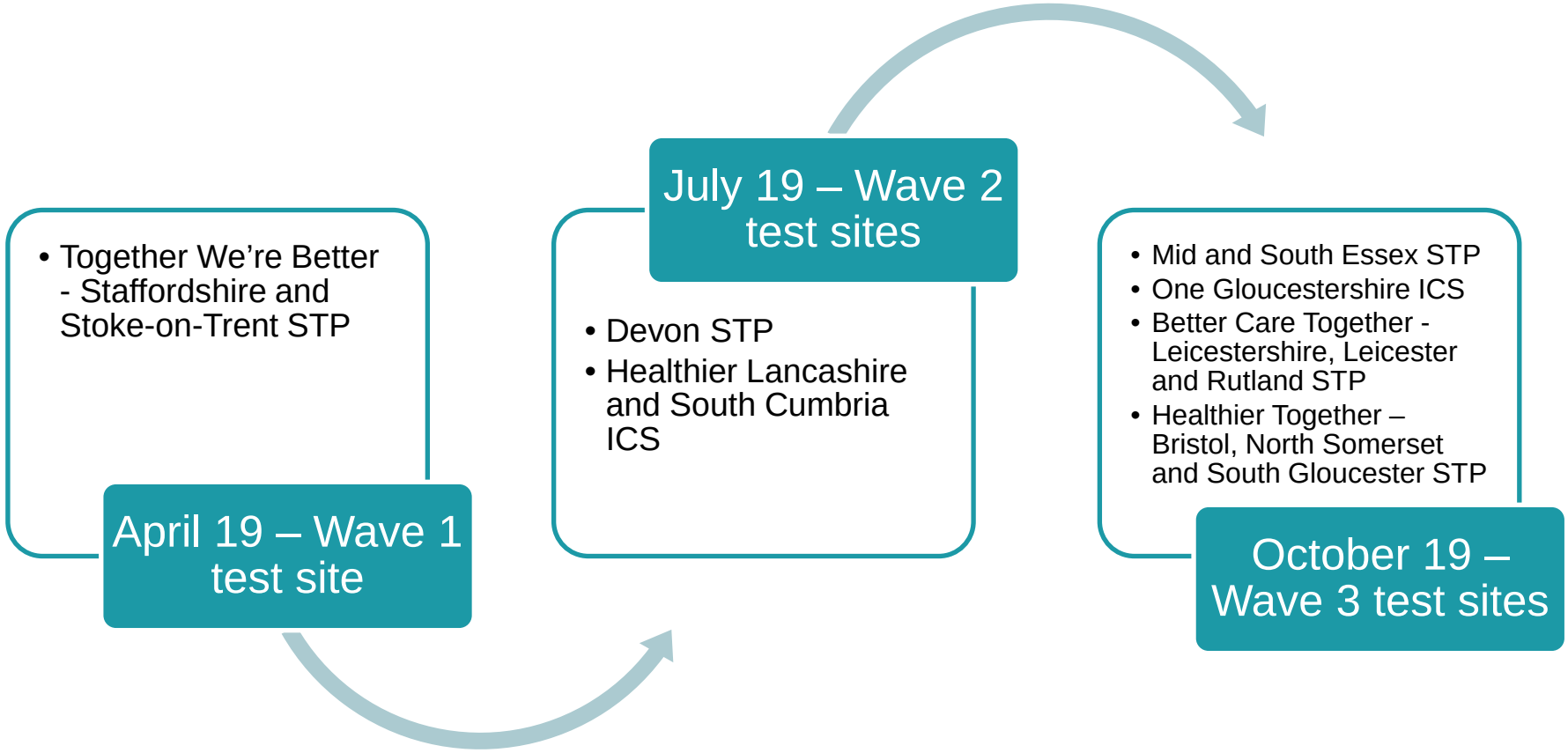
TOGETHER WE'RE BETTER

Transforming health and care for Staffordshire & Stoke-on-Trent

Context, mandate & expectation – a requirement to change:

- Lord Rose and Ed Smith Reviews (2015)
  - lack of clear, visible pipeline of leaders ready to take up more senior leadership roles with skills to succeed within our new and evolving health and social care environment
  - lack of compassionate and inclusive leadership
- Developing People – Improving Care (December 2016)
- Need to ensure representation, at Board level, of the diverse population they serve
- NHS Long-term plan – need to improve leadership and talent management
- Emergent Regional Talent Boards

Appointed testing sites (2019-2021)



Introducing the High Potential Scheme (HPS)

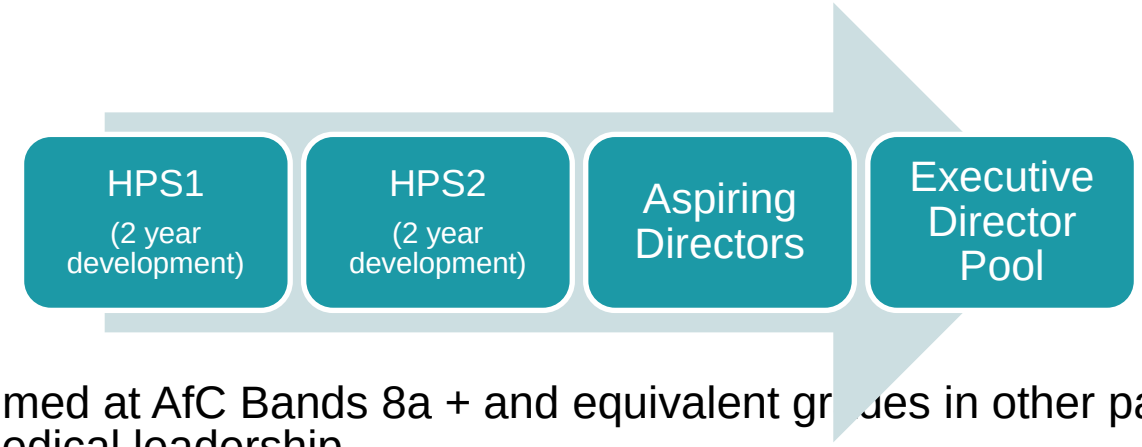
Ground breaking new programme that offers bespoke development to participants to help them fulfil their potential and progress into more senior roles at a faster pace – 'furthest, fastest'

The scheme will identify, develop and support a diverse cohort of aspiring senior leaders with potential to:

- Progress into more senior roles within the NHS at a faster pace
- Gain cross-sector experience (health and social care)
- Provide Staffordshire and Stoke-on-Trent STP with outstanding leadership for the future
- Utilise individual's high potential to enable better patient care
- Harness skills to create more inclusive cultures within the Staffordshire and Stoke-on-Trent STP
- Retain talent within our Staffordshire and Stoke-on-Trent STP

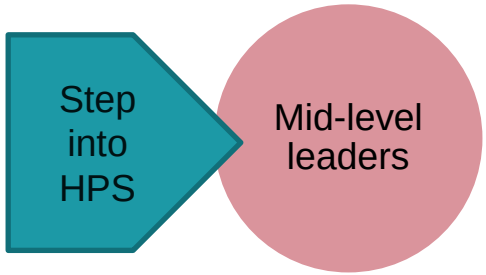
Scheme Outline:

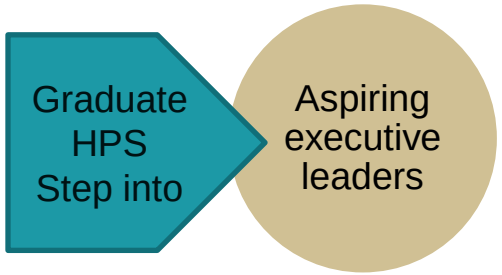
- Unprecedented scale: 2,000 participants at full maturity
- Two entry points: ‘HPS1’ and ‘HPS2’



- **‘HPS1’** – aimed at AfC Bands 8a + and equivalent grades in other pay structures, including medical leadership
- **‘HPS2’** – aimed at AfC Bands 8c + and equivalent grades in other pay structures, including medical leadership
- Each entry point is a bespoke two year development programme

Key Transitions





First key Transition

Transition 1: Focus becomes more on **system wide change / management** – within a framework

Second key Transition

Transition 2: Move towards **system leadership with greater accountability** – providing the answers

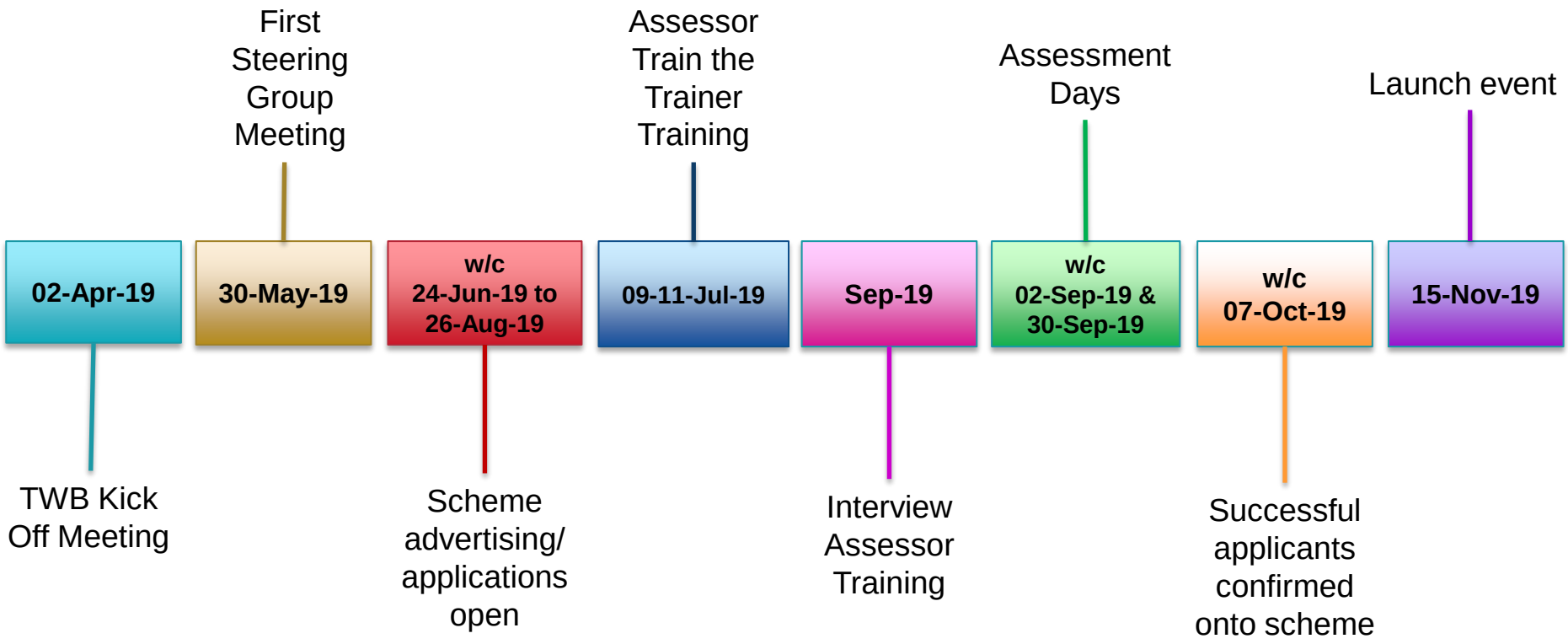
Third key Transition

Transition 3: Step into an Aspiring Director role, first level of senior/system leadership

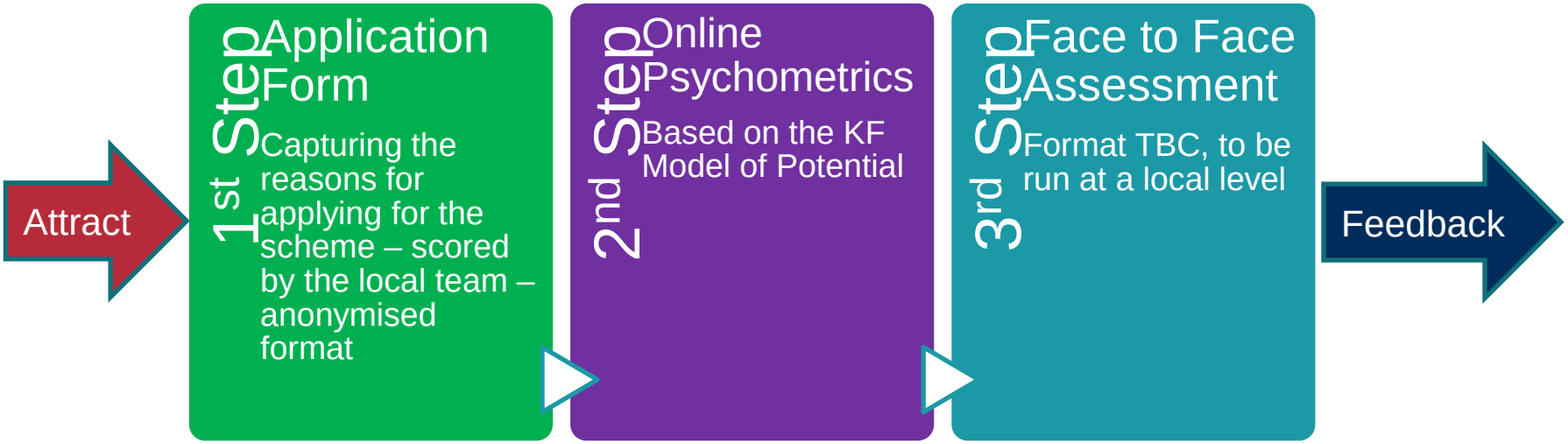
The aim of the HPS will be to:

- ✓ Identify those people with the greatest potential to progress to senior executive roles
- ✓ Recruit and develop cohorts of high potential leaders that are diverse
- ✓ The scheme itself will model inclusive leadership in its content, design, process and operations
- ✓ The process should provide insight into candidates behaviours/values as well as potential
- ✓ The process should feel developmental for both successful and unsuccessful applicants
- ✓ Provide appropriate support and stretching development opportunities
- ✓ Track high potential participants during and after the scheme providing evidence of the value of the scheme to progress their careers

Programme of Work

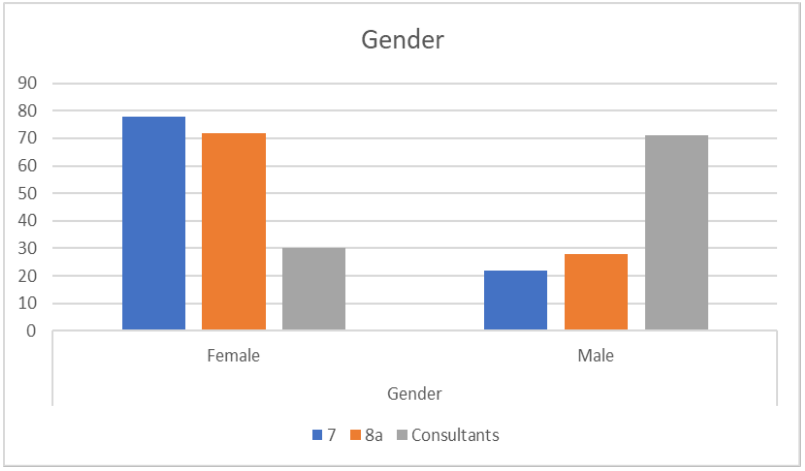


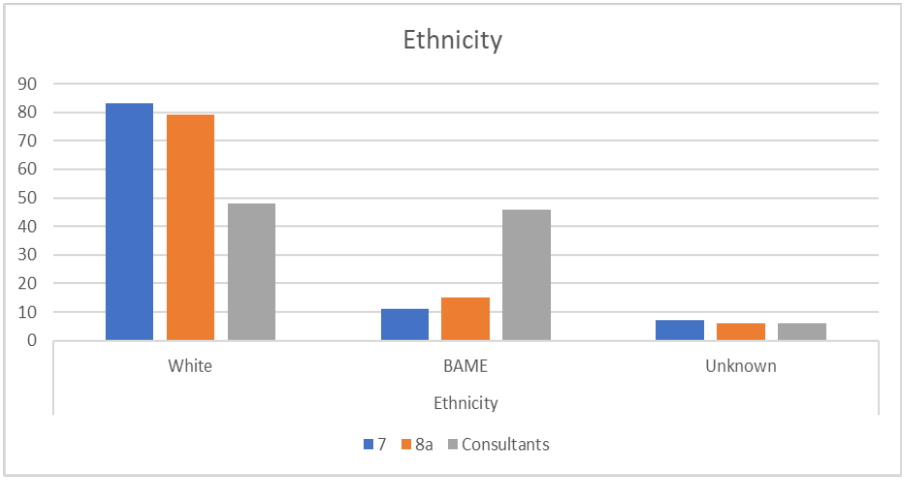
The assessment process

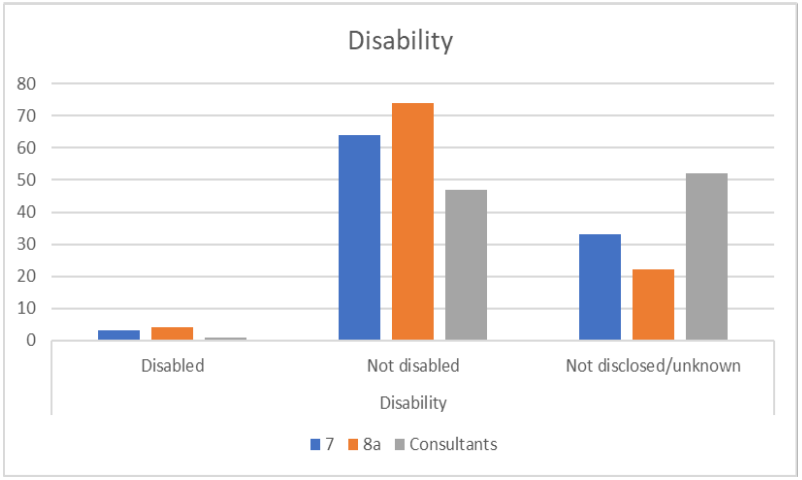


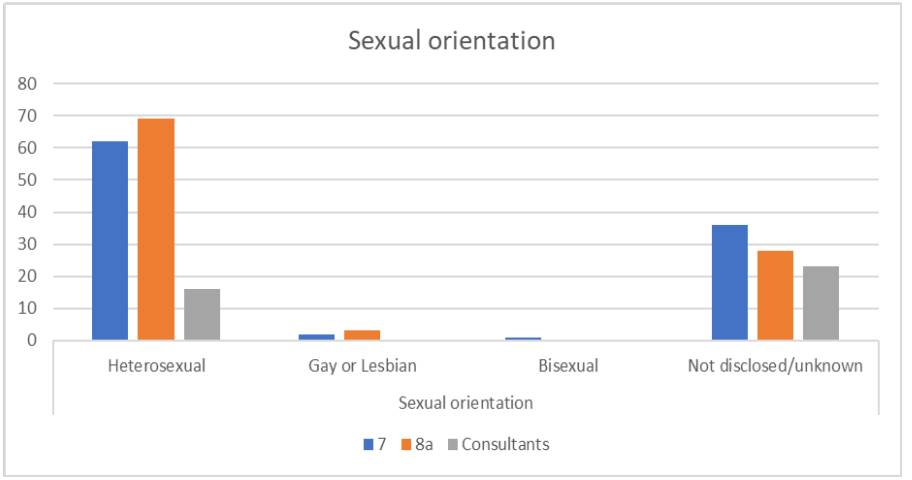
Monitoring and active management of the diversity of applicants

Protected characteristics data summary



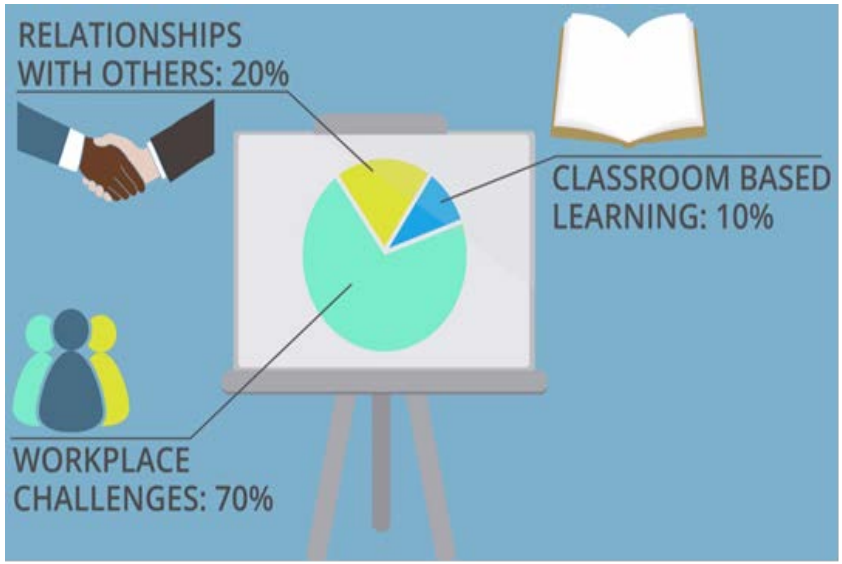






The Development Offer

- Models the 70:20:10 approach
- Targeting development where most needed for the participant
- Give ownership to participants for own development
- Development opportunities provided across the STP: job moves, projects, secondments, stretch assignments
- Maximise development already available locally/nationally
- Enable participants to learn from one another – Community and alumni



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REPORT TO OPEN TRUST BOARD

Enclosure No: 20

Date of Meeting:	27TH June 2019		
Title of Report:	Together We're Better Update		
Presented by:	Peter Axon, CEO		
Author:	Simon Whitehouse STP Director		
Executive Lead Name:	Peter Axon, CEO	Approved by Exec	☒

Executive Summary:	Purpose of report	
Attached is the Together We're Better Update (STP Directors Report) for May 2019.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People, Culture & Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Primary Care Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration. ☐ 2. To provide the highest quality, safe and effective services ☐ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☐ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. ☐ 7. Take a lead role in partnership working and integration. ☒		
Risk / legal implications: Risk Register Reference	Nil		
Resource Implications: Funding Source:	Nil Nil		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	Nil		
STP Alignment / Implications:	Nil		
Recommendations:	To receive for information		

Version	Name/group	Date issued

Report to: **Together We're Better Health and Care Transformation Board**

To be held on:

Report Title:	STP Directors Report							
How this paper supports delivery of; ✓ **Together We're Better System Plan** ✓ **TWB Localities Manifesto** ✓ **System clinical and financial sustainability**	This report provides detail on a number of areas of work across the STP that are not detailed elsewhere on the agenda, including operational performance, the STP PMO, the developing discussions around the Transformation Delivery Unit and an update on the Integrated Care System work.							
Report presented by:	Simon Whitehouse, STP Director							
Report prepared by:	Simon Whitehouse, STP Director							
Recommendation:	For decision		For discussion	X	For assurance		For information	X

Recommendations / action required:

The Health and Care Transformation Board is asked to:

1. Note the current performance position for our system
2. Note the update from the STP PMO
3. Note and comment on the escalation issue raised by the Mental Health Programme Board.
4. Support the development of this work
5. Agree to receive a detailed paper at the June HCTB with an approach and timetable for establishing the unit.

Executive Summary:

This report details:

- The month 12 operational performance within the health and care economy.
- Updates from the STP PMO, including changes to programme leads and programme highlights.
- An update on the emerging Transformation Delivery Unit discussions.
- An update on the Integrated Care System work.

STP Director's Report

This report sets out a number of key areas that are not detailed elsewhere on the agenda.

1. STP Performance Dashboard

1.1 The paper found in Appendix 1 provides an overview of current performance of commissioners and providers across Staffordshire and Stoke-on-Trent. Key challenges continue across a number of constitutional standards.

1.2 Key points to note are:

1.2.1 **A&E Performance** waits (seen within 4 hours, 95% standard): UHNM March position (81.5%) has increased slightly from the February position (80.3%). There were no 12-hour Trolley breaches at UHNM in March.

1.2.2 **Planned Care**: 18-week referral to treatment incomplete pathways (92% standard): STP performance reported at 85.5% for March which is a slight deterioration on the 86.7% position in February. UHNM continues to fail against the standard, and performance has deteriorated further in March (78.9%).

52-week breaches: 1 breach was reported across the STP in March, but no breaches were reported by UHNM.

1.2.3 **NHS 111** calls answered in 60 seconds (std 95%): Performance for March was reported as 74.1%, a slight improvement from the February position (66.9%).

1.2.4 **Delayed Transfers of Care** (standard 3.5%): UHNM performance is still below trajectory reporting 5.8% in February.

1.2.5 **Cancer 62-day** std (standard 85%): STP position, although slightly improved is still not meeting the standard in February (76.3%) from a January (69.8%) position. Performance at UHNM has also slightly improved in February (78.5%) from a January (69.3%) position.

Cancer 2 week wait std (standard 93%). STP February performance has slightly increased to 93.3% from 93.2% position the previous month. UHNM February position is 97.8%.

1.2.6 **Mental Health**:

- **IAPT access standard** (standard 4.75%): All 6 CCGs are meeting the IAPT Access standards in January. STP January rolling quarter position is 5.03%. IAPT STP recovery January position is 57.1%, above the 50% standard.
- **Dementia**: Overall, the STP (Feb position 70.9%) is meeting the 66.7% diagnosis rate standard for February. However, three CCGs (South East Staffordshire & Seisdon Peninsula, Stafford & Surrounds and East Staffordshire) continue to underperform against the 66.7% standard in February.
- **Early Intervention Psychosis** (standard 53%): All CCGs are meeting the standard in February.

The Board is asked to note the current performance position for our system

2. STP PMO Update

2.1 Programme Leads Update (SOP005, version 2.4, Issued 4.4.19)

The STP PMO re-issued an updated version of Programme Leads (SOP 005) across the STP on 4 April (attached at Appendix 2). This includes the changes listed below and replaces all previous versions of SOP 005. A further update will be issued in July 2019. The changes to this version are:

- Digital: Paddy Hannigan (CCG) has commenced as clinical SRO replacing Caroline Donovan.
- Planned Care & Cancer: John Gilby (CCG) has commenced as Clinical Lead for primary care.
- Children & Young People: Jacquie Ashdown (SOT CC) has commenced as programme Director
- Prevention: Andrew Donaldson (Staffordshire CC) has commenced as Programme Director
- Workforce: Rachel Gallyot (CCG) has commenced as Primary care Clinical lead

Since April, Peter Axon (NSCHT) has commenced as SRO for Mental Health replacing Caroline Donovan and Gwyn Thomas has stepped down as Strategic Lead for Digital. We would like to welcome new colleagues to the STP and thank outgoing-colleagues for their contributions to the programmes.

2.2 Programme Changes and Notifications

Following the departure of Caroline Donovan as SRO for OD & Leadership, discussions have been taking place to align this programme into a single portfolio with Workforce with a single SRO and governance structure. This will enable greater maximisation of the opportunities across these delivery areas. Work is ongoing on the governance to support this change.

2.3 Welcome Pack

A 'Welcome Pack' to support new leads to STP programmes and to aid induction has been developed for use throughout the STP. This includes information about STP vision and priorities, programme priorities, key contacts, planning and processes used within the STP and PMO. The pack has been produced with and shared via Programme Directors and programme managers.

2.4 STP Operating Model

The PMO has pulled together the operating model across the STP programmes into a single document. This explains and sets out the systems and processes used to support and manage across the programmes, including governance structures, stocktake processes, standard operating processes, structure and functions of programmes etc. The Operating process has been produced with and shared via Programme Directors and Programme Managers.

2.5 Programme Highlight Reports

Appendix 3 shows the most recent Highlight Reports from the UEC, Mental health, Workforce and Digital Programmes and details progress and delivery to date, risks and issues faced by each programme and any issues requiring escalation and resolution by the HCTB.

There is one escalation issues requiring resolution by the Board raised by the Mental Health Programme, which is:

- *Financial challenges affecting funding of services and achievement of MHIS – Programme to audit and sign off achievement of MHIS by CCGs.*

The Board is asked to

i) Note the update from the STP PMO

ii) Note and comment on the escalation issue raised by the Mental Health Programme Board.

3. Transformation Delivery Unit

3.1 National policy sets out a new 'system' focused architecture for care delivery by April 2020, requiring commissioners & providers to work differently around geographies. To support this, and to address the system financial deficit issues, the Staffordshire and Stoke-on-Trent system has agreed an ambition to create a single financial plan & a single delivery plan - moving away from separate financial planning and separate CIP/QIP and transformation delivery. The recent development of delivery 'sprint' projects scoped over a 6 weeks period for delivery during 2019-20 has set out a methodology and approach for rapid delivery which will be adopted.

3.2 To facilitate the above, work has commenced on creating a new delivery & support environment, signalling a shift in emphasis from single organisational approaches (i.e. QIPP/CIP/transformation and other delivery planning & implementation) to a 'system transformation delivery' approach. As part of this, a new system-wide unit will be established with the aims of: strengthening the system through joined up/integrated delivery, achieving greater joint accountability at project delivery and organisational level, more efficient working across organisations/entities and cost-out & transformation for system.

3.3 Principles underpinning the new delivery environment include:

- Any changes should not stop, slow or impede current delivery
- A move away from organisational focus to partnership focus
- A single pan-organisation, common governance/approach/monitoring process
- A 'straight line' between transformation, QPP, CIP – so that they fit together &
- complement each other within the broad transformational agenda
- Ensuring best use of resources, removing duplication
- Develop in conjunction with & in agreement with partners
- Build around current STP programme areas

3.4 The HCTB are asked to support the development work that is being undertaken. A pan-organisation working group has been established (comprising STP, MSFT, UHNM, CCG, NSCHT) reporting to the weekly CEOs Confirm & Challenge meeting.

The Board is asked to

- **Support the development of this work**
- **Agree to receive a detailed paper at the June HCTB with an approach and timetable for establishing the unit.**

4. Integrated Care System Update

4.1 Together We're Better has now commenced our Integrated Care System Support Programme that colleagues from PwC will be running alongside us for the next 16 weeks. The programme will be *co-designed as a system;* reflecting our challenges and ambitions for the future as well as supporting the development of our ICS in the context of the NHS Long Term Plan, statutory organisational responsibilities and the new Primary Care Networks that will be developing across Together We're Better.

4.2 Over the next 16 weeks, PwC will help us to progress towards achieving our ambition of becoming ICS. There will be a strong focus on achieving a number of specific outcomes and outputs, ultimately feeding into our own ICS development roadmap. We have already held an initial planning meeting with PWC on 1st May to talk through the opportunity and shape the bespoke elements of the programme. A presentation has also been delivered to the Exec Forum session on the 9th May to provide system leaders with a facilitated discussion regarding current ICS maturity self-assessments and to agree priorities, objectives and ways of working going forward.

4.3 A Stakeholder ICS Reference Group has been established to guide the development of the programme; which will meet for the first time on Monday 13th May to ensure all parts of the system have an opportunity to influence the programmes development; to ensure it becomes a valuable investment to support us in moving towards integrated health and social care system.

4.4 The Programme is being designed to deliver four full-day, tailored workshops structured in two parts: *Morning sessions* designed for content delivery, keynote presentations and peer learning. *Afternoon sessions* with bespoke workshops consisting of exercises and discussion topics. Three further Action Learning Sets (ALS) will be delivered facilitated to support alignment, decision making and enable system priorities to be explored. Dates of key events are noted as follows:

Event	**Date**
Workshop 1 – Vision, strategy & governance (1)	Wednesday 29th May
Leadership development session with Mike Farrar	Friday 31st May
Workshop 2 - Vision, strategy & governance (2)	Monday 17th June
ALS 2	W/C 1st July
Workshop 3 – Care redesign	Tuesday 9th July
Workshop 4 - Finance	Tuesday 16th July
Wrap-up meeting (ALS 3)	W/C 29th July

4.5 Ongoing updates relating to the ICS Development Programme will be delivered to the Health and Care Transformation In Board in due course.

Simon Whitehouse
STP Director
May 2019