North Staffordshire Combined Healthcare NHS
NHS Trust

MEETING OF THE TRUST BOARD

TO BE HELD IN PUBLIC ON THURSDAY 30 JULY 2015, 10:00AM, BOARDROOM, LAWTON HOUSE, TRUST HEADQUARTERS, BELLRINGER ROAD, TRENTHAM LAKES SOUTH, STOKE ON TRENT, ST4 8HH

	AGENDA	
1.	**APOLOGIES FOR ABSENCE** *To NOTE any apologies for absence:* Dr. I Laws, C Donovan	Note
2.	**DECLARATION OF INTEREST RELATING TO AGENDA ITEMS**	Note
3.	**DECLARATIONS OF INTERESTS RELATING TO ANY OTHER BUSINESS**	Note
4.	**MINUTES OF THE OPEN AGENDA – 04 JUNE 2015** *To APPROVE the minutes of the meeting held on 04 June 2015*	Approve Enclosure 2
5.	**ACTION MONITORING SCHEDULE & MATTERS ARISING FROM THE MINUTES** *To CONSIDER any matters arising from the minutes*	Note Enclosure 3
6.	**CHAIR'S REPORT** *To RECEIVE a verbal report from the Chair*	Note
7.	**CHIEF EXECUTIVE'S REPORT** *To RECEIVE a report from Dr B Adeyemo, Medical Director on behalf of the Chief Executive*	Note Enclosure 4
	FOCUSING ON QUALITY AND SAFETY AND BEING AN EMPLOYER OF CHOICE	
8.	**SPOTLIGHT ON EXCELLENCE** *To PRESENT the Spotlight on Excellence Team and Individual Awards to staff* *To be introduced by the Chief Executive and presented by the Chair*	Verbal
9.	**PRESENTATION FROM TRUST'S ADULT COMMUNITY MENTAL HEALTH TEAM – Ashcombe Centre** *To RECEIVE an introduction to the team led by Mr. A Oakes, Head of Directorate*	Verbal
10.	**STAFF RETIREMENTS** *To EXPRESS our gratitude and recognise staff who are retiring.* *To be introduced and presented by the Chair*	Verbal

11.	**QUALITY COMMITTEE REPORT** *To RECEIVE the Quality Committee assurance report from the meetings held on 16 June and 21 July 2015 from Mr. P Sullivan, Chair of the Quality Committee*	Assurance Enclosure 5
12.	**NURSE STAFFING MONTHLY REPORT – April 2015** *To DISCUSS and APPROVE the assurance report on the planned versus actual staff variances from Mr. M Dinwiddy, Interim Director of Nursing & Quality* **NURSE STAFFING SIX MONTHLY REPORT** *To RECEIVE for assurance purposes the six month analysis report from Mr. M Dinwiddy, Interim Director of Nursing & Quality* ***Both papers received by the Quality Committee***	Assurance Enclosure 6.1 Enclosure 6.2
13.	**QUALITY ACCOUNT 2014/15** *To RECEIVE the final version of the Quality Committee approved by the Quality Committee from Dr. B Adeyemo, Medical Director* ***Paper received by the Quality Committee***	Assurance Enclosure 7
14.	**INTEGRATED QUALITY REPORT Q4 2014/15** *To RECEIVE for assurance purposes the Q4 2014/15 report from Dr. B Adeyemo, Medical Director* ***Paper received by the Quality Committee***	Assurance Enclosure 8
15.	**SERVICE USER AND CARER COUNCIL** *To RECEIVE a report for approval on the Service User and Carer Council presented by Mr. M Dinwiddy, Interim Director of Nursing & Quality* ***Paper received by the Quality Committee***	Approval Enclosure 9
16.	**THEMES AND LESSONS LEARNT FROM NHS INVESTIGATIONS INTO MATTERS RELATING TO JIMMY SAVILE -** (Independent report for the Secretary of State for Health February 2015 - Authors: Kate Lampard & Ed Marsden) *To RECEIVE a report detailing the Trust's response presented by Mr. M Dinwiddy, Interim Director of Nursing & Quality* ***Paper received by the Quality Committee***	Assurance Enclosure 10
17.	**BOARD TO TEAMS VISIT REPORT Q1 2015/16** *To RECEIVE for assurance an analysis of Board to Team Visits from Mr. M Dinwiddy, Interim Director of Nursing & Quality* ***Paper received by the Quality Committee***	Assurance Enclosure 11
	DELIVERING OUR FINANCIAL PLAN AND ENSURING GOOD GOVERNANCE	
18.	**FINANCE REPORT – Month 3 (2015/16)** *To RECEIVE for discussion the month 3 financial position from Ms. A Harrison, Interim Director of Finance* ***Paper received by the Finance & Performance Committee***	Assurance Enclosure 12

19.	**ASSURANCE REPORT FROM THE FINANCE & PERFORMANCE COMMITTEE CHAIR** *To RECEIVE the Finance & Performance Committee Assurance report from the Committee Chair, Mr. T Gadsby from the meetings held on 18 June and 23 July 2015*	Assurance Enclosure 13
20.	**NHS ENGLAND – FIVE YEAR FORWARD VIEW** *To RECEIVE summary of the forward view and business plan from Mr. A. Hughes, Interim Director of Strategy and Development*	Note Enclosure 14
	CONSISTENTLY MEETING STANDARDS	
21.	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 3** *To RECEIVE the month 3 Performance Report from Ms. A Harrison, Interim Director of Finance* ***Paper received by the Finance & Performance Committee***	Assurance Enclosure 15
22.	**SELF CERTIFICATIONS FOR THE NHS TRUST DEVELOPMENT AGENCY** *To APPROVE the Self Certifications for the TDA from Ms. A Harrison, Interim Director of Finance*	Assurance Enclosure 16
23.	**BOARD ASSURANCE FRAMEWORK Q1 2015/16** *To RECEIVE for assurance progress against the Trust's Principal Objectives and Principal Risk Register, from Dr. B Adeyemo, Medical Director*	Assurance Enclosure 17
	BEING AN EMPLOYER OF CHOICE, DEVELOPING ACADEMIC PARTNERSHIPS AND EDUCATION AND TRAINING INITIATIVES	
24.	**PEOPLE AND CULTURE DEVELOPMENT COMMITTEE REPORT** *To RECEIVE the People and Culture Development Committee assurance report from the meetings held on the 22 June & 20 July 2015 meeting from Mr. P. O'Hagan, Committee Chair*	Assurance Enclosure 18
25.	**STAFF ENGAGEMENT** *To RECEIVE the LIA Pulse Check Results from Mr. P Draycott, Director of Leadership & Workforce* ***Paper received by the People and Culture Development Committee***	Assurance Enclosure 19
26.	**WIDENING PARTICIPATION** *To RECEIVE a progress report on the HCSW development programme and widening participation and development of the support workforce from Mr. P Draycott, Director of Leadership & Workforce*	Assurance Enclosure 20
27.	**To *DISCUSS* any Other Business**	
	QUESTIONS FROM MEMBERS OF THE PUBLIC	
28.	*To ANSWER questions from the public on items listed on the agenda*	

	DATE AND TIME OF THE NEXT MEETING	
	The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday 24 September 2015 at 10:00am.	
30.	**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

A meeting of the North Staffordshire Combined Healthcare NHS Trust will take place in private at 1:00pm, in the Boardroom, Trust Headquarters.

	DECLARATIONS OF INTEREST	Note
	DECLARATIONS OF ANY OTHER BUSINESS	Note
	SERIOUS INCIDENTS	Assurance
	CEO UPDATE , inc STAFF ENGAGEMENT, MANGEMENT RESTRUCTURE, R&D	Note
	BUSINESS CASES	Note
	ANY OTHER BUSINESS	

TRUST BOARD

Minutes of the open section of the North Staffordshire Combined Healthcare NHS Trust Board meeting held on Thursday, 4 June At 10:00am in the Boardroom, Trust Headquarters, Lawton House Bellringer Road, Trentham, Stoke on Trent, ST4 8HH

Present:

Chairman:

Mr K Jarrold
Chairman

Directors:

Mrs C Donovan
Chief Executive

Mr D Rogers
Non-Executive Director

Dr B Adeyemo
Medical Director

Mr P Sullivan
Non-Executive Director

Mr P O'Hagan
Non-Executive Director

Ms A Harrison
Interim Director of Finance

Mr P Draycott
Director of Leadership &Workforce

Dr K Tattum
GP Associate Member

Mr T Gadsby
Non-Executive Director

Mr M Dinwiddy
Interim Director of Nursing and Quality

Mr A Rogers
Director of Operations

Dr I Laws
GP Associate Member

In attendance:

Mrs S Storey
Trust Board Secretary/Head of Legal and Corporate Affairs

Mrs J Scotcher
Executive PA

Ms J Harvey
UNISON

Mrs A Roberts
Head of Communications

Team Spotlight:
Support Services
Anne Melville
Sue Buckley
Glenda Harvey
Christine Bentley,
Wendy Chadwick
Sue Petrozzi

Individual spotlight
Chris Mobberley
Supported by Alastair Forrester

Members of the public:
Hilda Johnson - North Staffs User Group

The meeting commenced at 10:00am.

38/2015	**Apologies for Absence** Apologies were received from Mr A Hughes and Mrs B Johnson. The Chair welcomed Dr Ian Laws, recently appointed GP Associate Board member, to his first meeting.	**Action**

39/2015	**Declaration of Interest relating to agenda items** There were no declarations of interest relating to agenda items.	
40/2015	**Declarations of interest relating to any other business** There were no declarations of interest.	
41/2015	**Minutes of the Open Agenda –30 April 2015** The minutes of the open session of the meeting held on 30 April 2015 were approved as a correct record, with the exception of ; ***Under 15/2015 – PQMF – Month 12*** Mr Sullivan made some observations and raised some concerns regarding the number of reds increasing month on month. He felt It is important we see improvements particularly in areas that would appear straightforward to resolve e.g. Mental Health Tribunal process. This is also important as it has serious legal implications."	
42/2015	**Matters arising** The Board reviewed the action monitoring schedule and agreed the following:- **08/2015 - Priority Referral Team - CYP Directorate -** Mrs Donovan queried what was the impact from changes at Stafford on the Trust. Dr Barton stated that statistics were available from when Stafford closed A&E services. It was noted that we need to transparency for commissioners; Mr A Rogers to take forward to provide more information to the Board. ***Mr Rogers commented that this issue is slightly wider than the Priority Referral Team, it is in relation to Mid staffs activity transferring to Stoke. This has been raised at Commissioning Board and they have recognised our case in this regard. This is ongoing and will bring back to the September meeting to provide the Board with a further update.*** **11/2015 - Safe Staffing Monthly Report -** Mr Sullivan was pleased to hear that community teams would be included and welcomed the increased data and metrics. He further noted that he would like to see complaints and incidents contained within the report. ***Mr Dinwiddy commented that with regard to the community metrics the work is ongoing to finalise the methodology for collating this information. It was noted that the six monthly report would be submitted***	**Mr A Rogers**

	to next month's Trust Board in July 2015 **11/2015 - Safe Staffing Monthly Report -** The Chair requested that the Board receive a regular report on recruitment. Mr Draycott to take forward. ***Mr Draycott commented that progress with recruitment was outlined in today's CEO report. The recruitment drive is well under way. There are also plans for another round of recruitment on a wider scale with regional campaigns, local papers and media towards the end of June 2015. He further noted that there are 4 nurses returning from training as Mental Health nurses and an additional Health Care Support Worker returning as a qualified nurse; continuing links with Keele student nurses for offer of employment.*** **11/2015 - Safe Staffing Monthly report** - Ms Harvey commented that the report gave clear information and wondered how we can share better? She queried whether this could come to JNCC in order to share with trade unions. It was agreed this would be very beneficial and logical. Mr Dinwiddy to forward to Ms Harvey. ***Completed – remove from schedule*** **12/2015 - Assurance Report - Finance and Performance Committee - 23 April 2015 - (FINANCE TEAM)** - It was proposed to write thank you letters to all those concerned for the impressive year end position – this is in hand with letters planned for completion by the end of the week. ***The Chairman suggested that this action be left on the schedule and removed once completed.*** **15/2015 - PQMF Month 12** - Mr Dinwiddy noted that action has been taken to review our links with the Tissue Viability Tem and this is being led by Ward Manager Janet Taylor on Ward 5. A further update will be reported to the Board next month. ***Mr Dinwiddy confirmed that we have organised a Tissue Viability Lead and finalised the Tissue Viability policy; currently reviewing the Service Level Agreement with SSOTP. In addition, engaging with Tissue Viability link meetings with SSOTP– complete remove from schedule*** **15/2015 -PQMF Month 12 -** Mrs B Johnson noted that the MH tribunal action plan lacked timescales for deadlines. Ms Harrison to take forward ***Completion dates now included – remove from schedule***	**Mr Dinwiddy**

	15/2015 - PQMF Month 12 - Sharing good news story with regards to the Access Team with LMC ***Completed – remove from schedule***	
43/2015	**Chair's Report** This is our first meeting since the election and my remarks are about the post-election scene as it is emerging. The Chair noted 3 points; First the new Government is facing very difficult choices on public expenditure in the context of the economic policy they have chosen. The Chair imagined that there are two schools of thought in the Treasury as the chancellor prepares his autumn statement. On the one hand there are all the promises made during the election. My favourite is George Osbourne's article in the Guardian when he said that the NHS would have all the resources it needs! On the other hand there must be those who are whispering in the Chancellor's ear and saying – do you really need to give all that money to the NHS given that we have just won a majority after 5 years of the lowest growth rates in the history of the NHS and facing a main opponent who consistently had a significant lead in public opinion on the NHS. We will soon know what the outcome will be. Second it is clear that the Five Year Forward view is the dominant policy framework. As you know I strongly support the Forward View and its emphasis on the integration of services. However, I have two concerns. The first is the capacity in NHS England, the Trust Development Authority and Monitor to implement the radical programme set out in the Forward view. The second is that there is a danger that the focus on integration will be diluted by the emphasis already being placed on other policy objectives. The Prime Minister in his first major speech after the election set out the case for a 7 day NHS. Simon Stevens in an interview this week talked about completely redesigning emergency care within 3 years. These are both massive initiatives that could take up all the energy and time available. The irony is that neither can be achieved without triple integration. – the integration of health and social care, of physical and mental healthcare and of primary and secondary services. Third the Government had some difficult choices to make about how much of the Lansley reforms should be preserved and how much should be ditched. Should the purchase/provider system remain, what about Payment by results, how much competition should there be and what should be the role of the private sector.	

	These three issues are likely to dominate NHS policy in this Parliament. We need to watch carefully and take the opportunities as they arise. Ms Harvey stated that the Trade Unions had concerns. Questioned whether the Health & Social Care Act would be repealed. Mr O' Hagan commented on the award of the local Cancer Care contract and that it was interesting that a party involved in this is involved in the wider restructuring and discussions regarding services in Staffordshire. Questioned whether there was a conflict of interest. The Chair noted that Board members should look at the House of Commons Parliamentary Debate of the 3 June 2015, which makes reference to the health service debate in Staffordshire. ***Received***	
44/2015	**Chief Executive's Report** Mrs Donovan, Chief Executive, presented this report which provides an update on the activities undertaken since the last meeting in April 2015 and draws the Board's attention to any other issues of significance or interest. **Quality Assurance** Plans and preparations are progressing for the CQC Comprehensive Inspection which has been confirmed for visit 7 – 11 September 2015. Mrs Donovan stated she was really pleased everyone is actively engaging in this and that it is important people feel as relaxed as possible with no script to revise and that there is openness and honesty about the services we provide. Each team has completed their self-assessment against the 5 domains; with some have actions to improve on. It was further noted that the Peer Review process will commence next week; – reviewing each of their services. Approximately 100 pieces of data have been submitted in response to the requests by the CQC/ Mrs Donovan thanked all those who supported this. . **Enhancements in Access to Services** The Access Team re-structured from beginning of January 2015. Previously there had been Home Treatment and Crisis; however Home Treatment are focusing on just that and Crisis have been integrated into Access to provide a 24/7 service. There have been a number of improvements since these measures have been put in place as follows ;	

	The following data highlights the outcomes as a result of the changes put in place: • 63% increase in the number of crisis referrals seen in 4 hours • Trend indicates increasing number of people receiving Home Treatment • Ward occupancy averaged below 100% for three consecutive months for first time in over a year • 21% increase in ward admissions and 23% increase in discharges • 18% reduction in average length of stay on wards • 5% reduction in detentions on wards • No increase in serious incidents or complaints across AMH services • 20% increase in readmissions Two dedicated lines have been put in place; one for primary care colleagues, to allow for easy referral when a client is seen by a GP and requires additional support and one for gatekeeping, to allow speedy access to an inpatient bed if needed. The improvements we have seen have taken place subsequent to a review, reported on in May by Healthwatch Stoke-on-Trent, into the experience of people in Stoke-on-Trent when they are accessing Mental Health services. The report focuses on the experiences of users of the Access service in the six months prior to the report publication. **Recruitment of additional nursing staff** The Trust has agreed additional funding for a number of areas, including staffing for acute inpatient wards, in order to support the high level of occupancy. We are committed to ensuring the right number of staff with the right skill mix are in place and we need to continually develop our strategies to plan ahead for change We have already begun a targeted recruitment process to provide improved stability, particularly in inpatient areas. We have already appointed 12 Health Care Support Workers (HCSW) and four registered nurses into our Adult and Neuro and Old Age Psychiatry Directorates, with further interviews scheduled for today, Thursday, 4 June 2015. **Listening into Action** The Listening into Action Programme continues moving into phase 2 with 14 new teams. We had first conversations with our HCSWs and will be having more conversations tomorrow. It is about staff feeling valued and working lives being as positive as possible.	

As part of this, we have launched a shadowing programme to really help us to understand each other's roles. Members of the Executive Team will be shadowing a range of professionals, including nurses, HCSWs, caseload managers and others. The shadowing programme will also be extended to take place out of normal working hours.

Healthwatch Report into Ward 4
Ward 4 has been subjected to a number of visits from CQC, TDA, CCGs and Healthwatch; all of which have been very positive. It is hoped that the ward will continue, however it is subject to funding from commissioners

Dear Caroline
The 'Dear Caroline' website was launched in February 2015. We have now shared information within the organisation in order to demonstrate to people what actions have been taken. The details are now available on the intranet. Overall themes were around leadership and management, staffing levels and workload.

Healthcare Awards
We have been shortlisted to the next stage of the two national awards in the Healthcare People Management Association (HPMA) Awards and are now finalists. The HPMA Excellence Awards 2015 recognise and reward outstanding work in healthcare human resource management.

We have also been shortlisted in the HSJ Value in Healthcare Awards for the partnership working between our Community Triage Team and Staffordshire Police.

Early Intervention Team celebrates progress
The Trust's Early Intervention Team celebrated its progress supporting young people with early psychosis at a special event.

The event shared some of the innovative approaches to working with younger people experiencing a first episode of psychosis that have helped develop the service. Mrs Donovan noted that the event was attended by the Chairman.

New Beginnings Event at Edward Myers Unit
The independent service user and carer group supporting people with drug and alcohol dependence held its latest Open Morning at the Edward Myers Unit during May.
The New Beginnings event was formally opened by the Chairman.

	The event heard a number of inspiring stories from those who have experience of using the Trust's Substance Misuse services and are now on the path to recovery, giving thanks also to the support from New Beginnings. **Mental Health Awareness Week in Staffordshire Moorlands** Staff across the Trust held a series of events showcasing the work that they do for the Mental Health Awareness Week. The Moorlands Mental Health festival was held at Foxlowe Arts Centre, in Market Place, Leek and featured a range of activities. **Trust and Fire Service Partnership Drop in Event** Fire and rescue service representatives were on hand at Harplands Hospital in early May, to provide advice and promote fire safety and prevention to people using the Trust's services and their carers. Mr O'Hagan commented on the forthcoming CQC visit and staff approach; celebrating excellent services which we deliver, this is a chance for us show how good we are. Mrs H Johnson commented on the Ward 4 visit of which she was part of the team. She also noted that she was lucky enough to carry out a PLACE inspection; whereby she noticed that the staff had already implemented suggestions made on the visit. Mrs Johnson further added she hoped the funding would continue. Mrs Johnson also stated that she had attending the Early intervention event and this was extremely positive. The Chair thanked Mrs Johnson for her comments and also noted that she too deserves credit for all her hard work and support for the Trust. Dr Adeyemo commented on the Listening in Action programme and that it had been a privilege to launch the 'Big conversation' with the junior docs; this is a group of staff who are often overlooked. Mr Draycott commented that the pulse check for Listening into Action was due to close tomorrow and results are encouraging so far. A progress report will be brought to the next People, Culture and Development Committee and Trust Board.	Mr Draycott

	Mr A Rogers was pleased to note feedback from the System Resilience Group regarding Ward 4 (which is still in draft); quote – '***Although the shared care beds on ward 4 was an unfunded scheme and was therefore implemented on an extremely short timescale, exceptional clinical leadership had supported a rapid cycle of learning and development. The service demonstrated a very positive multidisciplinary team approach and strong cross-organisational working, as well as flexibility and 'clinical common sense'.*** Mr A Rogers stated that he attended the Healthwatch Staffordshire event last night in conjunction with Newcastle Borough Council on health and social care services. Some lively debates focussing on hearing aids, particular focus on dementia and also on Autistic Spectrum Disorder (experience of service user) clearly the Trust was commissioned for this last year however, nothing commissioned for ongoing support; there was recognition by commissioners there is a gap . Finally, the Chair noted the events for the Early Intervention and New Beginning day, which was a privilege for him to launch and about the power of a story, rather than endless reports, the impact of someone standing up and telling their story. He further suggested that it may be beneficial to have staff stories as well as patient stories at the Board. The Board agreed this should be considered for the future. Mr Draycott to take forward ***Received***	Paul Draycott
45/2015	**<u>Individual Spotlight Award</u>** **<u>Chris Mobberley, Administrator, Intensive Support Team Learning Disabilities Directorate</u>** Chris has been an administrator with the newly developed Intensive Support Team for almost 10 months. During this time, he has supported the setup of the team, developing a range of technical systems and processes. Chris's motto is to make things simple. He has achieved this by creating a clinical pathways tool which is a programme where all the information relating to service processes are in one place and accessible for everyone. This has helped enormously with the efficient running of the team and saved a huge amount of time and energy as everything needed for the work of the team is in one place. The systems he has helped to create, enable effective use of IT and eliminate the need for paper copies of information. Chris is always happy to help anyone and has helped to empower individuals to use information technology in a different way. He is also helping to introduce this tool in other parts of the directorate. Chris is innovative, enjoys a challenge and is creative in his thinking.	

	Chris reflects all the Trust values, but the one that he demonstrates most is 'providing high quality innovative care', His innovative approach has meant that time is saved on administration tasks, service quality is improved, mistakes are reduced and processes are easy to follow, as information is recorded in a chronological order relating directly to the teams timeline. **Team Spotlight Award and Presentation** **Support Services Team – Corporate Services Directorate/Operations Team** The Support Services team comprises 16 staff, providing professional leadership and management in domestic services, catering, linen, non-urgent patient and courier transport, fleet management and associated external contracts. We are registered as an Accredited Centre with the Chartered Institute of Environmental Health for the delivery of Food Safety Training Level 2 to Trust staff. They work in close partnership with clinical teams to deliver a well-regarded cleaning and house-keeping service in all patient and non-patient areas. Our services consistently deliver a high quality, safe environment which meets patients and public expectations demonstrating the Trusts commitment to reduce the incidences of healthcare associated infections. The support services team demonstrate all the Trust values, but in particular 'working together for better lives' through their partnership working with clinical teams and service users to ensure that the environment is well maintained, safe and clean. They also contribute to 'high quality innovative care', through continuously working with service users to understand which areas of work undertaken by support services would improve their experience whilst in our care. Mr D Rogers thanked the team and noted that the standards across the Trust are clearly very high and that it would be good if the Board could use these other facilities He queried what aspirations have the team got to make things even better? Mrs Melville stated that the team would like to engage more with service users in food tasting at the Harplands Hospital. Mrs Melville also remarked on the high scores achieved with cleanliness; the team review the environment from a clinical perspective as well and hygienic. The team achieve high standards and strive to maintain them.	

	Ms Harvey commended the team and reminded the Board that she too, had started her NHS career as a domestic and what great teams of domestic staff we have. She also remarked on how proud she was that the Trust had kept these services in-house as some Trusts outsource in this area. She further noted that domestic staff can be hit the hardest with changes to services, closures of hospitals, as many of them live locally. Domestic staff are now treated as part of the team and their importance within the team has now become more recognised. Ms Harvey noted that she was passionate about support services and made reference to when she was a patient and how support services staff helped look after her during her hospital stay. Dr Tattum thanked the team and congratulated them on their impressive scores; he noted the lowest score of 91.86% in relation to Privacy, Dignity and Wellbeing - what can this Board do to help improve that? Mrs Melville remarked that some of the scores can be skewed or vary ie The Darwin have not got any integral blinds. Dr Tattum stated perhaps the Trust needs to invest in this area. It was agreed that all environments were under review. Mr Draycott thanked the team for their presentation and remarked that all support services staff are always helpful, accommodating and professional. He was delighted to see that the team are using the Aston team approach. He also remarked on feedback from Maureen who is an RCN on how incredibly clean our environment is. Mrs Donovan commented on the fabulous PLACE assessment scores and how much higher the Support Services Team are against national benchmarking within England. Secondly, she remarked on the support of the Cleanliness Technician provided by the Estates Team, providing maintenance support under the direction of the Support Services Manager. Mrs Donovan queried what was the relationship like with Carillion – how do you work together? Mrs Melville confirmed working relationships were positive and she attended the Contract Monitoring meetings. There has been joint working with menus and with the dieticians. As previously mentioned, taste testing and pureed new deserts is planned. Mr A Rogers thanked the team and commented on their Estates and Transport functions. He noted that savings have been made in this area and sometimes this has been through other directorate budgets; due to Support Services reconfigurations.	

	Mrs S Storey responded to Mr Rogers' comments about the use of other facilities and highlighted proposals to take the Trust Board on the road and hold at different venues. Mrs H Johnson noted that there was good opportunity for volunteers to get involved in PLACE assessments and other areas. She noted that staff take pride in their area and the working relationships with Carillion and the Trust are very good and this is apparent on the wards. The Chair thanked the team and noted that the quality of our environment is really important and that all staff should be congratulated on continually maintaining high standards. ***Received***	
46/2015	**Staff Retirements** Mrs Donovan recognised 3 staff who are retiring this month as follows, unfortunately these staff were not able to attend today : **Geoff Wilson** Geoff has been an NHS UNISON representative for over 12 years and in 2004 became he the full time staff side lead for the KSF element of Agenda for Change. Since then, his working life was been devoted to Staff Side work within the trust, negotiating on behalf of staff and representing UNISON members. His work often involved supporting staff at the most difficult and distressing time of their career, and Geoff has always carried this out with a heartfelt empathy and sensitivity. As busy as he was, Geoff would always put listening to members concerns at the highest priority, even when off duty. The union office can often be a fraught environment and one of Geoff's strengths has always been his ability to puncture the tension with a well-timed aside. We will certainly miss his razor sharp sense of humour All of the staff side reps and the managers he has worked with have a lot to thank Geoff for, but not as much as the many staff members he has helped and supported over more than a decade, and we all wish him the very best in his retirement. **Denise Pearson** Denise joined the NHS in 1977 as a cadet nurse and nursing assistant at Stallington Hospital. Going on to undertake her student nurse [LD] training in 1978. Denise qualified in 1981 as a Staff Nurse working at Stallington Hospital. In 1982 Denise progressed to undertaking her student nurse training [MH] moving to Bagnall Hospital in 1983 and moving on to a Ward sisters post at St Edwards Hospital leading on the development of the Rehabilitation Services. Subsequently Denise has had a	

	number of roles within the Trust including Ward Manager and subsequently Centre Manager at the Bennett Centre between 1992 and 2008. At this point as part of the progression of the integration of Community Social Care and Health Services Denise took up the post as Head of Service [Health] working alongside colleagues from the Local Authority and within the Trust to deliver the Partnership Agreement with Stoke City Council which remains in place today. More recently Denise has been involved in a number of operational manager roles. Denise was integral to the planning and implementation of significant changes to the community mental health teams over the last 2 years as part of phase 1 and phase 2 of the Trusts development programme and as latterly, been integral to the work to deliver improvements within the IAPT Healthy MINDS Service. Outlining Denise career path does not fully do justice to her impact upon both the Trust and people with mental health issues throughout the last 30 years. She has had profound influence on many members of staff and colleagues with whom she has been both a mentor, manager and supportive friend. Her vast experience, personal skills and knowledge have been invaluable in delivering safe and productive services for people who have experienced difficulties. She is a trusted and well loved colleague by all her friends and associates who are clearly going to miss her pragmatic and personal approach when looking for support or solutions. On a personal level Denise also met and married her husband David whilst they both worked within the Trust and has managed to both deliver and develop her professional role whilst bringing up her three wonderful daughters and supporting David in his career. Denise will be hugely missed by everyone who has the pleasure to work with her over the last 30 years. Everyone will wish Denise all the success and happiness she deserves in the future.	
47/2015	**Quality Committee Summary held on 19 May 2015** Mr Sullivan, Non-Executive Director, presented the summary of the Quality Committee held on 19 May 2015 for assurance purposes. The Quality Committee approved/extended or withdrew the following ; • MHA 18 DOLS • MHA01 Community Treatment Order • MHA02 Responsible Clinicians	

	• MHA03 Nurse Holding Power • MHA04 Holding Powers of Doctors and Approved Clinicians • MHA06 Guidance on Conflict of Interest • MHA09 Section 117 Aftercare • IC2b Sources of Advice for Infection Control • IC6 Notifiable Diseases • IC3 Standard Precautions • 5.19 Zero Tolerance • 5.31 Legionella • 5.35 Medical Devices • 1.46 Falls Policy • 4.40 Being Open (incorporating Duty of Candour) • 1.27 Rapid Tranquilisation • 5.37 PITS Procedure • 1.71 Duty to Cooperate with MAPPA – approve until 31.03.2016 • 1.52a & 1.52a Research & Development Strategy and Policy – approve until 31.03.2016 • 1.55 Advance Decisions and Statement • 1.72 Direction on Choice – withdraw, no longer required • 5.38 Lockdown Policy • 4.25 Consent to Examination • 1.28 Non acute delays Protocol • 1.67 Smoking Policy – approve for 12 months • 4.38 Reimbursement – approve for 12 months ***Ratified*** A summary document was presented to the Quality Committee to share the results of the new Audit of Schizophrenia. This noted good performance, there were some actions to address for improvements. Other reports scrutinised by the Quality Committee ; • Nurse staffing report – *which is on today's agenda* • Quality Metrics from the Performance Quality Management Framework Month 1 – *also on today's agenda* • Quality Account 2014/15 – *reads well*	

	• Clinical Effectiveness Annual Report 2014/15 – extremely helpful document Clinical Audit programme 2015/16 – *very detailed information and large programme.* In terms of assurances, the Quality Committee received; Self Harm Ligature Incident Analysis report; Mental Health Act Code of practice ; Healthwatch report; Directorate Performance reports; Care Quality Commission work ; Patient Council update ; Briefing on Kings Fund – Reconfiguration of Clinical Services ; Update on out of area patient from South London and Maudsley Dr Adeyemo clarified that in respect of the Self Harm Ligature Incident Analysis report; it was not the incidents that had increased, but the method of ligatures that people were using. ***Received***	
48/2015	**Safe Staffing Monthly report** Mr Dinwiddy, Interim Director of Nursing and Quality, presented the assurance report. This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during the data collection period (1 -31 May 2015) Mr Dinwiddy updated the Board as follows; The performance relating to the fill rate (actual numbers of staff deployed vs numbers planned) on the wards for April 2015 being a total fill rate of 99.8% registered nurses and 102% for HCSWs. Unify data will reflect that the Trust achieved safer staffing levels based on total fill rates The report will detail fill rates broken down by inpatient areas for registered nurse and care staff attaching a RAG rating based on percentage fill rate. Telford Unit will reflect an amber rating based on fill rate of 87.3%. Shortfall of registered nurse day shift cover has affected the overall fill rate. The report presents additional quality related metrics for monitoring against the staffing fill rate and will provide Ward Manager narrative on key issues for each clinical team. The report provides an update on the developments in community safer staffing	

	It was further noted that the data is an amalgam of day and night shifts and this month there is an improved set of metrics as agreed, which includes incidents and complaints. Mr Dinwiddy stated that we have noted continued pressure on occupancy levels across the acute wards. We have taken this information to commissioners which has informed the new investment in staffing levels. As discussed previously at Board, Mr Dinwiddy remarked on the accepted level of fill. He confirmed that the TDA use a figure of 80%; however the Trust uses a scoring mechanism of 90%. The occupancy had been RAG rated throughout the report at green with the exception of Telford Unit, scoring amber at 87.3% due to staff sickness Mr Dinwiddy further noted that unfortunately, there is no detailed data in respect of community; this is due to there being no national agreed methodology to record this. Secondly, there are issues regarding the recording and reporting of data. It was noted that the Trust has a Caseload Management Group, whereby the tool is being developed for community data and we want to ensure the metrics are tied in, before we report information to the Board. This is an improvement going forward and will continue month on month. Mr Dinwiddy also confirmed he is working with Ms Harrison to take this forward. Furthermore, it was noted that some of the sickness rates were 0% recorded; however this was a reflection on not being able to obtain the data out of system at the time of this report. Mr A Rogers also noted that within the Trust occupancy levels are based on home/leave measures ie Darwin showing 100% whereas 8 out of 10 filled due to 2 on home leave. Mr Dinwiddy to pick this matter up with Dr Adeyemo for further consideration with the data. Ms Harrison confirmed that the Trust is in the process of completing a Bed Capacity Model and would work with Mr Dinwiddy in this respect ie patients sleeping out. Mr Dinwiddy stated that we needed to reflect those numbers. Mrs Donovan further clarified that as part of the Listening into Action programme; Ms Harrison was leading on the Bed Management and Mr Dinwiddy leading on the Caseload management. Ms Harrison confirmed she had devised a system whereby 'Out of area beds' ; we can now transfer the financial responsibility to the appropriate Clinical Commissioning Group.	**Mr Dinwiddy**

	Mrs H Johnson noted that she had seen the bed occupancy rising. Technically we cannot discharge someone when they are on leave. However, she did state that 'home leave' patients are able to come back to the ward should they need to do so. Dr Laws commented that the nurse coverage on A&T is quite low and were there any current vacancies there? Mr Dinwiddy commented that there has been some sickness in that area; however this is now improving. The Board should be aware that there are only 11 beds on this unit and it is joined together, so staff do move around across the 2 units. Mrs Donovan further noted to Dr Laws that the current tool is still not sophisticated enough to link bed occupancy and staffing levels, however other metrics have been introduced to better understand the position in particular regarding staffing levels and quality metrics. Mrs H Johnson commented that the display boards in respect of staffing levels on the wards are not always being completed. Mr Dinwiddy agreed to address this. The Chair thanked Mr Dinwiddy and concluded that the information provided month on month is much improved and will continue to do so with these assurances. ***Received***	**Mr Dinwiddy**
49/2015	**Financial Performance – Month 1** Ms A Harrison, Interim Director of Finance, presented this report and highlighted the headline performance for the period to the end of 30 April • The Trusts financial performance is a retained deficit of £0.127m and £0.084m deficit at 'adjusted financial performance'. This performance is a favourable variance against Plan of £0.01m. • The in-year cost improvement target is £2.6m. • The cash balance as at 30 April 2015 was £7.96m. • The capital expenditure is £0.012m, which is slightly behind the Plan of £0.02m. • The Continuity of Service risk rating is reported as 3 in line with the plan Ms Harrison further noted the financial performance to-date is on plan. It was further noted that the Cost Improvement schemes have not yet been put into budgets, but this will be actioned by Month 2.	**Ms Harrison**

	The Board was also pleased to note that there is a significant amount of cash from underspends that will serve us well with the Capital Plan for this year and future. ***Received***	
50/2015	**Assurance Report - Finance and Performance Committee Report – 28 May 2015** Mr Gadsby, Non-Executive Director, presented the assurance report to the Trust Board from the Finance and Performance Committee held on 28 May 2015. Mr Gadsby reiterated Ms Harrison's comments regarding the financial performance is on plan. The Trust does need to focus on the Cost Improvement Programme, in respect of recurring and non-recurring and there has been a revised format for CIPS to ensure clear focus for the Finance and Performance Committee. Secondly, with regard to Capital, the Board will receive during the Closed session today a number of Business Cases. The reality is the phasing of the capital within the budget and reporting this to TDA. The impact otherwise will mean that the Trust is reporting behind every year and it may be prudent to put them in our position, even though we are not spending we are forecasting not spending. The Finance and Performance Committee also received papers summarising the base case Long Term Financial Model (LTFM) key metrics for the period 2015/16 to 2019/20 together with the LTFM metrics resulting from a downside scenario and mitigations assumptions over the same period. Following discussion on the assumptions and mitigations on the Base and Downside metrics the Committee recommend acceptance of these scenarios to the Trust Board. Furthermore, the Finance and Performance Committee received a report on the pay protection within the Trust as a result of a number of Management of Change processes. The Report outlined the costs associated with Pay Protection and gave an overview of the organisational changes that gave rise to the protection cost. Currently there are 42 members of staff who were able to be retained under the protected pay scheme which has allowed the Trust to retain skills whilst mitigating the cost of redundancy.	

	Ms Harvey challenged the pay protection statement and stated that this was contractual and should not be described as a scheme. She further noted that within the NHS down banding is becoming more regular practice and at one time should only have been applied through the disciplinary process. Mr Gadsby noted and agreed to revise the terminology accordingly and that it was not intention to phrase this as a scheme. ***Received***	
51/2015	**2014/15 Annual Accounts** Mr Blaise, Deputy Director of Finance, was in attendance for this item only and presented the Annual Accounts 2014/15. It was noted that the Annual Accounts were completed in line with the statutory financial duties. The Accounts were submitted on schedule and have been scrutinised by our External Auditors, KPMG with a positive outcome. Mr Blaise highlighted the following areas ; In 2014/15 both Income and expenditure had reduced by approx. £12m when compared to 2013/14 mainly as a result of the transfer of research networks, that had been temporarily hosted by the Trust in 2013/14, to other NHS organisations. The Accounts showed that the Trust had made a retained surplus of £425k in 2014/15 which, following allowed adjustments for technical accounting reasons, reports an adjusted operations retained surplus level of £768k. The surplus was £34k ahead of the Trusts 2014/15 plan agreed with the TDA. The Statement of Financial Position showed a that non-current assets had reduced between reporting years as a consequence of the application of depreciation and that certain land had now been declared as a “held for sale” asset. The Trusts provisions value had also reduced between 13/14 and 14/15 mainly as a result of the settlement of a number of restructuring and other provisions. It was noted, however, that the Trusts cash position as at 31 March 2015 remains healthy.	

	It was also highlighted that the breakeven note reported in the Trusts Accounts now showed that the Trust had achieved a surplus in each of the last 10 reporting years. (2005/06 – 2014/15). Mrs Donovan thanked Mrs Blaise and his team for completing the Accounts on time and their positive outcome. The Board reviewed and formally accepted ; • Annual Accounts • Management representation Letter • Annual Governance Statement – the AGS has been considered by the Audit Committee and Mrs Donovan advised that the document was prepared in accordance with the mandated guidance and the auditors gave assurance that the document contained the required disclosures. It was further noted that the auditors gave significant assurance about the Trust's system of internal control and that there were no issues that required declaring in the governance statement. This is a really good position for the Trust. • ISA 260 (to note) There is one recommendation and a series of minor presentational changes made by the auditors. The recommendation is in respect of improving our performance and spend on Capital programme The Chair thanked Mr Blaise and Ms Harrison for making this a relatively easy process; it is worth noting that the Trust is not in deficit and that this enables the Trust to focus their energy in other areas. ***Approved***	
52/2015	**2015/16 Operating Plan** Mrs Donovan, Chief Executive, presented this report on behalf of Mr A Hughes, Interim Director of Strategy and Planning. The Operating Plan brings together our clinical and quality ambitions and describes the workforce, financial and wider infrastructure implications of achieving them.	

	The Board have previously received this document and contributed to this at Board of Directors sessions. This is the final version and is aligned with the 5 Year Plan. Mrs Donovan noted that the Trust has received some indicative feedback from the TDA; it is anticipated the plan will be rated as Green, which is very positive. Formal comments should be received by 16 June 2015. ***Received***	
53/2015	**Performance and Quality Management Framework Report (PQMF) Month 1** Ms Harrison, Interim Director of Finance, presented this report. The report provides the Board with a summary of performance to the end of Month 1. Ms Harrison noted that the performance has improved, particularly with IAPT, these improvements have a trajectory for improvement. The report highlights challenges in ASD and RAID performance, which are not part of the CCG contract. The Board also reviewed the Quality Dashboard within the report. Mr Sullivan noted this information was beneficial. Mr Gadsby noted that the Quality Dashboard was discussed at the Finance and Performance Committee and that he could give assurance by exception for future reporting. Mr Draycott anticipated that training would be moving to green in the near future . The Chair thanked Mr Gadsby for this suggestion and stated that report was improving and getting good focus. ***Received***	
542015	**Self-Certifications for the NHS Trust Development Agency** Mrs Harrison, Interim Director of Finance, presented the executive summary . The summary indicates that the Executive Team have reviewed the declarations ,with no change from last month's position of compliance Declarations include ; • Fit proper directors • Registration with CQC	

	• Provision of integrated care • Effective arrangements for monitoring and continually improving the quality of healthcare • Compliance with TDA Accountability framework The Board noted the Trust is compliant. ***Received***	
55/2015	**Assurance Report form the Audit Committee** Mr D Rogers, Chair of the Audit Committee/Non-Executive Director, presented a verbal report summarising the Audit Committee meeting held on 2 June 2015. The main focus of the Audit Committee was to approve the Annual Accounts and to give assurance to today's Trust Board for final sign off and although this item is on the agenda after the Annual Accounts, it should be noted this was discussed prior to formally accepting the Annual Accounts Mr D Rogers confirmed that the Audit Committee received for assurance purposes ; • a draft of the Board Assurance Framework • the Final Annual Governance Statement (2014/15) from Mrs Storey which noted that independent auditors concluded that the Trust did not have any significant control issues or concerns that required disclosing in the statement. This is an extremely positive position for the Trust.) • Principal Risk Register Assurance Report • LCFS Annual Report 2014/15 It was noted that the Audit Committee is currently reviewing its effectiveness to ensure that it remains fit for purpose. ***Received***	
56/2015	**People and Culture Development Committee Report** Mr Sullivan, Vice Chair of the PCD Committee/Non-Executive Director, presented this report which is a summary from the People and Culture Development Committee meeting which took place on 18 May 2015.	

	The PCD Committee considered the revised Personal Development Review (PDR) policy noting minor word changes, but mainly to align with the new Pay Progression Policy. The Board is asked to ratify their approval for 3 years. ***Ratified*** In terms of assurance, the PCD Committee received ; • Workforce Reports from each of directorates which included a number of metrics in relation to training, and sickness/absence. There were no major issues in relation to those reports. In addition, there were two reports for approval ; • Revalidation – Quality Assurance Framework for Responsible Officers • Workforce plan The PCD committee received a presentation from Dr Nasreen Fazal-Short regarding the Review of Psychological Services which stimulated a good debate. Finally, the PCD committee held a development session on the Trust's current values this was well facilitated by Amy Garside, first asking if these are the right values currently for the organisation and if staff understand those values and what is expected from them both personally and professionally. It was agreed that this was a start of a much broader discussion required within the organisation and that the outputs from this session will help to inform whether a new set of values should be introduced linked to expected behaviours. Progress to be reported back to the PCD committee as part of the normal reporting process in due course. Board members noted discussions with regard to the Trust Values and the Chair proposed that this may be an area which Board members can also consider. Debate took place amongst Board members in respect of obtaining feedback from more junior members of staff. Mr Draycott and Mrs Donovan acknowledged that the big conversations achieved this through the Listening into action programme and would give further outputs accordingly.	**All**

	Ms Harvey also acknowledged the importance and focus of the Listening into Action programme, the working groups are encouraging staff to get involved and this all links to behaviours. She also highlighted staff need to be treated as an individuals. Mr Sullivan agreed but was sceptical as well, with regard to driving this forward and sometimes it is only a small minority that can destroy it. Mr Dinwiddy made reference to the '*Caring for, Caring about'* document which outlines values and expectations; the Trust needs to draw into that. Mrs H Johnson remarked that a service user had undertaken some voluntary work in the Psychology Service and had worked closely with the team which demonstrates our values. The Chair thanked the Board for the discussion and reiterated the importance of Trust Values and embedding these within the organisation. ***Received***	
57/2015	**Update of the Aston Team Leader Programme – May 205** Mr. Draycott, Director of Leadership and Workforce, presented this report for assurance on progress and plans for future embedding of the team development process. The report presents a summary of the Aston Team Leaders programme and related CQUIN as at May 2015 with recommendations for action in terms of achieving the maximum return on investment. The Board reviewed the Comparison of Average Scores for First, Second and Third ART+ and noted the improvements. It was further noted that the Trust has now started the next cohort of Team Leaders to ensure teams continue with this process. The Chair and Mrs Donovan were pleased to note the progress made and clearly the investment into this area had been worthwhile. Mrs H Johnson noted that a strong team is always prominent when you visit the wards. ***Received***	

58/2015	**Any other business** None recorded	
59/2015	**Date and time of next meeting** The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday, 30 July 2015 at 10:00am, in the Boardroom, Lawton House, Trust HQ.	
60/2015	*** 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 12.30 pm

Signed: _____ Date_____

Chairman

Board Action Monitoring Schedule (Open Section)

Trust Board - Action monitoring schedule (Open)					
Meeting Date	Minute No	Action Description	Responsible Officer	Target Date	Progress / Comment
30-Apr-15	08/2015	Priority Referral Team - CYP Directorate - Mrs Donovan queried what was the impact from Stafford or Mid Staffs.. Dr Barton stated that statistics were available from when Stafford closed A&E. It was noted that we need to transparency for commissioners ;Mr A Rogers to take forward to provide more information to the Board.	Mr A Rogers	24-Sep-15	Mr Rogers commented that this issue is slightly wider than the Priority Referral Team, it is in relation to Mid staffs activity transferring to Stoke. This has been raised at Commissioning Board and they have recognised our case. This is ongoing and will bring back a further update for September meeting.
30-Apr-15	11/2015	Safe Staffing Monthly Report - The Chair requested that the Board receive a regular report on recruitment. Mr Draycott to take forward. Mr Draycott commented that progress with recruitment was outlined in today's CEO report.	Mr P Draycott	30-Jul-15	The recruitment drive is well under way. There are also plans for another round of recruitment on a wider scale with regional campaigns, local papers and media towards the end of June 2015. He further noted that there are 4 nurses returning from training as Mental Health nurses and an additional Health Care Support Worker returning as a qualified nurse; continuing links with Keele student nurses for offer of employment.
30-Apr-15	12/2015	F&P Assurance Report - thank you to all staff for year-end position	Chair/CEO	30-Jul-15	The Chair asked for this to remain on the schedule until complete. Post the June meeting this is now complete
04-Jun-15	44/2015	CEO report - the Chairman suggested that it may be beneficial to have staff stories as well as patient stories at Board. C13	Mr P Draycott	30-Jul-15	Verbal update at meeting on how this is progressing
04-Jun-15	48/2015	Safe Staffing Monthly Report - Mr A Rogers also noted that within the Trust occupancy levels are based on home/leave measures ie Darwin showing 100% whereas 8 out of 10 filled due to 2 on home leave. Mr Dinwiddy to pick this matter up with Dr Adeyemo for further consideration with the data. Ms Harrison confirmed that the Trust is in the process of completing a Bed Capacity Model and would work with Mr Dinwiddy in this respect ie patients sleeping out. Mr Dinwiddy stated that we needed to reflect those numbers.	Mr Dinwiddy/Ms Harrison	30-Jul-15	Now considering in the Safer Staff model

Board Action Monitoring Schedule (Open Section)

Meeting Date	Minute No	Action Description	Responsible Officer	Target Date	Progress / Comment
04-Jun-15	48/2015	**Safe Staffing monthly report** - Mrs H Johnson commented that the boards in respect of staffing levels on the wards are not always being completed correctly. Mr Dinwiddy to pick up.	Mr Dinwiddy	30-Jul-15	Verbal update at meeting
04-Jun-15	49/2015	Financial Performance Month 1 - Ms Harrison further noted the financial performance to-date is on plan. It was further noted that the Cost Improvement schemes have not yet been put into budgets, but this will be actioned by Month 2.	Ms Harrison	30-Jul-15	The majority of CIP budget adjustments have been completed and the remainder will be completed in M3. The only schemes outstanding are those being finalised, not due to commence until later in the year plus and NR CIP that is under review with the workstream lead.

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: Open Trust Board

Date of Meeting:	Thursday 30 July 2015
Title of Report:	Chief Executive's Report to the Trust Board
Presented by:	Mrs Caroline Donovan
Author of Report: **Name:** **Date:** **Email:**	Caroline Donovan, Chief Executive Caroline Donovan 23 July 2015 Caroline.donovan@northstaffs.nhs.uk
Purpose / Intent of Report:	• For Information
Executive Summary:	This report updates the Board on activities undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest.
Which Strategy Priority does this relate to: **How does this impact on patients or the public?**	• Customer Focus Strategy • Clinical Strategy • ~~IM and T Strategy~~ • Governance Strategy • ~~Innovation Strategy~~ • ~~Workforce Strategy~~ • ~~Financial Strategy~~ • ~~Estates Strategy~~
Relationship with Annual Objectives:	To ensure safe provision of clinical services
Risk / Legal Implications:	N/A
Resource Implications:	N/A
Equality and Diversity Implications:	N/A
Relationship with Assurance Framework [Risk, Control and Assurance]	N/A
Recommendations:	To receive this report for information

North Staffordshire Combined Healthcare Trust

Chief Executive's Report to the Board of Directors
30 July 2015

1. 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

2. QUALITY ASSURANCE

The forthcoming CQC Comprehensive Inspection, which is confirmed for 7th – 11th September 2015, has provided a real focus for the Trust to evidence the areas on which we will be assessed.

We are confident that our staff strive to deliver Caring, responsive, Effective, Well-led and Safe services. The CQC inspection rigorously challenges the way in which these domains are evidenced across our services consistently and in line with Trust and national policies.

One of the ways in which we have reviewed how well each of our teams performs in these domains is to ask them to undertake a Self-Assessment of how they perform against metrics supporting each domain – the Key Lines of Enquiry. Subsequently, teams from other service areas have undertaken a similar assessment but as a peer review. This has not only provided us with the opportunity to understand areas on which more focus is needed, but also has been an excellent way of sharing best practice across services in a first-hand experience way.

As part of the inspection, the CQC will want to meet with key clinical staff groups, commissioners and Healthwatch partners. Invites have gone out to a range of stakeholders and posters have been displayed around our sites offering families and carers the opportunity to contact the CQC Inspection Team if they would like to share their experience of our services. The Inspection Team will gather the views of patients and those currently using services during the inspection week.

The inspections – which are carried out by a mixture of inspectors, clinicians and Experts by Experience – will assess whether the service overall is: safe, effective, caring, responsive to people's needs and well-led. Following the inspection, each provider will receive an overall rating of either: Outstanding, Good, Requires Improvement or Inadequate.

The clear message for staff is that the CQC inspection is an opportunity to showcase the excellent services and care they provide across North Staffordshire and Stoke on Trent. CQC inspectors will be reviewing our services to ensure they are caring, responsive, effective, well-led and safe. If you have any feedback on any of these areas, or would like to speak to someone about the CQC inspection, please contact Claire Holmes, Project Lead, via 0300 123 1535 FN1390 or email CQCquality@northstaffs.nhs.uk

3. APPOINTMENTS

I'm delighted to report that we have successfully appointed a substantive Director of Nursing. Maria Nelligan, who has held the post of Associate Director of Nursing and Therapies for 11 years and is also the Director of Infection Prevention and Control at Cheshire and Wirral Partnership NHS Foundation Trust, takes up the executive director role in October 2015.

Maria has a passion for patient and service user experience and the ongoing development of nurses. She also has a reputation for being a compassionate nurse, a supportive manager and a leader in nursing development.

Although Maria doesn't official join the Trust until the autumn, she will be spending time with us on a phased induction, getting out and about and meeting people until she starts full-time on Monday 12th October.

We had a strong shortlist of applicants for the post and candidates were interviewed by three different panels - a wider stakeholder panel, including external partners; a professional nursing panel; and a final appointment panel chaired by Trust Chair Ken Jarrold, including Board members, the NHS Trust Development Authority and an external Mental Health Director of Nursing. As I am sure you would expect the candidates were put through a rigorous assessment process. I would like to take this opportunity to thank Mark Dinwiddy, who has provided excellent support in this important role on an interim basis.

I am also pleased to report that we have appointed a Patient, Service User and Carer Experience Lead. This role will lead on supporting the establishment of the Patient, Service User and Carer Council and supporting teams to work with service users and carers to continually improve our services through active engagement.

4. NEW FAMILY AND CARER GROUP

In addition to the Patient, Service User and Carer Council, which provides a voice across the organisation for people using our services, a new group has been set up in our Substance Misuse Directorate which specifically supports the family and carers of people with a dependence on drugs and alcohol.

New Beginnings, an independent group helping those on the path to recovery from addiction, has launched its Family and Carer Support Group to provide much-needed help and the opportunity for relatives and friends to talk about their experiences.

Led by a group of people who have used addiction support services, New Beginnings works with THE Trust to provide support for people experiencing issues with drugs, alcohol and other addictive substances and is also involved in helping to develop the Trust's substance misuse services.

This new support group is another great example of the commitment New Beginnings has to helping people who wish to change their use of substances. It recognises the impact felt by

families and carers of people in this situation and we are delighted to continue to work alongside them in this extension of their work.

The group meets every Wednesday from 7-8pm at the Edward Myers Unit, located at Harplands Hospital, in Hilton Road, Stoke-on-Trent ST4 6RR. All are welcome to attend and tea and coffee are provided. For more information about the group, contact Kerrie Merriman, Medical Secretary, at kerrie.merriman@northstaffs.nhs.uk or Jackie Richards, Medical Secretary, at jackie.richards@northstaffs.nhs.uk

5. LISTENING INTO ACTION UPDATE

As reported at previous Trust Board meetings, our Listening into Action programme is putting power in the hands of staff, to deliver the changes needed to the way Trust services are run. I am delighted to report that, according to the results of our latest Pulsecheck survey, the culture of staff engagement is changing for the better.

Around 530 staff took part in the Trust's latest Pulsecheck questionnaire. The Pulsecheck survey measures how valued and engaged staff feel and comes a year after the first Pulsecheck questionnaire, launched at the start of the LiA process.

Significantly, the results show an improvement in each of the survey's 15 questions compared to 12 months ago.

The percentage of staff who feel communication between senior management and staff is effective has increased by 17.4% – this is mirrored by the percentage of staff who feel managers and leaders seek their views on how to improve services having risen by almost 17%.

Furthermore, the percentage of respondents who feel the Trust communicates clearly with staff about its priorities and goals is up by 17.5%; while the percentage of staff who would recommend the Trust to family and friends has risen by 13.8%.

On top of this, NSCHT is now higher than the national average in 14 of the 15 Pulsecheck questions; in particular in terms of how valued staff feel for the contribution they make and the work they do; and how many staff believe the Trust is providing high quality services to patients and service users.

Among the changes introduced as a result of the LiA approach include:

- The development of a more consistent approach for all those using Trust services at the point of access; for example through the introduction of a 24/7 Access service providing for all crisis and urgent response for those aged 16 and over
- Introducing a more streamlined and speedier recruitment process for new employees at the Trust
- Addressing instances where technology can be improved through a dedicated digital hit squad

We have also launched several new ways for staff to engage with the senior leadership team, including through my weekly CEO Blog and Team Brief on the Road, wherein the

Executive Team travel to locations throughout the organisation to deliver the Trust's regular corporate update directly to frontline staff.

Meanwhile, the launch of my Dear Caroline website has provided an anonymous way for staff to raise any concerns they may have about service quality.

A lot of work has gone in over the past 12 months to improve the staff engagement culture within the Trust and the results of this latest Pulsecheck survey indicate this hard work is starting to pay off.

I'm very encouraged by the results we have seen and am proud of everyone who has joined us on this journey to support the Trust in delivering the best possible care for our service users. Our staff are the single most important asset we have, so it is vitally important we do all we can to support them in delivering the best possible care for our service users.

I'm delighted by the number of staff who have really embraced this new way of working, but we are far from complacent. We now need to redouble our efforts to use the knowledge, ideas and enthusiasm of staff to continue to make real changes to services.

6. GARDEN IN BLOOM COMPETITION

One of the highlights of the year for the inpatient areas at Harplands is the annual Garden in Bloom competition. The seaside came to Harplands Hospital when staff and patients transformed each of the wards into a picture postcard scene for the annual Garden in Bloom competition. There was plenty of friendly competition across Ward 1-7 for the contest, in which staff and patients on the wards were challenged to come up with the most original and colourful garden display.

The judges encountered a marvellous variety of displays, including beach scenes, a coconut shy, Punch and Judy show, boat, ice cream van, wet sponges and even a donkey!

After much deliberation, Ward 3 was selected as the overall winner, although special prizes were awarded to each of the wards in recognition of their superb efforts.

Each year we run the Garden in Bloom competition, the judges are bowled over with the wonderful variety of the displays by each of the wards and this year's selection was the best yet.

I'd like to say a big thank you to Harplands Contract Monitoring Officer Tracy Whalley, who organises the event each year and led the team of judges to determine the winner.

7. ANNUAL GENERAL MEETING

The Trust will be holding its Annual General Meeting on Tuesday 22 September this year, from 1pm – 4.30pm. The AGM provides an opportunity not only for the Trust's accounts to be formally presented publically, but also for people with an interest in mental health services to come along and find out more about the excellent services delivered every day

by staff and volunteers across our organisation. More details will be shared shortly regarding the venue and the format of the event.

NATIONAL UPDATES

8. MONITOR AND NTDA CLOSER WORKING

In June, the Secretary of State announced the move to a single leader of Monitor and the Trust Development Authority (TDA), the organisations who are together responsible for providing increased support to hospitals to continue to improve care and boost efficiency.

The NHS, along with Monitor and TDA, have risen to the challenge presented by the Francis Report in the wake of Mid Staffs, but this new move will embed hospital safety as a key priority. The closer working between Monitor and TDA will encompass those functions and duties carried out by both organisations.

This change will mean that all NHS providers, whether they are foundation trusts or trusts, are under the oversight of one chief executive, overseeing teams working closely together. All hospitals need access to the same kinds of support, and should be subject to the same kinds of intervention if their performance isn't delivering the level of care that patients have a right to expect.

9. LORD CARTER REPORT

Also in June, Lord Carter of Coles published an interim report outlining the work that has been carried out to review the productivity of NHS hospitals, working with a group of 22 NHS providers. Report recommendations include:

- better management of staff, rotas and shifts
- improving the management of annual leave and sickness absence
- optimising the medicines used in hospitals
- cutting the number of product lines of everyday consumables that the NHS uses from more than 500,000 to fewer than 10,000 and being better at procurement

He identified control of staff costs as a central issue, amounting to 63% of total spending by hospitals, arguing that "unless workforce management and productivity are addressed, all other areas of opportunity pale into insignificance".

In the autumn, Lord Carter will publish details of a tool which will allow comparisons between overall productivity and efficiency at different hospitals.

Lord Carter was appointed by Health Secretary Jeremy Hunt to chair the NHS Procurement and Efficiency Board in June 2014.

Here at NSCHT, we are doing with well in reducing temporary staffing by using our internal staff and an excellent Bank system. We have also invested more in staffing to reduce reliance on temporary staffing.

10. THE KING'S FUND CALLS FOR MERGER OF NHS AND SOCIAL CARE BUDGETS

A new report by The King's Fund suggests there should be a single pooled budget for all health and social care services in every area by 2020 at the latest. The study also recommends that the Department of Health be given control of the national budget for social care and says the government should consider how a single commissioner should be regulated. While CCGs are currently regulated by NHS England, councils do not have equivalent oversight.

We welcomed the report locally, which reinforces the way we already work in partnership with Local Authority colleagues, particularly in terms of our Section 75 arrangements and in the development of Learning Disability Services.

11. NHS SUCCESS REGIME

On 3 June Monitor, TDA and NHS England published The Success Regime: a whole systems intervention, a guidance document for the new success regime for challenged local health economies. This regime is intended to create the conditions needed in these health economies to overcome the challenges they face, through aligned intervention and support. The regime signifies a shift from focussing solely on institutions to taking a system-wide approach to dealing with challenges.

Again, we welcome this report, which reinforces the way in which the Staffordshire-wide economy is working to embed a Commissioning Congress, with the support of local providers; I will be leading on the Workforce and Leadership Transformation stream of this programme of work.

12. FIVE YEAR FORWARD VIEW: TIME TO DELIVER

The arm's length bodies (NHS England, Monitor, TDA, Public Health England, CQC and Health Education England) with private input from NHS Providers, have published an overview of the progress made with the Five year forward view to date, and the steps that need to be taken if the ambition of FYFV is to be delivered. The report can be accessed here and Andrew Hughes will provide more information in a paper which is on the agenda.

Caroline Donovan
Chief Executive
Thursday 23 July 2015

North Staffordshire Combined Healthcare NHS Trust

REPORT TO: **Open Trust Board**

Date of Meeting:	30 July 2015
Title of Report:	Summary of the Quality Committee meetings held on the 16 June and 21 July 2015
Presented by:	Mr Patrick Sullivan, Chair of Quality Committee
Author of Report: Name: Date: Email:	Sandra Storey, Trust Secretary, Head of Corporate and Legal Affairs 23 July sandraj.storey@northstaffs.nhs.uk
Purpose / Intent of Report:	• For decision / assurance
Executive Summary:	This report provides a high level summary of the key headlines from the Quality Committee meetings held on the 16 June and 21 July 2015. The full papers are available as required to Trust Board members
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Customer Focus Strategy • Clinical Strategy - • Governance Strategy
Relationship with Annual Objectives:	Ensure provision of safe clinical services
Risk / Legal Implications:	N/A
Resource Implications:	N/A
Equality and Diversity Implications:	N/A
Relationship with Assurance Framework [Risk, Control and Assurance]	The Quality Committee has an integral relationship with Improving Quality/ Registration.
Recommendations:	• To note the contents of the report • Ratify the policies highlighted in both reports

Key points from the Quality Committee meeting held on 16 June 2015 for the Trust Board meeting on the 30 July 2015

1. **Introduction**
   This is the regular report to the Trust Board that has been produced following the last meeting of the Quality Committee.

2. **Director of Quality Report**
   The report updates the committee on activities undertaken since the last meeting and draws the committee's attention to any other issues, local or national, or of significance or interest. Notable items as follows:

- **Healthwatch England –** Have raised concern over early discharge in mental health and that patient now spend six fewer days in hospital than in 2012-13. The concerns from the report indicate a concern about the timing of discharge and getting the right amount of support in the community.

  The committee were informed on the work going on in the Trust:
  - Secured additional funding from commissioners to increase the availability of our crisis response tam 24/7 and increased capacity in home treatment
  - Placed greater emphasis on supporting people on discharge rather than avoiding admission
  - Given the increased incidence of substance misuse issues a Dual Diagnosis Nurse Consultant is now supporting the wards
  - The Psychology Team have led the development of a new approach based on Dialetic Behaviour Therapy for people with Personality Disorders.

- **New judgement in Deprivation of Liberty case**
  This judgement clarifies the scope of parental control to include consenting to a deprivation of liberty but the importance is that this is "fact specific". Clinical teams within children's inpatient have been made aware of the case and actions to be taken.

- **End of Life Care across the Health Service**
  The Health Service Ombudsman has published a report into End of Life Care and what some families have experienced as patients near death. More should be done to recognise or to accept that a patient is dying to ensure they have a dignified death. Given the nature of the Trust's services, it was noted that the Trust through the leadership of the nursing team for older people are in the process of refreshing palliative care guidelines to take into cognisance issues raised by the Health Ombudsman and it is intended these will be presented to the next meeting of the Quality Committee.

3. **Policy Review**
   The committee received a policy progress report noting the status of policies that fall under the responsibility of the committee. Members discussed the position and noted the significant progress made. There was also a forward view of policies up to 2018 which highlighted a number of policies requiring review later this year and the action being taken to ensure the work is completed on time by the relevant policy leads.

The committee also received information on policies that had been reviewed and made recommendations for withdrawal, extension or approval. The recommendations were supported by the committee for ratification of the policies by the Trust Board for a period of 3 years or to be extended or withdrawn as follows:

- **5.19 Zero Tolerance and 5.07 Violence & Aggression - policies merged**
- **Staffordshire & Stoke on Trent Interagency Section 135**
- **Staffordshire & Stoke on Trent Interagency Section 136**
- **4.34 Intellectual Property Policy**
- **IC8 Cleaning -** approve until 31.7.2016
- **IC17 Specimen Management –** approve until 30.09.2016
- **R05 Restricted Access and Locked Doors**
- **5.13 Critical Incident Stress Management -** approve until 31.07.2016
- **Standing Operating Procedure – Return and Replacement of Ligature Cutters –** to be appended to the Ligature Risk Reduction Policy

4. **Quality Impact Assessment of Cost Improvement Schemes (CIPs)**
   Dr Adeyemo reported that there had been a positive meeting with the commissioners in terms of their assurance and giving their support with regards to what is being done in respect to CIP. It was further noted that all individual CIP schemes had been quality impact assessed and 2 additional schemes would be reviewed accordingly.

5. **Nurse Staffing Performance monthly report – May 2015**
   The committee received the nursing staff performance on a shift by shift basis for the month of May 2015. This noted that while there are still some challenges overall the position was noted to be rated as green. The committee will receive the six monthly report that drills down into the details of staffing performance at its next meeting.

6. **Quality Metrics from the Performance Quality Management Framework Report (PQMF) month 2 2015/16**
   The committee reviewed the quality metrics extracted from the wider PQMF. As noted previously, the role of the committee is to consider the impact of metrics potentially going off track. Exception reports were noted in respect to an incident of healthcare associated c-difficile, a patient being admitted with a pressure ulcer and the actions being taken by the inpatient to review the number of readmissions within 30 days of admission.

7. **Serious incidents 1 January 2015 – 31 March 2015**
   The committee discussed the number and type of incidents that have occurred during the final quarter of 2015/16. The report concluded that there are no emerging trends by clinical area. It further noted that all investigations were submitted in the required deadline of 40 working days. NHS England published a revised serious incident framework to be implemented from 1 April 2015 which has extended timeframes for investigations to 60 working days; any changes to the Trust contract are still to be agreed.

8. **Annual Programme of Work for Infection, Prevention and Control**
   The committee received the objectives and priorities in minimising the risk of infection for the coming year. The programme aims to both sustain and strengthen the Trust's position in achieving compliance with the Health & Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance. The committee welcome this programme of work and will receive updates on progress against the plan as part of its cycle of business.

9. **Monitor's Quality Governance Assurance Framework – progress against action plan**
   The committee received a report outlining the progress made against the action plan. This showed that the small number of outstanding actions were complete. The committee noted their assurance with the report and agreed to close the action plan.

10. **Quality Account 2014/15**
    By 30th June 2015, all organisations are required to develop and publish a Quality Account to assure commissioners, patients and the public that trust boards are regularly scrutinising each and every one of their services. The committee received the final draft of the Quality Account for review and comment. It was noted that this document had been circulated for review and comment by the Board as well as committee members. The committee used their delegated authority to approve the document on behalf of the Board (given the timing of the next board meeting).

11. **Trust Equality Objectives 2015-18**
    The committee received a report which provided progress against the Trust's Equality objectives 2012-15 and proposed new Equality Objectives for the period 2015–18. The Trust has four Equality Objectives and these were agreed by the Quality Committee and People and Culture Development Committee.

    1. **Developing a more inclusive, diverse and representative organisation**
    2. **Using Information to support positive action on inclusion**
    3. **Co-ordinating effective action on inclusion**
    4. **Meeting our NHS Contract requirements>**

    The committee will receive reports on progress as part of its cycle of business

12. **Kate Lampard Report into the actions of Jimmy Savile**
    The Lampard report was published in March 2015 and made a number of recommendations for NHS Trusts to take forward in respect to cultures, behaviours and arrangements that allowed Savile to gain access and influence various NHS hospitals. The committee received the report and the action the Trust has taken in areas such as policy and procedure for managing visits by celebrities and review of its voluntary service arrangements,

13. **Nurse Revalidation**
    The NMC has committed to introduce a proportionate and effective model of revalidation by the end of 2015. This model does not replicate the medical revalidation model. It was noted that a number of sites are piloting the NMC provisional document "How to revalidate with the

NMC". The NMC will undertake an evaluation of the pilot before this is rolled out in April 2016. It is anticipated that the final revalidation document will be published in the Autumn 2015. The committee received a report on what this means for the Trust and the work ongoing to ensure preparedness for the new revalidation process.

14. Board Assurance Framework (BAF)

The Board has been working with the Good Governance Institute to review its arrangements for integrated governance and risk – including redefinition of a Board Assurance Framework. Each of the strategic objectives in the IBP (and mirrored in the operating plan) have been framed within the recommended BAF template.

For each objective the BAF shows: an Executive owner; the Assurance Committee that will oversee the objective; the risk associated with the objective; a risk appetite and initial, current and target risk scores (in most cases).

It was noted that the committee will receive further reports on the BAF and will oversee the objectives that it has responsibility for, the minimum would be on a quarterly basis.

15. Risks to Quality of Services – June 2015

Committee members considered the report for quality risks, noting the risk treatment plans in place. Risks have been mapped to the new annual objectives and 5 year objectives and trend arrows have been included. It was noted that future risk reports would be presented as part of the BAF.

16. Directorate Performance Reports

The Committee received the monthly performance reports from each of the Directorates including information on key risks, serious incidents and complaints. The new directorate performance dashboards will continue to evolve over time in order to give the information and assurance required by the teams and committee.

17. Business Cases for Service and Capital Development

This paper provided a briefing to the committee on the current position with regards to business cases. The committee supported the proposals for the cases that had merit for immediate approval, and cases which the commissioners are actively involved in. The committee and Board will receive further information on the cases in due course.

18. CQC Quality Assurance Programme Update

The committee received a paper summarising the progress made by the Quality Assurance Programme Board including key priority actions, recent inspection activity and an update in terms of the Trust's registration. The paper also included an information update around CQC publications and national mental health inspections.

The committee discussed the inspection report following the visit to the Darwin Centre and action plan for information and monitoring.

19. Patient Stories

The committee received a paper summarising the storytelling framework, associated benefits and the value of also including staff stories. The paper proposed a structure to the approach to storytelling which the committee accepted. The Patient Experience team will review the process in six months time to see how this has developed and how this might evolve further.

20. Domain Updates

The committee received each of the domain reports for assurance purposes in respect to:

- **Patient safety** , **Clinical effectiveness, Organisational safety and efficiency** , **Customer focus**

The committee undertook a "deep dive" into the Clinical Effectiveness domain to gain a further understanding of the work being undertaken and any issues raised.

21. Next meeting: 21 July 2015

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

Sandra Storey
Trust Secretary / Head of Corporate and Legal Affairs
01 July 2015

Key points from the Quality Committee meeting held on 21 July 2015 for the Trust Board meeting on the 30 July 2015

1. **Introduction**
   This is the regular report to the Trust Board that has been produced following the last meeting of the Quality Committee.

2. **Director of Quality Report**
   The report updates the committee on activities undertaken since the last meeting and draws the committee's attention to any other issues, local or national, or of significance or interest. Notable items as follows:

- **Health Service Ombudsman publicises NHS Complaints Information -** this draws attention to the work of the Ombudsman and the range of cases they have considered during the period October and November 2014. This report has been reviewed by the Trust's complaints team which has been seen as a helpful source of information to learn and inform local complaint management arrangements.

- **Medicines and Healthcare Products Regulatory Agency (MHRA) report on counterfeit medicines –** the report notes that counterfeit and unlicensed medicines worth nearly £16m were seized by the agency. They warn of the illegal drugs market in the UK and for people to protect their health by visiting their GP in order to get a correct diagnosis, buying medicines from a registered Pharmacy. In respect to the Trust's practice, it was noted that medicines are purchased through a service level agreement with the University Hospital North Midlands to ensure they are good quality and legitimate. Our patients are dissuaded from purchasing medicines from the internet . An information leaflet is available on the Trust's choice and medication website for teams to use with patients and carers to highlight this area of concern.

- **Mental Health Crisis report and what we are doing locally**
  In January 2015 the Trust took an opportunity through temporary funding to increase the Access Service to operate 24/7 and to focus the Home Treatment Team to concentrate their resources during the hours of greatest need. Underpinning the change project was an adjustment to service aims, whereby a greater emphasis was placed in supporting people to be discharged from wards as opposed to preventing admissions.

  The change project has been monitored through triangulating reports across Crisis activity, Home Treatment activity, Acute Psychiatric bed use, plus complaints and serious incidents. These reports have consistently indicated month on month since January:

  - Increasing numbers of people receiving home treatment
  - 55%-72% increase in the number of crisis contacts offered within 4 hours
  - Increased admission & discharge rates to wards but reduced length of stay
  - Increase in readmissions rates
  - Downward trend for ward occupancy
  - Downward trend for detentions under the mental health act on wards
  - Downward trend for serious incidents and no change to the low number of complaints received

Services note the increase in readmissions rates is a result of staff feeling able to mitigate threats of harm and reduce risk in supporting service users in the community through access to acute psychiatric admissions

3. Policy Review

The committee received information on policies that had been reviewed and made recommendations for withdrawal, extension or approval. The recommendations were supported by the committee for ratification of the policies by the Trust Board for a period of 3 years or to be extended or withdrawn as follows:

- MHA16 Mental Capacity Act
- 7.05 One Staffordshire Information Sharing
- 4.36 External Visits Policy
- Policy to Manage Visits by VIP / Celebrities
- 1.74 Ligature Risk Reduction – replace with Environmental Ligature Risk Assessment Policy
- Palliative Care in MH and LD Services

The group noted that there is ongoing work with regards to reviewing Trust Policies and Procedures. As such it was agreed that proposals for any changes could be circulated virtually by the Trust Secretary to the committee in the absence of an August meeting.

4. Quality Impact Assessment of Cost Improvement Schemes (CIPs)

Dr Adeyemo noted that there were no new schemes to report since the last meeting. All individual CIP schemes have been quality impact assessed and 2 additional schemes will be reviewed accordingly once information submitted.

5. Six Monthly Safer Staffing Review

The committee received a paper outlining the process that ensures there are adequate staffing levels in place. The report provided assurance that the Trust is meeting the requirements set out by the National Quality Board and NHS England in relation to reporting on ward daily staffing levels. The report also gave assurance that following analysis of the data planned staffing levels across all inpatient areas had been achieved for the majority of the reporting period with variance in the learning disability service. It was noted that where a shortfall occurs, the ward manager will undertake an increased amount of clinical hours in addition to mitigations of the involvement in care delivery of the wider multidisciplinary team.

There has been two safer staffing acuity reviews to inform a review of the current establishment. In addition, a first review of a number of further indicators to ensure that additional secured monies are allocated according to acuity, occupancy, structure, registered to care staff ratio, and will additionally include a number of clinical sessions within the ward manager role to strengthen and enhance clinical leadership across the Trust.

The final model is anticipated for completion in July 2015. This will have the full involvement and engagement of senior clinical staff in the allocation by commissioner's of the additional finance that was identified to support and deliver the recommendations from the safer staffing acuity

reviews. Progress against the review and plans will be reported to the Quality Committee and Trust Board in September 2015.

6. **Nurse Staffing Performance monthly report – June 2015**

The committee received the nursing staff performance on a shift by shift basis for the month of June 2015. While there are still some ongoing challenges including difficulties recruiting to some vacancies, overall the position was noted to be rated as green. There was some discussion around differences identified in the staffing levels required for day and night shifts across the acute wards and a further drill will be undertaken to address any data anamolies.

7. **Quality Metrics from the Performance Quality Management Framework Report (PQMF) month 3 2015/16**

The committee reviewed the quality metrics extracted from the wider PQMF. As noted previously, the role of the committee is to consider the impact of metrics potentially going off track. Of the total 72 metrics at month 3, 1 quality metric was noted to be rated as red and 4 rated as amber. These relate to Improving Access to Psychological Therapies (IAPT) and compliance with Personal Development Review (PDR) targets. The committee discussed the mitigation plans to improve performance.

Committee members also reviewed the proposed Balance Scorecard that will be adopted by the committees going forward. This document, presented using the quality objectives, was well received by the committee. It is intended that this will reduce the number of reports that are presented to the committee in the future and the scorecard captures a significant amount of this information such as performance by Trust and Directorate level in respect to key metrics, benchmarking, nurse staffing, patient experience and so on.

This report will be developed further to include information, where available and appropriate, relating to audit, research and development and risk. Members were also keen for this document to be accessible for use with a PC, laptop or IPAD.

8. **Integrated Quality Report Q4 2014-15**

The Integrated Quality report focuses on key trends and lessons learnt, monitoring against the key priorities in the Trust's Quality Account, and qualitative data to support the Performance & Quality Management Framework and reporting of performance across the range of key performance indicators.

The report noted that at Q4 the majority of key performance metrics had been delivered. Key points extracted from this report related to the management of incidents, meeting the milestones for CQUINS, improving Patient Experience and handling of complaints, work by Directorates in respect to the CQC Compliance Monitoring Framework and the action being taken to improve compliance with statutory and mandatory training.

9. **Mental Capacity Act Group - Terms of Reference**

The committee approved the Terms of Reference for the group that has been established to focus on responsibilities relating to the Mental Capacity Act and Deprivation of Liberty Safeguards. The group will report on any areas of non compliance and any emerging concerns. The group will

meet quarterly and will report to the Quality Committee. The Terms of Reference will be reviewed again in 12 months.

10. Complaints Performance Q1 2015/16

The committee received information on the number of complaints received (Q1:11), which had decreased by 7 in comparison to the previous quarter. Following analysis there appears to be no obvious trends across the service areas or particular concerns that required additional scrutiny. The report noted the lessons learnt during this period including a number of initiatives that are currently in progress which are intended to strengthen the process by which complaints and PALS contacts are handled, with a view to improving the experience for both service users and staff.

11. Serious incidents 1 April 2015 – 30 June 2015

The committee discussed the number and type of incidents that have occurred during the first quarter of 2015/16. The report concluded that there are no apparent seasonal or monthly trends. It was noted that there have been changes to the reporting system in May 2015 which has impacted on the analysis of the data against previous quarters and therefore Q1 cannot be read as a direct comparison against Q4. There is a new categorisation on the system titled 'pending review'. Reporting will be clear at month 2 when all data is consolidated in line with the new STEIS framework. At the time of reporting there were no immediate concerns that were brought to the attention of the committee.

12. Eliminating Mixed Sex Accommodation – Q1 2015-16 update against action plan

The revised Operating Framework for 2010-11 made it clear that NHS organisations are expected to eliminate mixed-sex accommodation except where it is in the overall best interest of the patient or their personal choice. The committee received a detailed report on the actions undertaken during Q1 and declaration that there were no breaches during the reporting period. The committee took assurance and were satisfied following review of the action plan that the Trust is appropriately declaring EMSA compliance.

13. Commissioner Led Quality Visit to the Trust's Access Team – March 2015

An announced Commissioner led quality visit to the Access Service was undertaken on the 18 November 2014. At that time the service was undertaking a review and degree of restructuring to become a more responsive 24/7 service with a focus on urgent and crisis referrals with aspects of the routine work moving to the Community Mental Health Teams.

The visit report was presented and discussed at the Clinical Quality Review Group meeting on the 30 January 2015 and it was agreed that a further assurance visit would be undertaken with a representative from the Trust. This announced visit took place on the 18 March and the main finding set out in a report presented to the committee. The committee discussed the improvements to the service and future developments, including environmental changes and strengthening supervision arrangements. Committee members also acknowledged the positive feedback received from GPs and Healthwatch Stoke.

14. Draft Service User and Carer Experience Strategy 2015 'Caring for and Caring about

The committee received a comprehensive summary of the Trust's current position regarding feedback from service users and carers. 10 responsive improvement objectives are included within the document aligned with current developmental initiatives including the Service User

and Carer Council and Service User Standards. The purpose of the strategy is to develop and support a culture that places the quality of the service user experience at the very heart of all that we do; 'Caring for and Caring about' in equal measure. The strategy and supporting action plan will be monitored at quarterly intervals by the Trust's Service User and Carer Council. A quarterly progress report will also be presented to the Quality Committee and Trust Board.

15. **Progress update regarding Service User and Carer Council**

The committee received a paper outlining the work undertaken to develop a Service User and Carer Council, the intention of which is to serve as a rich source of consultation, advice and feedback for the Trust. It demonstrates the Trust's commitment to engaging with service users, partners and carers and reflects the Trust's objectives as set out in the Operating Plan 2015/16.

The committee considered the proposals which were agreed in principal. The first meeting of the Council is anticipated in August and this work will be developed further.

16. **Board to Team Visits Q1 2015-16**

In March 2015, a revised scheduled programme of visits to all clinical areas was devised, pairing an Executive and Non Executive Director to undertake allocated visits throughout the year. The report provided a summary of the visits undertaken during Q1. It was noted that at times it has been difficult to maintain the schedule of visits for a various reasons and consequently visits have been rescheduled to ensure that 'backlogs' do not occur. It is also proposed that members of the incoming Service User and Carer Council may wish to be involved in the visits providing an additional dimension of patient/carer led inspection of the care environment.

The committee reviewed the report and welcomed hearing about the positive practice and some of the challenges raised by patients and staff as well as actions being taken to improve people's experiences of Trust services.

17. **Quarterly report against implementation of the Institute for Innovation Improvement High Impact Actions and the Chief Nursing Officers 6 C's: Care, Compassion, Competence, Communication, Courage, Commitment**

The committee received a detailed report highlighting the positive progress being made against the six action areas and highlights commitment in sustaining progress through current work streams and actions planned for 2015/16. The committee welcomed the quarterly progress monitoring reports in respect to this important area of work. .

18. **Infection, Prevention and Control Annual Report 2014/15 and programme of work for 2015/16.**

The report provided information and assurance to the committee that the Trust has achieved compliance with the Health & Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance (Department of Health 2010) and other key national documents. The report also provided progress against the annual programme of work setting out key objectives for 2015/16 which was approved at the June Quality Committee meeting.

19. **Board Assurance Framework (BAF) and Risk to Quality of Services**

At the last meeting of the committee it was noted that the committee would receive reports on the BAF and will oversee the objectives that it has responsibility for on a quarterly basis. This would help inform the work plan of the committee. Risks have been mapped to the new annual

objectives and 5 year objectives and trend arrows have been included. Committee members considered the report for quality risks, noting the risk treatment plans in place. No immediate concerns were raised and these remain the current risks for the committee.

20. Directorate Performance Reports

The Committee received the monthly performance reports from each of the Directorates including information on key risks, serious incidents and complaints. Members discussed if there were any safeguarding issues (as none were specifically raised in the reports) and there were no issues raised at the meeting. Committee members also spent time considering the draft Performance Balanced Scorecard, noted earlier at point 7 in this report. This dashboard will continue to evolve over time in order to give the information and assurance required by the teams and committee.

21. Business Cases for Service and Capital Development

The committee received a briefing on the current position with regards to the business cases discussed at the last meeting of the committee. The committee supported in principal the proposals for the cases that had merit for immediate approval, and cases which the commissioners are actively involved in. Work is ongoing to complete financial appraisals and quality impact assessments. The committee will receive the full business cases as appropriate when this work is complete. The committed

22. CQC Quality Assurance Programme Update

The committee received a paper summarising the progress made by the Quality Assurance Programme Board including key priority actions, recent inspection activity and an update in terms of the Trust's registration. The paper also included an information update around CQC publications and national mental health inspections.

23. Domain Updates

The committee received each of the domain reports for assurance purposes in respect to:

- **Patient safety** , **Clinical effectiveness, Organisational safety and efficiency** , **Customer focus**

The committee will undertake a "deep dive" into the Organisational Safety & Efficiency domain to gain a further understanding of the work being undertaken and any issues raised.

24. Next meeting: 15 September 2015

On behalf of the Committee Chair, Mr Patrick Sullivan, Non Executive Director
Sandra Storey
Trust Secretary / Head of Corporate and Legal Affairs
23 July 2015

Encl 6 .1

REPORT TO THE TRUST BOARD

Date of Meeting:	30 July 2015
Title of Report:	Safe Staffing Review Monthly
Presented by:	Mark Dinwiddy Interim Executive Director of Nursing
Author of Report: Date: E-mail:	Carol Sylvester-Deputy Director of Nursing July 2015 Carol.sylvester@northstaffs.nhs.uk
Purpose / Intent of Report:	• For information and discussion
Executive Summary:	This paper provides the analysis of the monthly staffing data for June 2015 as reported onto UNIFY2. The paper also includes performance information for each area with regards to sickness absence, mandatory training, PDR, incident data and complaints and serious incidents The paper will note the following points: • Planned staffing has been RAG rated based on registered and care staff. Ward Managers have supported the data with narrative reporting with no reports of challenges to the delivery of safe care • Where the planned staffing has fallen below 90%, ward managers have used additional data such as occupancy, incidents, sickness and training to provide an overview of any challenges to safety and quality and have confirmed that there has been no impact on either as a result of staffing • The report will detail the UNIFY submission for June 2015 and will be posted on the Trust website
Which Strategy Priority does this relate to? How does this impact on patients or the public?	• Customer Focus Strategy • **Clinical Strategy** • Governance Strategy • **Workforce Strategy** • Financial Strategy
Relationship with Annual Objectives	Supports the delivery of the Trust's Annual Objectives and the delivery of high quality care
Risk / Legal Implications:	Delivery of safe staffing is a key requirement to ensuring that the Trust complies with National Policy direction
Resource Implications:	

Equality and Diversity Implications:	Supports the delivery of accessible and responsive services
Relationship with Assurance Framework [Risk, Control and Assurance]	Supports the Trust's Assurance Framework and Risk Management Processes
Recommendations:	• That the Board note and discuss the contents of this report

	• The Board will continue to receive regular assurance in respect to staffing levels going forward

In patient safer staffing metrics-June 2015

Ward	Performance (% planned vs actual)		Overall fill rate%	Bed Occupancy (including home leave)	Sickness %	Mandatory training	PDR	Incidents	Serious Incidents	Complaints
	Registered Nurse %	HCSW %								
One	113.9%	95%	104.4%	89% ↓	3.50%↓	85% ↑	86% ↔	52 ↔	0↓	1↑
Ward Manager narrative: • No issues with occupancy • Sickness improving • Vacancies are subject to a recruitment campaign during July • Incidents generated by one patient predominantly with one serious incident as a result of staff injury from violent incident										
Two	103.4%	105.3 %	104.3%	99% ↓	15.67↑	79↔	75 ↓	19↑	0 ↓	0↓
Ward Manager narrative: • Vacancies either recruited to or being recruited to currently • Sickness has increased this month. No obvious themes • Shifts staffed to 6/6/4 rather than establishment due to high patient acuity/levels of observation										
Three	120.4%	110.8 %	115.6%	99%↔	4.80% ↑	78% ↑	95↓	16↑	0↓	0↔
Ward Manager narrative: • Over occupancy on 4 occasions • Vacancies recruited to apart from 0.8 band 3										

- Mandatory training completed as rostered
- PDR`s have commenced for 15/16

Four	103%	80.1%	91.5%	102%↑	Not reported	92%↑	16% ↓	15 ↑	0↔	0

Ward Manager narrative:
- Some pressures in recruitment of staff to fixed term post based on suitability
- No occupancy pressures although ward is running at 15 occupied beds
- Some care staff shifts unable to be covered due to bank/agency unavailability. Covered by registered staff or site movement

Five	104.8%	133.%	119.3%	94↓	2.85%↑	93%↑	92% ↓	13↑	0↔	0↔

Ward Manager narrative:
- No occupancy pressures
- No significant staffing issues. Actual fill rate appropriate for patient acuity
- Recruitment to posts ongoing in July

Six	97.2%	87.8%	92.5%	96%↓	4.58% ↑	79%↑	93% ↓	31↑	0↔	1↑

Ward Manager narrative:
- A number of delayed discharge patients reported
- Three long term sick staff members. Sickness managed in line with policy
- Successful recruitment in to vacancies
- Safer Staffing weekly meetings identify site wide shortfall and support from other wards as needed

Seven	105.2%	95.8%	100.5%	96%↑	7.87% ↑	91↑	84% ↑	13↑	0↔	0↔

Ward Manager narrative:
- No occupancy pressures
- Short term sickness only
- 1.4 vacant band 5 posts currently out to recruitment

EMC	108.6%	84.6%	96.6%	81%↑	8.63%↑	89%↑	81% ↓	9↓	0↔	0↔
Ward Manager narrative: • No occupancy pressures • Two vacant posts subject to trust wide recruitment in July • No staffing issues overall. Some difficulty in bank staff availability to cover shifts some of which have been covered by registered staff										
A&T	76.6%	109.1 %	92.8%	94%↓	7.62↑	94%↑	93% ↔	16↑	0↔	0↔
Ward Manager narrative (combined A&T and Telfor): • No pressures on occupancy • Reducing sickness of registered staff. Shortfall covered by cross cover support between Telford and A7T and by the Unit Manager covering shifts • Vacant post not recruited due to unsuitability of applicants. Readvertised • No impact on quality as reported by the unit manager •										
Telford	94.05%	88%	91.0%	94%↑	5.59↓	96%↓	100% ↔	14↓	0↔	0↔
As above										
Summers View	98%	102%	100%	102%↓	5.13%↔	77%↑	100% ↔	13↓	0↔	0↔
Ward Manager narrative: • No pressures on occupancy • Staffing levels filled as needed • Reduction in incidents • No complaints or SI`s										

Florence House	109%	93.6%	101.3%	99%↑	4.79↓	90%↓	95↓	15↑	0↔	0↔
Ward Manager narrative: • No occupancy pressures • Shifts filled , no pressures										
Darwin Centre	88.6%	92.4%	90.5%	88%↑	00.0%↓	91%↑	94% ↓	62↓	0↔	0↔
Ward Manager narrative: • Two band 5 vacancies, one recruited to and one re-advertised • Some pressures to staff all registered shifts, in part due to sickness and also availability of bank/agency staff. • Despite high acuity relating to one youngster in particular, the ward manager reports no impact on safety or quality										
Dragon Square	93.1%	92.5%	92.8%	68%↓	0.00%	84%↓	94↓ %	2↑	0↔	0↔
Ward Manager narrative: • The unit has had a period of 3 nights closed in order that staff complete all training • The unit has required less staff than usual due to lower occupancy										

Total Trust fill rate Registered Nurse for June 2015 is 109.1%

Total Trust fill rate Care Staff for June 2015 is 97.85%

Total Trust Fill Rate for June 2015 is 103.47%

Unify return –June 2015

Inpatient area	Day				Night			
	Registered nurses		Care staff		Registered nurses		Care staff	
	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual
Ward 1	900.00	1019.00	1800.00	1578.25	322.00	369.24	964.30	993.14
Ward 2	900.00	960.95	1350.00	1067.20	321.60	321.60	642.90	846.10
Ward 3	900.00	942.33	1350.00	1280.50	321.60	437.99	642.90	814.43
Ward 4	1350.00	1568.00	1800.00	1020.15	553.50	498.08	829.76	858.74
Ward 5	900.00	935.50	1350.00	1521.75	281.10	297.40	562.20	871.49
Ward 6	937.50	885.00	1815.00	1515.00	281.10	281.10	843.30	777.78
Ward 7	900.00	872.50	1350.00	1327.50	281.10	319.02	562.50	525.38
A&T	900.00	479.50	1182.00	1396.75	161.25	161.25	1128.75	1128.75
Telford	768.00	676.75	1200.00	912.25	161.25	161.25	483.25	483.25
Edward Myers	900.00	1054.50	900.00	663.00	281.10	281.10	562.20	537.01
Darwin Centre	1020.00	1050.00	1110.00	1115.50	385.00	346.00	602.00	799.75
Summers View	1050.00	1008.00	1050.00	1060.00	292.04	292.04	898.52	898.52
Florence House	450.00	530.80	900.00	785.50	312.90	312.90	312.90	312.90
Dragon Square	450.00	433.00	940.00	893.00	277.50	249.75	277.50	249.75
TOTALS	**12325.50**	**12415.83**	**18097.00**	**16136.35**	**4233.04**	**4328.72**	**9312.98**	**10096.99**

Encl 6.2

REPORT TO THE TRUST BOARD

Date of Meeting:	30 July 2015
Title of Report:	Six Month Safer Staffing Review
Presented by:	Mark Dinwiddy Interim Executive Director of Nursing
Author of Report: Date: E-mail:	Carol Sylvester-Deputy Director of Nursing July 2015 Carol.sylvester@northstaffs.nhs.uk
Purpose / Intent of Report:	• For information and discussion
Executive Summary:	This paper outlines the performance of the Trust in relation to the National Quality Board expectation *"The Board:* *• Receives an update containing details and summary of planned and actual staffing on a shift-by-shift basis* *• Is advised about those wards where staffing falls short of what is required to provide quality care, the reasons for the gap, the impact and the actions being taken to address the gap* *• Evaluates risks associated with staffing issues* *• Seeks assurances regarding contingency planning, mitigating actions and incident reporting* *• Ensures that the Executive Team is supported to take decisive action to protect patient safety and experience* *• Publishes the report in a form accessible to patients and the public on their Trust website (which could be supplemented by a dedicated patient friendly 'safe staffing' area on a Trust website)".* The paper describes the escalation process in place to manage nurse staffing levels. It also outlines that results of the planned vs actual nurse staffing levels during the data collection period 1st January 2015 to June 30th 2015. The report will detail additional quality indicators in addition to planned and actual staffing data across the 6 month period for all Trust inpatient areas. The report will additionally detail the ongoing review of the acuity assessments to revise baseline establishment, skill mix, ward manager supervisory and clinical status .
Which Strategy Priority does this relate to? How does this impact on patients or the public?	• Customer Focus Strategy • **Clinical Strategy** • Governance Strategy • **Workforce Strategy** • Financial Strategy
Relationship with Annual Objectives	Supports the delivery of the Trust's Annual Objectives and the delivery of high quality care
Risk / Legal Implications:	Delivery of safe staffing is a key requirement to ensuring that the Trust complies with National Policy direction

Resource Implications:	

Equality and Diversity Implications:	Supports the delivery of accessible and responsive services
Relationship with Assurance Framework [Risk, Control and Assurance]	Supports the Trust's Assurance Framework and Risk Management Processes
Recommendations:	• That the Board note and discuss the contents of this report • The Board will continue to receive regular assurance in respect to staffing levels going forward

REPORT TO TRUST BOARD

Date of meeting:	30 July 2015
Report title:	**Safe Staffing – 6 Monthly Report**
Executive Lead:	Mr Mark Dinwiddy – Interim Director of Nursing and Quality
Author:	Miss Carol Sylvester – Deputy Director of Nursing
Presented by:	Mr Mark Dinwiddy – Interim Director of Nursing and Quality

1. Executive Summary

This report details the actions currently being taken to ensure that adequate staffing levels are achieved to keep service users safe within North Staffordshire Combined Healthcare Trust in-patient services. The report also provides assurances that the Trust meets the requirements set out by the National Quality Board (NQB) and NHS England in relation to reporting on ward daily staffing levels.

From June 2014 nursing and care staffing capacity and capability has been discussed at public board meetings on a 6 monthly basis. The report will include workforce information, comprising of the number of actual staff hours, compared to the planned staffing level, during the previous six months. Where there are shortfalls in staffing, managers deploy additional staffing from temporary staffing (bank) and deploy agency and overtime in exceptional circumstances. On a monthly basis the board receive an exception report on wards staffing levels most recently presented in a dashboard style format detailing nursing staff fill rate in addition to quality sensitive indicators including sickness, PDR, training, incident, complaint and occupancy data. This data will be displayed on the Trust website in accordance with the National Quality Board (NQB & NHS England, 2013) requirements.

Each ward throughout the Trust has displayed information about the registered nurses and care staff present on each ward on each shift therefore ensuring this information is available to patients and the public

This report provides an overview of safer staffing metrics for the period January 2015 to June 2015 including planned and actual fill rate for registered nurses and care staff, a range of quality indicators, narrative detailing exception reporting and mitigating actions taken.

The report will detail planning to progress the recommendations from the safer staffing acuity review undertaken in 2014 in establishment uplift in addition to progress in recruitment to vacant posts.

2. National Context

Nationally, considerable discussion has taken place regarding the impact nursing staffing levels have on the quality and safety of patient care.

The Care Quality Commission (CQC) and NHS England issued guidance to support implementation of the requirements set out in in the National Quality Board (NQB) report “How to ensure the right people, with the right skills, are in the right place at the right time” and the Government`s commitments set out in “Hard Truths: The Journey to Putting Patients First”. Further guidance was issued by the CQC and NHS England in March 2014 regarding the publishing of staffing data.

The Berwick report made a clear recommendation that healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times (2013).

The Keogh report highlighted further concerns regarding staffing levels. The review teams that visited the 14 trusts found inadequate numbers of nursing staff in a number of ward areas, particularly out of hours – at night and at the weekend. This was compounded by an over-reliance on non-registered support staff and temporary staff (bank) (2013).

The Mid Staffordshire public inquiry final report stated that evidence presented suggested that the Trust did not have reliable figures for its nursing establishments and that the decline in skills and standards was associated with inadequate staffing levels (2013).

3. Context in North Staffordshire Combined Healthcare Trust

NSCHT provides in-patient care across 13 inpatient wards supporting people with mental health, learning disabilities.

Registered nurses and health care assistants provide 24hour support and care to patients 7 days a week 365 days a year.

Adequate staffing levels on inpatient units are vital in providing interventions which support the patient's recovery. In addition the wards require multi-disciplinary support and interventions.

Ward staffing currently consists of substantive staff hours supplemented by bank staff that are used to backfill shortfalls in substantive staff availability due to sickness, vacancies and secondment. In addition, bank staff are required to meet the additional needs of patients with complex needs and support peaks in workflow.

Planned staffing levels have been achieved predominantly by substantive staff and additionally, bank staff as required.

Common strategies employed to enable wards to maintain Safe Staffing levels, include:

- Risk Assessment of the current acuity/dependency levels of the patients on the ward to determine the appropriate level of staffing needed.
- Ward Managers working clinically, either full shifts, part shifts or extra shifts to provide clinical cover (though it is noted that this is not routinely captured in the Unify data)
- Substantive members of ward staff providing extra hours or shifts to help with cover.

To ensure the provision of safe, high quality services, current staffing establishments and skill mix are required to be reset to ensure the provision of safe, high quality care and to ensure that. nurses will be enabled to have the capacity to increase time spent with patients to provide direct care, they will have the capacity to fulfil indirect care requirements and they will be able to take breaks, undertake supervision and education.

The Trust are progressing a review of current registered to care staff ratio. We will progress a review of baseline establishments for nursing staff proposing a ratio of 50:50 registered nurse to care staff. This ratio acknowledges the wider multi-disciplinary input in the delivery of patient care including occupational therapists, activity workers, physiotherapy and nurse practitioners over and above the Unify data submission for Band 2 to 6 registered and care staff.

4. Inpatient Safer Staffing Fill Rate and Quality Metrics January 2015 to June 2015

RAG rating >90% GREEN <90% AMBER <80% RED

Ward 1	Performance (% planned vs actual)		Overall fill rate%	RAG Rating	Ratio Qual v Care	Occupancy Excluding Home LVE	Occupancy Including Home LVE	Sickness %	Stat/ Mand	PDR %	Incident Rate	S.I.
Month	**Reg Staff %**	**Care Staff %**										
January	105.95	161.2	186.5			84%	106%	10.11	*	79	40	0
February	107.3	99	103			97%	99%	6.88	73	74	51	0
March	106	82	94			91%	99%	7.23	74	93	64	1
April	116	92.2	104.1			92%	95%	12.03	72	93	117	1
May	88.3	101.2	94.75			89%	101%	9.01	79	86	52	1
June	113.9	95	104.4		48%	84%	89%	3.50	85	86	52	0

Ward 2	Performance (% planned vs actual)		Overall fill rate%	RAG Rating	Ratio Ratio Qual v Care	Occupancy Excluding Home LVE	Occupancy Including Home LVE	Sickness %	Stat/ Mand	PDR %	Incident Rate	S.I.
Month	**Reg Staff %**	**Care Staff %**										
January	90.55	100	95.25			85%	102%	6.90	*	85	25	0
February	87.5	136.3	111.75			78%	88%	5.93	83	85	15	0
March	95.12	131.5	113.05			94%	100%	6.91	78	84	19	1
April	92.9	152	122.7			92%	103%	6.09	73	83	20	1
May	97.2	118.5	107.85			89%	95%	12.36	74	79	17	1
June	103.4	105.3	104.3		51%	88%	99%	15.67	78	75	19	0

Ward 3	Performance (% planned vs actual)		Overall fill rate%	RAG Rating	Ratio Ratio Qual v Care	Occupancy Excluding Home LVE	Occupancy Including Home LVE	Sickness %	Stat/ Mand	PDR %	Incident Rate	S.I.
Month	**Reg Staff %**	**Care Staff %**										
January	95.1	127.2	111.15			93%	107%	14.04	*	93	11	0
February	98.7	143.75	121.2			84%	97%	10.79	72	100	14	1
March	94.5	159	126.7			89%	99%	8.86	75	100	17	0
April	100.5	104.6	102.55			93%	99%	6.27	77	100	6	0
May	109.3	111.2	110.25			93%	99%	5.41	76	100	15	1
June	120.4	110.8	115.6		51%	90%	99%	4.80	78	95	16	0

- Wards 1, 2 and 3 Adult Inpatient Acute ward data reflects that the ward has maintained planned staffing levels over the 6 month period.
- A Trust wide recruitment drive is currently underway and will address the current vacancies and address a small under fill on registered staff ward 1 to achieve the proposed 50:50 ratio of registered nurses to care staff.
- High acuity in March and April is reflected in an increase in incidents and serious incidents in ward 1 whilst 2 incidents on ward 3 relate to ward closures arising from infection outbreaks.
- Whilst there have been marked reductions in sickness over the reporting period, ward 2 has seen an increase in June.

Older Persons and Neuropsychiatry Inpatient Wards

Ward 4	Performance (% planned vs actual)		Overall fill rate%	RAG Rating	Ratio Ratio Qual v Care	Occupancy Excluding Home LVE	Occupancy Including Home LVE	Sickness %	Stat/ Mand	PDR %	Incident Rate	S.I.
Month	**Reg Staff %**	**Care Staff %**										
January	74.9	106.8	90.85			33%	34%	0.00	*	50	4	0
February	91.6	119.5	105.5			66%	69%	0.00	*	67	8	0
March	98	82.4	90			67%	69%	1.64	*	66	15	0
April	103.7	84.5	94.1			92%	105%	0.00	85	50	12	0
May	121.5	72.4	96.95			94%	110%	0.00	87	40	8	0
June	103	80.1	91.5		N/A	90%	102%	0.00	92	16	15	1

Ward 5	Performance (% planned vs actual)		Overall fill rate%	RAG Rating	Ratio Ratio Qual v Care	Occupancy Excluding Home LVE	Occupancy Including Home LVE	Sickness %	Stat/ Mand	PDR %	Incident Rate	S.I.
Month	**Reg Staff %**	**Care Staff %**										
January	94.5	177.65	136.05			94%	99%	4.71	*	100	33	0
February	96.75	155	125.7			93%	101%	4.20	85	100	23	0
March	101.4	99	100.2			92%	104%	4.33	85	96	20	0
April	104.25	130.4	117.3			88%	94%	5.20	88	96	9	0
May	121.1	160.6	140.85			93%	95%	6.83	89	93	26	0
June	104.8	133.8	119.3		43%	86%	94%	2.85	93	92	13	0

Older Persons and Neuropsychiatry Inpatient Wards (continued)

Ward 6	Performance (% planned vs actual)		Overall fill rate%	RAG Rating	Ratio Ratio Qual v Care	Occupancy Excluding Home LVE	Occupancy Including Home LVE	Sickness %	Stat/ Mand	PDR %	Incident Rate	S.I.
Month	**Reg Staff %**	**Care Staff %**										
January	107.5	93.5	100.5			90%	94%	11.03	*	97	15	1
February	101.4	99	100.2			94%	94%	12.37	75	100	12	0
March	104.5	87	95.75			93%	95%	6.89	77	94	11	0
April	115.5	80.25	97.8			94%	95%	9.11	77	94	13	0
May	111.9	89	100.45			97%	98%	6.20	77	93	14	0
June	97.2	87.8	92.5		47%	96%	96%	4.58	79	93	31	0

Ward 7	Performance (% planned vs actual)		Overall fill rate%	RAG Rating	Ratio Ratio Qual v Care	Occupancy Excluding Home LVE	Occupancy Including Home LVE	Sickness %	Stat/ Mand	PDR %	Incident Rate	S.I.
Month	**Reg Staff %**	**Care Staff %**										
January	100.5	111.4	105.95			94%	100%	1.78	*	91	13	2
February	88.8	100	94.4			87%	91%	4.03	83	88	15	2
March	90	93	91.5			82%	88%	6.17	83	88	10	1
April	100.4	96.85	98.6			85%	93%	4.52	85	88	13	0
May	97.7	115.1	106.4			85%	90%	9.38	85	84	12	0
June	105.2	95.8	100.5		44%	89%	96%	7.87	91	84	13	1

- Ward 4,5,6,7, our older persons and neuropsychiatry wards have achieved planned staffing levels over the reporting period.
- It is noted that ward 4, our shared care ward development is undergoing a transition period of establishment setting following the opening of the ward. The ward operated predominantly on a mix of substantive and block booking of temporary staff therefore six month data for training and sickness is being developed.
- Ward 7 has seen an increase in serious incidents reported. There are no emerging links between the incidents and staffing availability.

Substance Misuse Inpatient Ward

EMU	Performance (% planned vs actual)		Overall fill rate%	RAG Rating	Ratio Qual v Care	Occupancy Excluding Home LVE	Occupancy Including Home LVE	Sickness %	Stat/ Mand	PDR %	Incident Rate	S.I.
Month	**Reg Staff %**	**Care Staff %**										
January	102.5	98.25	100.35			80%	80%	0.21	*	100	6	0
February	100.5	82.5	91.5			81%	81%	2.52	92	100	9	0
March	99.5	80.8	90.15			80%	80%	8.12	91	100	14	0
April	101.5	83.5	92.5			77%	77%	6.53	85	84	6	0
May	102.5	85.7	94.1			79%	79%	8.16	87	85	10	0
June	108.6	84.6	96.6		54%	80%	81%	8.63	89	81	9	0

- Planned staffing levels have been achieved on the Edward Myers Unit during the reporting period.
- A Trust wide recruitment drive is anticipated to address the current vacancies.
- An over performance in the 50:50 registered to care staff ratio has been achieved.

Learning Disability Inpatient Wards

Assessment and Treatment	Performance (% planned vs actual)		Overall fill rate%	RAG Rating	Ratio Ratio Qual v Care	Occupancy Excluding Home LVE	Occupancy Including Home LVE	Sickness %	Stat/ Mand	PDR %	Incident Rate	S.I.
Month	**Reg Staff %**	**Care Staff %**										
January	101.35	110.8	106.05			100%	100%	8.46	*	93	55	0
February	77.5	112	94.7			86%	86%	4.36	95	96	31	0
March	71.65	113.3	92.4			80%	80%	4.30	95	96	17	0
April	80.4	101.4	90.9			82%	82%	6.99	94	93	10	0
May	79.5	106.4	92.95			100%	100%	7.75	93	93	9	0
June	76.6	109.1	92.8		32%	94%	94%	7.62	94	93	16	0

Telford Unit	Performance (% planned vs actual)		Overall fill rate%	RAG Rating	Ratio Ratio Qual v Care	Occupancy Excluding Home LVE	Occupancy Including Home LVE	Sickness %	Stat/ Mand	PDR %	Incident Rate	S.I.
Month	**Reg Staff %**	**Care Staff %**										
January	98.45	110.15	104.3			83%	83%	8.11	*	100	18	0
February	80	87.5	83.75			72%	72%	13.18	92	100	25	0
March	80	89.75	84.87			67%	67%	18.13	98	100	27	0
April	81.25	93.4	87.3			75%	75%	10.94	98	100	13	0
May	90.8	90.85	90.8			92%	82%	5.59	97	100	26	0
June	94.05	88	91.0		35%	84%	94%	5.59	96	100	14	0

- Learning Disability inpatient units have seen challenges to achieving planned staffing levels both on Telford Unit and Assessment and Treatment relating to registered staff fill rate however, this has been mitigated by the use of care staff to ensure safer staffing levels.

- The wards, whilst low in actual bed numbers and some under occupancy, acuity remains high predominantly relating to challenging behaviour.

- Ward establishments are undergoing a review process to part of which will include a review of skill mix of registered nurse to care staff.

- Sickness within both ward areas has presented additional challenges to fully covering vacant shifts.

CYP Inpatient Ward

Darwin Centre	Performance (% planned vs actual)		Overall fill rate%	RAG Rating	Ratio Ratio Qual v Care	Occupancy Excluding Home LVE	Occupancy Including Home LVE	Sickness %	Stat/ Mand	PDR %	Incident Rate	S.I.
Month	**Reg Staff %**	**Care Staff %**										
January	94.15	114.9	104.5			64%	85%	1.79	*	100	11	0
February	92	123	107.5			68%	86%	0.55	91	97	13	0
March	97.5	99.1	98.3			78%	199%	3.55	88	97	49	0
April	92.5	113.75	103.1			74%	100%	4.58	86	97	103	0
May	96.7	97.8	97.25			54%	83%	1.80	87	97	116	0
June	88.6	92.4	90.5		51%	62%	88%	0.00	91	94	62	0

- Planned staffing levels have been achieved on the Darwin Unit across the reporting period.
- The ward have recruited to a number of the current vacancies and awaiting new starters.
- The ratio of 50:50 registered to care staff has been achieved.
- Whilst there have been no serious incidents, the ward has seen a sustained period of high dependence / acuity requiring reliance on availability of the nurse bank to support activity levels.

Rehabilitation Inpatient Services

Florence House	Performance (% planned vs actual)		Overall fill rate%	RAG Rating	Ratio Ratio Qual v Care	Occupancy Excluding Home LVE	Occupancy Including Home LVE	Sickness %	Stat/ Mand	PDR %	Incident Rate	S.I.
Month	**Reg Staff %**	**Care Staff %**										
January	100.5	92.85	96.6			80%	100%	8.33	*	82	14	0
February	91.5	89	90.25			88%	94%	13.84	81	77	13	0
March	111	89.25	100.1			97%	100%	4.98	84	100	11	0
April	116	91	103.5			79%	87%	5.03	90	100	10	0
May	117.25	87.75	102.5			92%	97%	6.33	92	100	12	0
June	109	93.6	101.3		43%	95%	99%	4.79	90	95	15	0

Summers View	Performance (% planned vs actual)		Overall fill rate%	RAG Rating	Ratio Ratio Qual v Care	Occupancy Excluding Home LVE	Occupancy Including Home LVE	Sickness %	Stat/ Mand	PDR %	Incident Rate	S.I.
Month	**Reg Staff %**	**Care Staff %**										
January	86.15	113.8	99.9			89%	100%	14.97	*	91	7	0
February	96	87	91.5			98%	109%	12.83	88	95	9	0
March	104	102.5	103.2			92%	110%	10.36	82	100	14	0
April	98.25	99	98.6			75%	105%	6.56	76	100	8	0
May	107	100.6	103.8			81%	110%	5.95	75	100	32	0
June	98	102	100		50%	92%	102%	5.13	77	100	13	0

- Inpatient rehabilitation services have remained staffed to planned levels across the reporting period.
- Skill mix within the Florence House unit is being reviewed.
- Sickness has seen an overall reduction across both units.

Dragon Square Respite Unit for Children with a Learning Disability

Dragon Square Respite	Performance (% planned vs actual)		Overall fill rate%	RAG Rating	Ratio Ratio Qual v Care	Occupancy Excluding Home LVE	Occupancy Including Home LVE	Sickness %	Stat/ Mand	PDR %	Incident Rate	S.I.
Month	**Reg Staff %**	**Care Staff %**										
January	104.85	92.2	98.35%			55%	55%	0.00	*	100	1	0
February	103.5	91.5	97.5%			76%	76%	0.35	70	97	4	0
March	94.3	93	93.6%			64%	64%	4.04	72	97	8	0
April	95.25%	96.4%	95.8%			83%	83%	2.59	72	97	2	0
May	100%	100%	100%			76%	76%	0.86	85	97	1	0
June	93.1%	92.5%	92.8%		43%	68%	68%	0.00	84	94	2	0

- Dragon Square respite unit has achieved planned staffing levels across the reporting period.
- A review of skill mix and ratio registered nurse to care staff is ongoing.

Summary

The Trust is pleased to report that the monthly Unify data reflects that planned staffing levels have been achieved across all inpatient areas for the majority of the reporting period with variance in the learning disability inpatient service. It is noted that, where shortfall occurs, the ward manager will undertake an increased amount of clinical hours in addition to mitigations of the involvement in care delivery of the wider multidisciplinary team.

In addition to two safer staffing acuity reviews to inform a review of current establishment, the Trust has completed a first review of a number of further indicators to ensure that additional secured monies are allocated according to acuity, occupancy, structure, registered to care staff ratio and will additionally include a number of clinical sessions within the ward manager role to strengthen and enhance clinical leadership across the Trust.

The final model is anticipated for completion in July 2015 with the full involvement and engagement of senior clinical staff in the allocation by commissioner's additional finance identified to support and delivers the recommendations from the safer staffing acuity reviews.

Progress against the review and plans will be reported to the Trust Board September 2015.

Carol Sylvester
Deputy Director of Nursing and Quality

July 2015

North Staffordshire Combined Healthcare NHS
NHS Trust

Enclosure 7

REPORT TO: **Trust Board**

Date of Meeting:	30th July 2015
Title of Report:	2014/15 Quality Account – Final version
Presented by:	Dr Buki Adeyemo
Author of Report: Name: Date: Email:	Laurie Wrench, Head of Clinical Audit and R&D 14th July 2015 Laurie.wrench@northstaffs.nhs.uk
Purpose / Intent of Report:	• For Information
Executive Summary:	By 30 June 2015 all organisations were required to have developed and published a Quality Account. The Quality Account is produced annually to report to the public about the quality of services and should address: • What an organisation is doing well • Where improvements in the quality of services are required • The priorities for improvement in the coming year • How the Trust has involved service users, staff and others in determining these priorities for improvement It helps to assure patients, the public and key stakeholders that the Trust is regularly scrutinising and actively managing each of the services that it provides. Following a robust development and engagement process, the Trust's Quality Account for 2014/15 was completed and published ahead of the national deadline.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• **Customer Focus Strategy** • **Clinical Strategy** • IM and T Strategy • **Governance Strategy** • **Innovation Strategy** • Workforce Strategy • Financial Strategy • Estates Strategy

Relationship with Annual Objectives:	The Quality Account links with a number of the Trust's annual objectives namely those related to quality, patient experience, safety and engagement.
Risk / Legal Implications:	It is a legal requirement to publish an annual Quality Account
Resource Implications:	None
Equality and Diversity Implications:	Aspects of equality and diversity are covered throughout the Quality Account
Relationship with Assurance Framework [Risk, Control and Assurance]	It is necessary for the Trust to develop and publish an annual Quality Account; this is key to the Trust's Assurance Framework and is fully integrated within the Assurance Framework
Recommendations:	1. Accept the final version of the Quality Account for information purposes 2. Note that a summary version will be produced in preparation for the AGM in September

Quality Account

2014/15

North Staffordshire Combined Healthcare
NHS Trust

Contents

INTRODUCTION

PART 1

STATEMENT ON QUALITY

PART 2

PRIORITIES FOR IMPROVEMENT (LOOKING FORWARD)
& STATEMENTS OF ASSURANCE FROM THE BOARD

PART 3

REVIEW OF QUALITY PERFORMANCE FOR 2013/14 (LOOKING BACK)
& STATEMENTS FROM PARTNERS

Statement on Quality

FROM THE CHIEF EXECUTIVE

QUALITY IS AT THE HEART OF EVERYTHING THAT WE DO

The Trust's Quality Account provides a mechanism for us to share our quality priority initiatives over the last 12 months and our quality priorities looking forward with key partners and stakeholders and the wider general public. We are pleased with our achievements but realise there is always more we can do.

2014/15 has been a year of significant change – a change which feels positive. At the beginning of 2014, we launched the Clinical Pathway Redesign Programme, in partnership with our Commissioners, aiming to strengthen integration of physical health, mental health and social care clinical pathways across all the Trust services. We worked in partnership our NHS partners, social care, primary care, voluntary sector and service users and carers in the development of the Clinical Pathways. During the year, we have made significant progress in our service developments. New services have launched this year including the Adult Autism Spectrum Disorder service, One Recovery and Dual Care (Ward 4). Existing services have been reviewed and enhanced – our Access Team now operates 24/7 and the most recent data supplied shows a significant improvement in the way in which service users are able to access care and treatment in a more timely manner.

Building on our clinical pathway work, we developed our One and Five-Year Business Plans, which sets out how we will continue to best deliver our core services whilst developing specialist services. Our quality themes drive our ambitions for excellence and the Board has defined a new emphasis for the organisation based on four strands of quality that we are calling SPAR; over the next year, we will see a real focus on:

- 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** to service users and their carers.
- Our focus will be on the **Recovery** needs of those with mental illness.

In enhancing our approach to quality, this year we introduced a strengthened Quality Assurance Framework including the establishment of a Quality Assurance Programme Board with supporting structures at operational and team level. Our new approach means that teams are able to self-assess against the Care Quality Commission key quality domains with an internal peer review challenge to understand where we are doing well and where further improvements can be made.

We also introduced the Listening into Action programme which has seen real engagement across all teams in the organisation. It has also marked a change in the way the senior team engages with frontline staff. The results of our second PULSECHECK are extremely encouraging – we have seen marked improvements in all areas and benchmark very positively against not only our cohort, but also against other trusts nationally that have been involved in the LiA programme.

Finally, one of our most important developments took place at the end of the financial year. In March, we held our first Patient, Service User and Carer Council meeting, which was attended by over 60 people, all with a commitment to involving those who use or care for someone using our services more in Trust business and development of services. The Council has since held a second meeting, as we look forward to embedding this new way of working into our day-to-day practices. Key roles members of the Council will have will be to take a place on our committees and Directorate Management Groups, with the Chair of the Council joining the Trust Board; all of which will bring the patient and carer voice to key decision-making forums.

The coming year won't be without challenge; a new Government may lead to national NHS changes as we have seen in previous years. However, we are in an excellent position of strength and looking forward to the opportunities the Five Year Forward View and national focus on Parity of Esteem brings.
Closer working with our social and primary care colleagues is high on our agenda and we will continue to position the Trust as a viable, high quality, safe organisation, which services North Staffordshire and beyond.

Caroline Donovan
Chief Executive

Message
FROM THE CHAIR

QUALITY IS AT THE HEART OF EVERYTHING THAT WE DO

Quality is at the heart of everything that we do. The quality account sets out many of the good things that are happening but there is no complacency. Things do go wrong, and when they do, we are committed to learning from them and putting them right.

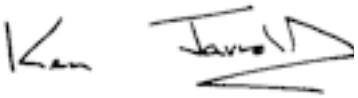
There are many definitions of quality. The one that has lived with me was first put forward by Robert Maxwell of the King's Fund. Robert suggested that there are six dimensions of quality;

- Effectiveness –is the treatment the best available in a technical sense?
- Acceptability – What does the service user think of it? Is it what we would wish for ourselves and for the people we care for?
- Efficiency – is treatment and care provided at a reasonable cost? Are resources well used?
- Access – can people get the treatment when they need it?
- Equity – are service users being treated fairly relative to others?
- Relevance – is the service the best that can be delivered taking account of the needs of the population as a whole?

My view of quality has been influenced by my work for the NHS but also by my personal experience as a patient and carer.

I believe strongly that the Trust Board and managers at all levels should be focused on supporting the staff who work directly with service users and carers. As Sir Roy Griffiths pointed out if we look after the staff they will look after the service users.

Ken Jarrold CBE



Introduction

WELCOME TO OUR TRUST

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

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

We also provide specialist mental health services such as Child and Adolescent Mental Health Services (CAMHS), substance misuse services and

psychological therapies, plus a range of clinical and non-clinical services to support University Hospital of North Midlands NHS Trust (UHNM).

Our team of 1232 whole time equivalent staff are committed to providing high standards of quality and safe services. We service a population of approximately 464,000 people from a variety of diverse communities across Northern Staffordshire. The Trust's closing income for the year (2014/15) was £75.5m against a plan of £75.1m.

For 2014/15, our main NHS partners remain the two Clinical Commissioning Groups (CCGs) – North Staffordshire CCG and Stoke-on-Trent CCG. We will also work very closely with the local authorities in these areas as we progress through 2015/16.

In addition, we work closely with agencies, which support people with mental health problems, such as North Staffs Users Group, Approach, ASIST, Brighter Futures, Changes, EngAGE, North Staffs Huntington's Disease Association, Mind, North Staffs Carers Association, Reach and the Beth Johnson Association.

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, performance and finances for 2014/15.

The Annual Report is available on the Trust's website at www.combined.nhs.uk

WELCOME TO OUR QUALITY ACCOUNT

Welcome to our latest Quality Account, which covers the financial year 2014/15 – 1 April 2014 to 31 March 2015.

We produce a Quality Account each year, which is a report to the public about the quality of services we provide and demonstrates that we have processes in place to regularly scrutinize all of our services.

In 2014/15 Independent Auditors, KPMG, were appointed by the Audit Commission to provide an independent assurance engagement and a limited assurance report to the Directors of the Trust. As a result, based on the results of their procedures, they concluded that the 2014/15 Quality Account was presented in line with requirements of the Regulations.

Patients, carers, key partners and the general public use our Quality Account to understand:

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

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

We also look forward to your feedback, which will assist us in improving the content and format of future Quality Accounts.

Feedback can be given through the Trust's website www.combined.nhs.uk or direct to qualityaccount@northstaffs.nhs.uk

SERVICES COVERED BY THIS QUALITY ACCOUNT

This Quality Account covers all six directorates provided by the Trust. The core services we provide are shown below under our clinical structure. (The Trust does sub-contract out a small number of services to another non-NHS body in respect of IAPT).

In November 2014, we introduced a new clinical structure. The change from three clinical divisions to six clinical directorates aimed to promote autonomy and better align our services to commissioning structures.

Part 1

STATEMENT ON QUALITY

1.1 QUALITY OF SERVICES - KEY ACHIEVEMENTS

We have a lot to be proud of. We have a dedicated workforce, excellent feedback from our service users and have actively managed significant changes over the past few years in line with local need as well as national policy. Our on-going commitment is delivering high standards of quality and safe services through on-going engagement with service users and key partners – *Working together, developing together.*

Feedback from service users and carers: The Trust enjoys close relationships with service users, carers, and a very well organised North Staffordshire User Group. The use of service user and carer stories, and service user surveys inform the focus on continuous improvement.

A recent discharge survey showed that 94% of service users were happy with the services provided.

KEY PRIORITIES FOR 2014/15 – COMMISSIONING FOR QUALITY INNOVATION SCHEME:
Last year we aligned our plans for improving the quality of services with the Commissioning for Quality Innovation (CQUIN) Scheme for 2014/15, which 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.

We identified six priority areas, which contribute to improved safety; clinical effectiveness; innovation and patient experience. Part 3.1 of this Quality Account provides a statement against each of the priority areas. Against the CQUIN financial framework, in total we achieved 99% of the schemes.

"The experience of people who come into contact with our services must drive every aspect of what we do. How they feel, the quality of the services they receive and the support they get to help recovery is fundamental to everything we do. The role of the Quality Committee is to do it's utmost to ensure that this occurs"

Mr Patrick Sullivan,
Non-Executive Director and
Chair of the Quality Committee

OUR VISIONS AND VALUES

Our core purpose is to improve the mental health and wellbeing of our local communities – some 464,000 people living across Stoke-on-Trent and North Staffordshire. Our strategy is to deliver an evidence-based model of care, which is appropriate to our service user needs and focuses on wellbeing and ongoing recovery. We aim to be recognised as a centre of excellence, bringing innovative solutions to the services we deliver and embedding a culture of continuous learning across our organisation. This is reflected in our Vision and Values:

Our Vision

- To provide patient centred mental health, specialist learning disability and related services for people of all ages

- To be the best in all that we do

- To work in partnership to deliver services that promote recovery, wellbeing and independent living

MAKING PROGRESS TO FOUNDATION TRUST STATUS:

Recent events over the last 3 months have seen our plans for determining the future shape of the organisation altered significantly. The Trust remains on course and focused on the delivery of high quality mental health and social care services across Stoke and North Staffordshire. Planning against this background of uncertainty has been short term and remains so for the foreseeable future nevertheless our business plan for 2014/16 includes ambition and drive in order to ensure that we continue to deliver high quality care and services for the population we serve over the next 2 years.

We have agreed with the CCGs and with the NHS Trust Development Authority [TDA] that further work on options for future sustainability of mental health and learning disability services should pause while further work on the options available and consideration of our Five year Integrated Business Plan is carried out.

CLINICAL PATHWAY DEVELOPMENT

The clinical pathways redesign work was a joint development programme between the Trust and local CCG's and was agreed at a clinical summit held in January 2014. The aim of the programme was to design and articulate a number of care pathways that will deliver an improved experience across the wide range of mental health services for those who live with and/or experience a mental illness in the North Staffordshire and Stoke area.

At the heart of the programme was the requirement to deliver integrated care which involves 'joining up' care and support across whole systems at a local level through a process of collaboration, co-operation, and co-production. The work involved health and social care providers integrating resources, systems and processes so that the physical and mental health care needs of the individual are seamlessly provided for within the resources available across the health and social care economy.

The approach was underpinned by the concept of person centred care that is built around the needs of the individual, their carers and families and gets the most out of every penny we spend. Integrated care is the means to the end of achieving high quality compassionate care resulting in better health and wellbeing for our local communities.

At the heart of this work was the service user and the need to design services that are safe, caring, and effective - key outcomes stakeholders will need to address. By working together to design care pathways that are recovery focused the system will be best placed to provide integrated, personalised care that is empowering, supportive and results in improved health and wellbeing.

We celebrated this work at an event in June 2014, held at Stoke City FC's Britannia Stadium which was attended by 21 partner organisations to share the latest stage of the clinical pathways redesign programme. The event included talks from a number of local health professionals on the work that had taken place to develop enhanced service integration; and a carer who spoke eloquently about the complex and emotional journey she has experienced caring for a loved one.

The event also featured a series of engagement and feedback sessions which focused on how existing services can be further improved for service users. A number of the pathways have been implemented, enhancing service delivery, collaborative working, improving access and service user experience.

> "We are well on the way to designing the best clinical pathways we can for the people of North Staffordshire and it's really heartening to see so many people from different organisations coming together to make this a reality."
>
> Dr Andrew Bartlam,
> Chief Accountable Officer
> for StokeonTrent CCG

> "We need to work better together for the people who need our services.Brighter Futures' Mental Health Inquiry listened to over 140 people who told us about the impact that their mental illness had on their life and their experience of using services. We won't get our services right until we listen to these voices and we should make addressing the issues they raise our key priority."
>
> Gill Brown,
> Chief Executive of Brighter Futures

Listening into Action

The Trust has adopted the "Listening into Action" (LiA) approach as our preferred method of cultural change and action, underpinning our belief that by putting staff at the centre of change and enabling them to take responsibility for the changes they want to see, is the best way to gain commitment and sustain changes over the long term.

Staff have been contributing to 15 pioneering team projects, delivering and implementing the changes in a challenging twenty-week timeframe. The changes were celebrated at a Pass-It-On event on 27 March 2015.

The Executive team and the whole board have been committed from the start of the LiA journey to the principle of staff engagement in change, working with and alongside staff for the best possible outcomes for staff and patients alike. This approach being the biggest transformational journey the trust has ever planned. Building engagement developing relationships and creating a culture staff wish to be part of has been vital.The LiA approach is not bound up with role status, but is focused on working with uncertainty, managing conflict and building success through influence of the many.

Trust wide 'big conversations' were held with 500 staff, from which our first fifteen pioneering teams were established. These teams took ideas and turned them into reality, they planned and completed the changes they wanted to see, to improve care for service users, and improve efficiency productivity and staff wellbeing. Ten teams were service specific, and five were crosscutting enabling teams.

We involved service users to tell us what they valued and what could be improved, and to co-produce solutions. The change teams worked closely with service users in one to one conversations and in workshops.

SOME ACHIEVEMENTS SO FAR:

- ✓ Introduction of volunteers to meet and greet users of the memory service, and to provide drinks and make the environment more welcoming. We have put up a comments board in the waiting area for comments to be posted.
- ✓ Memory Service invitation letters now include a photograph of the clinician whom users will meet.
- ✓ Our Section 136 ward has been renamed "Place of safety" with major physical environment changes. Service users and their families will have a far better experience, with more positive outcomes. Staff will feel proud of their service. Initial feedback from staff and service users is very positive.
- ✓ Single assessment process for learning disabilities document has been reduced from fourteen pages to one, and the multi-disciplinary team staff are trusting information inputted by other staff. Staff have welcomed this.

All changes are focused on improving patient care and experience. Increased staff wellbeing and satisfaction will support cultural change and commitment, as well as improving recruitment and reducing turnover and illness.

OUR DUAL CARE WARD

On 7th January 2015 under a mutual aid agreement with University Hospital North Midlands (UHNM), ward 4 opened as a dual care environment for patients whom are medically fit for discharge awaiting appropriate care package. The Ward mission is to:

"Provide high quality standards of care focusing on a holistic individualised approach to patients with complex physical and mental health needs".

To enable that patients' needs are met and a complete holistic re-assessment is able to take place the ward is staffed with a widely represented multi-disciplinary team including a mixture of both RMN's & RGN's.

Patients transferred to ward 4 are extremely vulnerable to rapid physical deterioration. Prior to transfer there are processes to give assurance that only suitable patients are transferred to ward 4 whose clinical needs can be safely met by NSCHC. Ward 4 works closely with the RAID Team and UHNM frail older persons services, with the ward senior team providing a regular 'in reach' service to UHNM identifying patients that are suitable to transfer to ward 4 strengthening the already excellent communications between the UHNM and our Trust. The ward continues to review, with plans to develop the skills and knowledge of current staff members with support of trust policies and procedures to enable the safe management of both physical & mental health interventions thus to reduce all possible risks of needing to be re-admitted to UHNM.

The ward is a welcoming, therapeutic and calm environment, the patients all have their own rooms and there is plenty of space to enable therapies to take place and allow patients to have time with relatives and friends. The patients are all out of bed during the day and are mobilised. They have access to quiet areas, to televisions and radios and they go through to the dining area to have meals. The environment has helped patients and relatives feel comfortable and supported. This change in environment and approach has led to patient's presentations altered and a positive change in their physical and mental health has been noted by staff, visiting staff from the Royal Stoke and relatives resulting in changes to initial discharge plans.

The ward has received some excellent feedback from patients, visiting professionals from UHNM and carers.

"Thank you so much for caring for my husband, he looks the best I have seen him in months, he looks happy and settled"

"I am very pleased with my husband's care, he's speaking more now than in the last 6 weeks, he is like a different person"

"Can I pass on my massive thanks to the staff of Ward 4 They are doing a wonderful job. The patients look really settled and families are happy. Terry, our ANP on the ward speaks really highly of the care given by the staff. What more can we ask for?"

Fiona Millington,
Associate Chief Nurse, UHNM

"Gratitude for the wonderful care and attention that my mum has received & I can only say with sincerity that everything about ward 4 was brilliant and sincerely hope that it will continue as a permanent feature so that other patients and family members and benefit from the same service that we have received"

'CARING FOR AND CARING ABOUT'

INTRODUCING OUR SERVICE USER STANDARDS

(SUPPORTING THE 6 Cs)

The Trust is committed to providing our local communities with safe, high quality effective care, where our service users truly feel cared for and cared about. Doing the right thing at the right time and getting it right the first time for our service users is priceless. Solving issues before they happen, takes less time than resolving them afterwards. With that in mind a number of service user standards have been developed 'Caring for and Caring About'.

Each of the standards are underpinned by 'The 6 C's' Care, Compassion, Competence, Communication, Courage and Commitment. The standards support our commitment to each one of our service users, wherever they may be accessing services, to do our best to ensure:

You feel safe, in a clean and comfortable environment, with professional staff working together and with you to ensure you are in safe hands.	**You feel cared about,** with kind and helpful staff with a courteous and respectful attitude towards you, listening and keeping you involved and informed at every step.	**You have trust and confidence,** in your care and treatment, provided by skilled and compassionate staff.
1. Cleanliness	**4. Courteous & Respectful**	**7. Informative**
2. Behaviour	**5. Communicate & Listen**	**8. Timely**
3. Honest & Open	**6. Helpful & Kind**	**9. Compassionate**

10. Continuous Improvement through listening and responding

Our standards will be launched shortly; a poster has been designed for each of the 10 standards and will be visibly displayed in all areas of the Trust.

DO...	DON'T...
Seen to be clean	
• Practice hand hygiene; encourage colleagues/visitors to do so too • Let service users see/know you have washed your hands • Show attention to detail in cleaning	• Don't be frustrated with service users if they ask you to wash your hands again • Don't only clean what's seen • Don't eat or drink in clinical areas
"I've just washed my hands, but I'm happy to wash them again if you want me to?"	"No need, I've already washed my hands."
Safe practice	
• Always put service user safety first • Follow all service user safety and infection control procedures • Speak up if you believe service user safety is being compromised	• Don't tolerate unsafe practice in any circumstances e.g. to meet a target • Don't criticise others for speaking up on behalf of service user safety
"Wait, safety comes first for all of us."	"Carry on, there's a lot to do."
Pride of place	
• Take pride in having a clean and tidy environment - not just your area but across all trust services • Tidy up litter, clutter or 'mess' if you see it, or immediately report it to the appropriate department to respond	• Don't just leave rubbish in the corridor • Don't walk past rubbish, mess or clutter without tidying up • Don't leave it for the cleaner, if you can clear it up straight away • Don't assume that it is somebody elses responsibility
"We're all responsible, we are all cleaners."	"Leave it, somebody else will deal with it."

CLEANLINESS
(SUPPORTING THE 6 Cs)

This means every one of us is vigilant across all aspects of safety, practices hand hygiene and shows attention to detail for a clean and tidy environment wherever we work.

A safe, clean, comfortable environment...

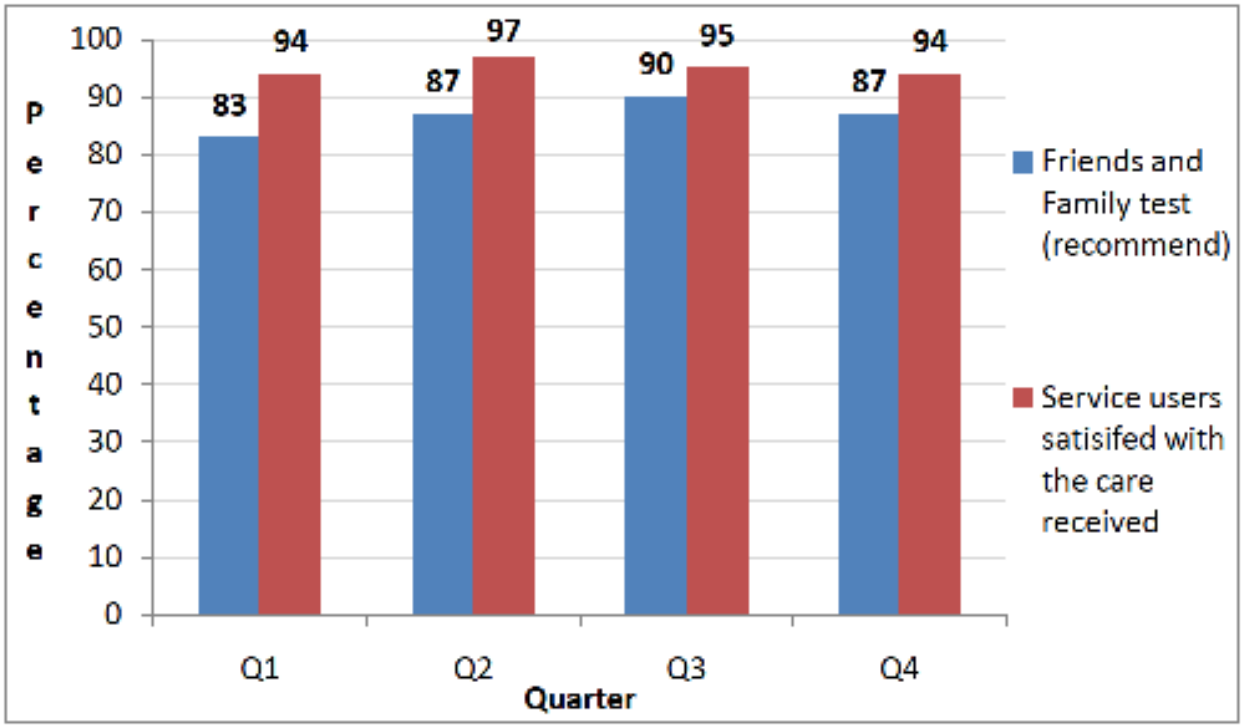
instills trust and confidence

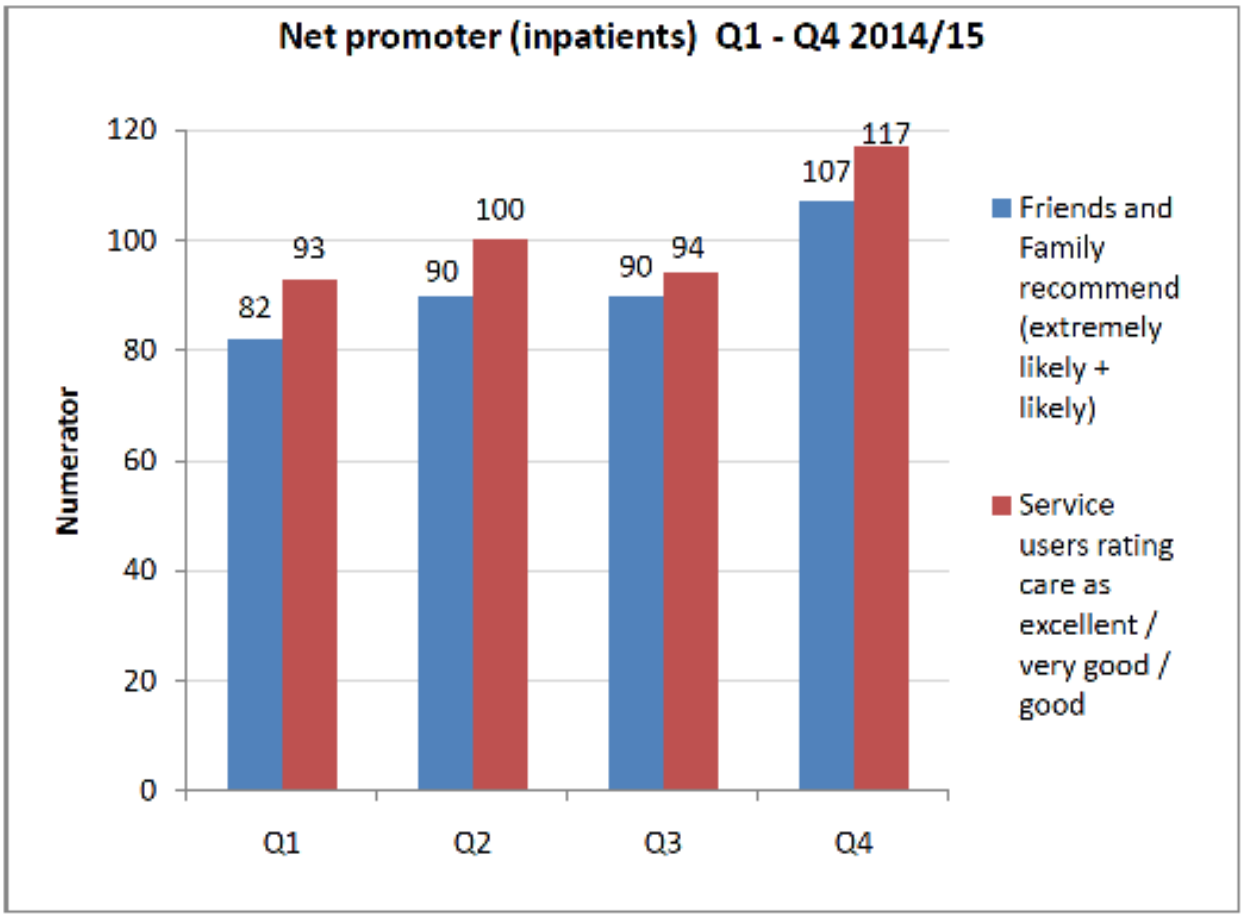
THE FRIENDS AND FAMILY TEST

What is the Friends and Family Test?

The Friends and Family Test is a method of obtaining feedback from service users and staff to determine how positively or negatively they view our services. The service user test asks how likely it is that the respondent would recommend the service to their friends and family. Respondents choose one of six options, ranging from "extremely likely" to "extremely unlikely". The results are then analysed in such a way as to provide the Trust with a percentage score, known as the Net Promoter Score.

What people told us:

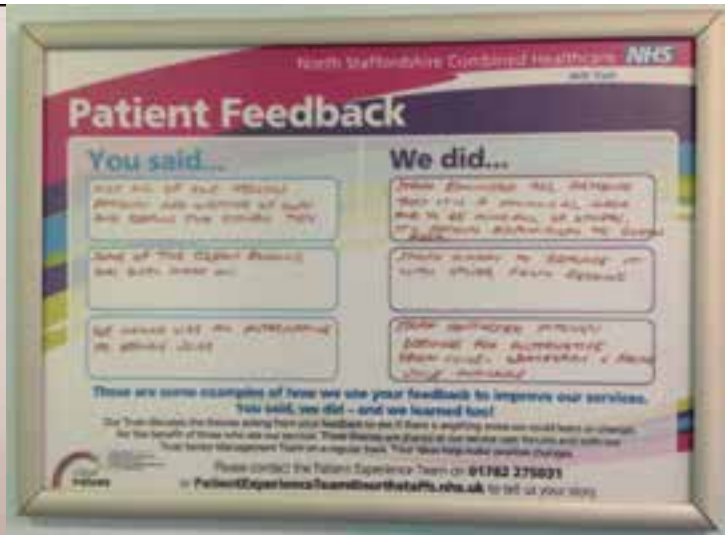



Net promoter (inpatients) Q1 - Q4 2014/15
Numerator
120
100
80
60
40
20
0
82
93
90
100
90
94
107
117
Q1
Q2
Q3
Q4
Friends and Family recommend (extremely likely + likely)
Service users rating care as excellent / very good / good

LISTENING AND RESPONDING TO FEEDBACK

During 2014/15 we introduced 'You Said, We Did' boards to evidence that the Trust listens and responds to feedback from services users and carers.

Anonymous service user comments are displayed with a summary of what action has been taken in relation to the specific feedback. We have also included information detailing how service users and carers can contact the Trust to provide their opinions, comments and complaints.



THE COMMUNITY TRIAGE TEAM

The Community Triage Team (CTT) was launched as a pilot project in November 2013, with the aim of reducing time that police officers were spending responding to, and dealing with, individuals suspected as suffering from mental disorder/distress. This allows the police access to an experienced mental health professional, who can provide a timely mental health assessment, ensuring that that most therapeutically appropriate intervention is reached.

The team consists of one Community Psychiatric Nurse and one police officer operating a 10 hour shift, between the hours of 4pm and 2am, seven days a week. A half-time Support, Time, Recovery Worker is also employed to facilitate follow-up and engagement of the client group. CTT covers the areas of Stoke-on-Trent and North Staffordshire, and is based at Northern Area Custody Facility in Stoke-on-Trent. They respond to calls from the police control room and officers attending incidents. Interventions include: telephone advice, telephone assessment and face-to-face assessment at the scene.

The Community Triage Team works alongside the Access/Crisis Team, Intoxication Observation Unit, Emergency Duty Team/ Emergency Duty Service and RAID – the Rapid Assessment Interface Discharge Team, to maximise smooth care pathways for those coming into contact with the police out of hours.

Recent statistics have demonstrated the success of the CTT, showing a significant decrease in the number of section 136 detentions and a reduction in police time. There are a number of ongoing developments including a better training package for a number of police cohorts, and improved police partnership working arrangements across the Trust by way of inclusion at professional and Care Plan Assessment meetings.

STAKEHOLDER ENGAGEMENT

The close collaboration with stakeholders during the clinical pathways development work was viewed by the Trust as an opportunity for trying to gauge and better understand stakeholders' experiences of the Trust in relation to a number of areas:

- *How we respond to stakeholder organisations (i.e. during face-to-face, phone, email, other contact);*
- *The quality of communication between us and other stakeholders (e.g. clarity of communication, lines of accountability);*
- *How stakeholders rate overall the quality of the relationship between their organisation and us.*

A survey was developed to collect baseline data on these questions and thus establish a picture of the current situation.

The initial stakeholder survey findings were published in October 2014. In total, 36 respondents completed the survey from a wide variety of stakeholder partners. Most respondents reported having either weekly or fortnightly contact with the Trust. The findings overall were generally positive with respondents being asked a number of statements to which they could either 'agree' or 'disagree.' Out of the 14 statements asked, in 10/14 cases the predominant response was 'agree.'

We also asked stakeholders their general opinion of the quality of their relationship with the Trust and 57% indicated that their current relationship with us was either 'good' or 'very good.'

ACTION PLAN

We launched our action plan in October 2014 using a 'you said, we did, we plan to' approach. We have made significant progress against these actions as detailed:

YOU SAID:

"How do you respond to queries?"

WE DID:

Staff are keen to provide a 'gold standard' customer service - our 'Listening into Action' staff Big Conversations highlighted an awareness of 'who does what' helps better signpost partners around our organisation. We used our monthly Team Brief to remind staff of the importance of taking personal responsibility for initial contacts with our service. We have undertaken a review of our intranet.

The implementation of a 24/7 Access Service strengthening our access points into services.

In November, we launched our new Directorate Structures. The new structure puts decision-making much closer to frontline services, promotes autonomy and ensures better alignment of our services to commissioning structures.

Our website has been developed to share information about each directorate and the teams that sit within them.

WE PLAN TO:

Work is ongoing to strengthen the access points into our services. Staff are being encouraged to take more responsibility to ensure their personal contact cards are up-to-date on email and our Outlook system, so that they can be easily contacted across teams.

A review of our intranet aims to improve the visibility of structure charts and team information so that staff can confidently signpost and support stakeholders contacting the organisation.

A structure chart will also be shared with key partners on a quarterly basis, to provide key contact details for each directorate and clinical service. We'll do this through our website, our stakeholder newsletter and by improving electronic signatures/contact cards on emails.

YOU SAID:

"We need clarity of your Management Structure."

WE DID:

Clarity of 'who's who' is key to healthy relationships with our partners. We have a hyperlinked Board Structure available on our website and posters displaying Trust Board members are on display in our main sites (Lawton House, Harplands Hospital and the Hope Centre).

http://www.combined.nhs.uk/aboutus/Board/Pages/OurTrustBoard.aspx

Our website has been developed to share information about each directorate and the teams that sit within them.

WE PLAN TO:

Improve visibility of structure charts

Further develop of our website.

A structure chart will be shared with key partners on a quarterly basis, to provide key contact details for each directorate and clinical service. We'll do this through our website, our stakeholder newsletter and by improving electronic signatures/contact cards on emails.

YOU SAID:

"How do you keep us up to date and how do you communicate with us?"

WE DID:

Stakeholders receive a wealth of information from numerous sources, and we are keen not to overload inboxes with unhelpful information.

Our Communications Team shares news via regular media releases, which are issued not only to the local and regional media, but also to an extensive list of statutory and voluntary sectors stakeholders. Media releases are focused on three main themes –1) informing on Trust business, 2) education around mental illness and 3) service promotion.

We have developed our stakeholder newsletter 'Combined Catch Up', which provides a snapshot of Trust news and events in one snappy email, with links through to our website. This is issued on a monthly basis to all partners in both statutory and voluntary sectors.

Trust members receive a monthly update called Members' News which provides a snapshot of service developments, events and news, with links to the Members' Zone on our website.

All of the regular communication with stakeholders is supported via Social Media. The Trust has a Twitter account -@nscht1 –and a Facebook page. We also have a dedicated YouTube section, which shares video updates on our services and service developments.

We are aware that much of the information we share with you is via electronic routes. We are also keen to talk face to face! We have a good track record of holding engagement events to map out changes in our services. A good example of this is the work we have done around developing our clinical pathways. Our launch event was well attended by partners from across Staffordshire from both third sector and statutory organisations.

WE PLAN TO:

Improve visibility of structure charts. Further develop of our website.

Share a structure chart with key partners on a quarterly basis, to provide key contact details for each directorate and clinical service. We'll do this through our website, our stakeholder newsletter and by improving electronic signatures/contact cards on emails.

Review our external stakeholder engagement strategy to ensure it takes into account the value feedback from those who influence our services can have on communication and, ultimately, service delivery.

We know that our website needs some TLC. We are working on refreshing and updating the current website to address some of the feedback we have had on what is important to our partners, including

- Updated directorate and service information
- Better signposting
- Better links across our services and those of our partners.

YOU SAID:

"How do you communicate within your organisation?"

WE DID:

In July, we began an expansive programme of staff engagement through an approach called 'Listening into Action'. This is an inclusive process, which gives staff a voice and provides them with the opportunity and support to tackle issues that get in the way of them delivering the best possible care to those who use our services and their carers.

We also use the following tools, routinely, to share information and offer staff the opportunity to communicate across teams and with senior management:

- Team Brief on the Road
- CEO Blog
- Weekly News Round
- Monthly Plenary and Team Brief

Staff have sight of all media releases before they are shared with partners and the media

WE PLAN TO:

Continue to roll out 'Team Brief on the Road' to more teams; particularly those who work more remotely to our Stoke-centric sites.

Support the One Recovery Team with a Team Brief on the Road in South Staffordshire, where the new service is based.

YOU SAID:

"How do you keep us informed on joint initiatives and the processes in place for joint working?"

WE DID:

Working together in partnership provides the best outcomes for those who use our services. We have demonstrated this through a number of successful partnerships including:

- One Recovery (ADS, Brighter Futures, ARCH and Changes)
- IAPT –Healthy Minds Stoke-on-Trent (Changes, NS Mind)
- IAPT Staffordshire (SSSFT)
- Hillcrest (Brighter Futures)

We share updates on these services through our regular communications mechanisms, including our stakeholder newsletter, Combined Catch Up and our GP News newsletter.

WE PLAN TO:

Continue to develop our service offer. By better understanding the full service range of our third sector and statutory partners, we will be better positioned to work more collaboratively in the future. We are therefore planning to develop a service directory of all partner organisations to take this forward.

YOU SAID:

"How do you involve us in decision making?"

WE DID:

Over the past 2 years, partners have been consulted on where any significant changes have been made in our services. For example, we worked closely with third sector and statutory partners through phases 1 and 2 of our Model of Care Programme and more recently have seen fantastic support from our partners in the Clinical Pathways work

http://www.combined.nhs.uk/aboutus/CPP/Pages/default.aspx

WE PLAN TO:

Continue to further strengthen this partnership working. Our stakeholder engagement strategy will focus on how we involve partners in decision making.

YOU SAID:

"How do you engage with key partners and stakeholders?

WE DID:

We have already started a process to engage with our key partners and stakeholders through the clinical pathways programme work. The event we held in June saw over 120 delegates representing 20+ organisations attend and help to shape the way we plan to deliver services in the future.

We shared our progress on the clinical pathways and gained feedback on the next steps, which was supported by a video of the event which has been shared widely.

We have also established a Patient and Carer Council to better engage with those who have first hand experience of our services so that they can influence the development of clinical care.

WE PLAN TO:

Host an external LiA type event to gain the views of our key partners and stakeholders on what they think is important and a 'what next' approach to progressing the clinical pathways programme. We also hope to re-establish the local stakeholder forum to meet on a quarterly basis.

YOU SAID:

"How do you interact with your clinical leaders?

WE DID:

We absolutely recognise that our clinical relationships are a key part of providing holistic care for those who access our services.

We have commenced more collaborative working with clinical colleagues and our Consultants are working hard to make connections within GP practices, particularly in community-based teams.

We have set up a GP Support email account for our primary care colleagues to use for general advice and non-urgent queries. Please do use GPsupport@combined.nhs.uk if you work in general practice and would like support from any of our services.

WE PLAN TO:

Continue develop consultant lead (named consultant) attached to each GP locality to further strengthen relationships and provide a single point of contact for communication.

BECOMING DIGITAL BY CHOICE

Our ambitions for the future will only be realised if our core infrastructure is the best that it can be. There are a number of enabling functions in which we will invest in the next strategic period including our information systems and informatics capability.

During 2015/16 we will continue the journey towards becoming a Digital by Choice organisation, which we started in 2014/15. We are partnering with the Staffordshire and Shropshire Health Informatics service in this endeavour. Key objectives for 2015/16 include:

- Establishment of a Service Management Board to replace the Hit Squad (April 2015).
- Clarification of our requirements for Electronic Patient Record, which may result in a bid for central funding supported by CSC in April 2015.
- Appointment of a Chief Information Officer (June 2015).
- Appointment of a Clinical Lead (July 2015) and Head of Portfolio Management (Autumn 2015).
- Exploration of predictive text analysis capability in partnership with SAS, concluding with an agreed project (by September 2015).
- Development of a service user app, in partnership with Staffordshire University, (piloted in Summer 2015 and launched in Autumn 2015).
- Definition of a Portfolio Programme, which will clarify key objectives and prioritise for investment for the next two years (by December 2015).

1.2 BUILDING CAPACITY AND CAPABILITY

BOARD DEVELOPMENT

Our continuous cycle of Board development activities acts as an organisational catalyst. Board development workshops led by the Chairman determine the future topics and agendas of the Board development programme, executive time out sessions, senior management plenary and directorate development activities; acting to cascade and co-ordinate learning activities across the Trust.

During the year, our Board was refreshed. We appointed a substantive Chief Executive and seen further changes in our Executive Team.

Consequently we have been recognised as an improving organisation shortlisted for Board of the Year.

Our two GP-Associate Board members continued in year to support and strengthen the board from a primary care perspective.

As a consequence, the Board has a very wide range of experience and skills to provide effective leadership and drive forward improvements in patient care and the delivery of our key priorities for 2015/16.

WORKFORCE

We employ 1232.60 staff (full time equivalent staff), with the majority providing professional healthcare directly to our service users.

We will continue to develop our leaders and identify and support leadership talent at all levels of the organisation:

During 2014-15 we introduced a Team Based Working Leadership Development Programme in conjunction with Aston OD, with a focus upon enhancing team effectiveness and developing innovation, empowerment, wellbeing and resilience.

We currently have ninety-one teams actively pursuing this, where they are working on clarifying the unique team purpose, objectives and role clarity for each member of the team. The development of inter and intra team dynamics through effective decision making, constructive debate and introduction of innovative practice is also being undertaken. All of this is has resulted in improvements to all areas of effective team working across a very high percentage of teams within the Trust, as evidenced by the achievement of 84% within the CQUIN Scheme to demonstrate improved staff engagement.

We will ensure that all of our staff have an annual review of their performance and personal development plan and that we continue to enhance this experience, including reviewing and implementing our Management and Clinical Supervision Policies during 2015:

This will continue to include discussions around talent management, allowing for succession planning discussions to take place, ensuring that all of our staff at every level of the organisation are working effectively and developing to meet the challenges of providing our services into the future.

Continue to develop our staff at all levels within the organisation:

During 2014/15 we launched a Healthcare Support Worker Programme for our Healthcare Support Workers. This five day foundation programme forms part of the Trust's overall development programme for Healthcare Support Workers, which encompasses skills development at a local level through clinical support leads and progresses to support staff to complete an advanced programme such as a Certificate in Community Mental Health.

BETTER USE OF INFORMATION

During 2014/15 the Trust's Data Quality Forum has helped deliver improvements in data quality, supporting enhanced patient care and continuing preparations for Payment by Results. Towards the end of the year the focus and membership of the Forum were reviewed, in order to better support both the Trust and the wider Local Health Economy in accessing accurate and timely information.

Progress continued to be made in 2014/15 towards paper-light working. The Trust's patient information system has been updated and work is under way to enable it to function as an electronic patient record. Once in place this will allow much more efficient access to patients' records for community and inpatient staff alike. Historic paper records continued to be scanned and added to the electronic system throughout the year, with quarterly audits of record tracking being introduced to improve efficiency.

National and local best practice recommendations throughout the year have been incorporated into our Information Governance Framework.

The Trust put a great deal of work into developing its "Digital by Choice" Strategy (IM&T) during 2014/15 and started an ambitious programme to replace all of its IT hardware that was greater than 5 years old and install wifi (for patients and guests, as well as staff) in all of its premises. This programme supports the efficient delivery of information to clinicians where they need it and when they need it and gives patients and visitors more freedom than ever to remain in touch with family and friends while they are with the Trust. The remainder of this programme will be completed in 2015/16

1.3 QUALITY OF SERVICES - KEY PRIORITIES 2015/16

We continue to be committed to providing high quality care for our service users and carers. We feel this is only achievable by maintaining our partnerships across the communities, which we serve. Our clinical services will deliver models of care and will reflect the needs of our service users and their experience of care. We will achieve this by having an on-going conversation with our service users and carers through a variety of both formal and informal feedback mechanisms. We are committed to the continued improvement of patient and carer feedback and we will be building on the successful implementation of the 'Friends and Family test' across our ward areas through to community services and for our workforce.

In working with colleagues from NHS commissioning bodies, we will ensure that the mental health and learning disability needs of the people of Stoke-on-Trent and North Staffordshire are appropriately measured and met through effective partnership working and appropriate service configuration.

We remain committed to working collaboratively with a range of partners and as such have again included 'three steps to engagement' in the development and publication of this Quality Account, which are outlined in section 3.3. This process included (at step 2) clear engagement in making the final choice of priorities for 2015/16, which were supported by stakeholders.

SAFE, PERSONALISED, ACCESSIBLE & RECOVERY FOCUSSED CARE

- ✓ **S***AFE*
- ✓ **P***ERSONALISED*
- ✓ **A***CCESSIBLE*
- ✓ **R***ECOVERY FOCUSSED*

FOCUSSING ON QUALITY AND SAFETY

During 2014 our Board of Directors defined a new emphasis for the organisation based on four strands of quality that we are calling SPAR:-

- Our services will be consistently safe
- Our care will be personalisedto 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

We will be receiving a formal Inspection under the terms of the Care Quality Commission's Chief Inspector of Hospital's regime between 7 and 9 September 2015. We have targeted a "Good" rating for this Inspection and our Board has already approved a governance structure to allow us to prepare under each of the five domains.

The new programme of work will build on the foundations that have already been laid within the organisation including the development of the new clinical directorates and pathways. A new Quality Assurance Programme Board has been established, chaired by the CEO, with the purpose of overseeing the delivery of service improvement.

The inspection is only a milestone, however, and will not distract us from plans that we had already developed as part of our improvement journey under the SPAR headings.

1.4 TRUST STATEMENT

We are pleased to publish this Quality Account for the financial year 2014/15, i.e. 1 April 2014 to 31 March 2015. It re-confirms our commitment to continually drive improvements in services and to remain transparent and accountable to the general public, patients, commissioners, key stakeholders 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.

Name and Position	Signature	Date
Ken Jarrold, Chairman		24/6/15
Peter O'Hagan, Non-Executive		24/6/15
Tony Gadsby, Non-Executive		24/6/15
Patrick Sullivan, Non-Executive		24/6/15
Bridget Johnson, Non-Executive		24/6/15
David Rogers, Non-Executive		24/6/15
Caroline Donovan, Chief Executive		24/6/15
Dr Buki Adeyemo, Executive Medical Director		24/6/15
Andy Rogers, Director of Operations		24/6/15
Paul Draycott, Executive Director of Leadership & Workforce		24/6/15
Ann Harrison, Interim Executive Director of Finance		24/6/2015
Mark Dinwiddy, Interim Executive Director of Nursing & Quality		24 JUNE 2015
Andrew Hughes, Interim Director of Strategy and Development		24 June 2015

1.5 STATEMENT OF DIRECTORS' 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 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 satisfy 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 is subject to appropriate scrutiny and review; and
- The Quality Account has been prepared in accordance with Department of Health guidance.

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

Ken Jarrold CBE
Chairman

Caroline Donovan
Chief Executive Officer

Part 2

PRIORITIES FOR IMPROVEMENT (LOOKING FORWARD) & STATEMENTS OF ASSURANCE FROM THE BOARD

2.1 PLANS FOR IMPROVEMENT

ENGAGING OUR PARTNERS & STAKEHOLDERS – '3 STEPS TO ENGAGEMENT'

In any year, trusts have a number of competing priorities to improve service delivery, provide value for money and the quality of the service provision. We are committed to working collaboratively with a range of partners and as such have included 'three steps to engagement' in the development and publication of this Quality Account. The three steps and comments from partners are included in section 3.3 which outlines how key partners have been involved determining our annual priorities.

Last year we built on our engagement techniques and have maintained this level of engagement for the 2014/15 Quality Account.

PERFORMANCE QUALITY MONITORING FRAMEWORK

This Quality Account is underpinned by a comprehensive Performance Monitoring Framework, which monitors the quality of services we provide as well as other key performance indicators. This includes both weekly and monthly dashboard reports to clinical teams and various Trust committees, with an overview maintained by the Trust's Board. Performance reporting during 2014/15 was extended to ensure that it many cases it can be monitored down to a much more detailed level than in previous years. Monthly Clinical Dashboards have also been introduced to provide a more visual view of the most important performance measures, thereby enabling trends to be more easily identified. The process of inspecting individual clinical teams to check their compliance with CQC and Mental Health Act standards continued during the year, with results being used to drive improvements in the services provided to patients. The use of benchmarking of our performance against other mental health trusts to compare and help improve services has continued in 2014/15 and this Trust remains a key advocate for mental health services on the national NHS Benchmarking Network Group.

The Trust's Quality Committee continued to actively monitor the quality of services throughout 2014/15 while responsibility for performance monitoring was passed to the Finance and Performance Committee, to ensure that robust assurance could be provided to Trust Board, service users and commissioners for both of these key measures.

2.2 PRIORITIES FOR IMPROVEMENT AND GOALS AGREED WITH COMMISSIONERS

KEY PRIORITIES FOR IMPROVEMENT

As described in section 1.3, Key Quality Priorities, we have aligned our priorities to SPAR. In determining our priorities we have engaged extensively with our stakeholders to ensure the priorities meet the needs of our local population.

Progress to achieve these quality priorities will be monitored and measured through the individual area milestones with regular reports to the Executive Team on progress made, risks identified and mitigation plans. Progress will also be reported through the quarterly Integrated Quality Report (IQR) and to the Commissioner-led Clinical Quality Review Group as well as through our own Quality Assurance Programme Board.

During 2015/16 we will continue on our quality improvement journey to drive the quality agenda by:

SAFE

- Developing a range of quality metrics to focus our key areas of quality and safety for improvement across all directorates and quality forums (by June 2015).
- Strengthening our mental health and physical health needs by the appointment of Clinical Skills Educator working closely with inpatient and community teams to further develop the importance of physical health and wellbeing (by September 2015).
- Updating the current supervision policy and developing a management supervision policy, ensuring structures are in place at all levels of the Trust identifying supervisors for all staff. We will develop a data system whereby supervision can be recorded and set supervision targets which are monitored through the directorate performance dashboards (by September 2015).
- Reviewing the Ligature Risk Review policy and environmental risk assessment tool, together with all risk assessment plans from wards and clinical areas to identify gaps/ problems (by September 2015).
- Undertaking monthly surveying of appropriate patients (as defined by the NHS Safety Thermometer guidance) to collect data in community settings on medication safety issues that can result in harm. Examples include: omission, medicines reconciliation, allergy status and high risk medicines use.
- We will report to our commissioners on a monthly basis and aim to hit the following targets.
    - *By the end of June 2015, Medicines Safety Thermometer to be rolled out across half of all appropriate community teams (details to be agreed by 1 May 2015).*
    - *By the end of August 2015, data collected and reported throughout the preceding three months.*
    - *By the end of September 2015, Medicines Safety Thermometer rolled out across all remaining community teams.*
    - *At the end of December 2015 and March 2016, re-assessment of the data collection and reporting for the preceding three months, together with reports describing lessons learned and any required service or process changes.*

- Increasing the 'maturity' (as defined by the Manchester Patient Safety Framework - MaPSaF) of our safety culture as part of a wider focus on patient safety metrics. MaPSaF offers objective insight into key behaviours such as how patient safety incidents are investigated, staff education, and training in risk management. We will report to our commissioners on a quarterly basis and aim to hit the following targets.
    - *By the end of June 2015:*
        - Pledge to Speak Out Safely and Sign Up To Safety, and publicise that commitment on our website;
        - Use MaPSaF with our Board, inpatient areas and two community teams to facilitate self-reflection on safety culture maturity.
    - *By the end of August 2015:*
        - Develop Heat Maps / Safety Dashboards for use in our Quality Committee and the commissioners' Clinical Quality Review Meeting to evidence that our clinical teams understand their own safety culture.
        - Identify higher and lower maturity teams to buddy up to share best practice.
        - Evidence that action planning has been facilitated through a series of half day workshops for the Board and identified teams.
        - Implement selected initiatives from Sign Up To Safety such as "what matters to me" and "safe, clean and personal boards".
        - Publish an Openness and Honesty report on our website.
    - *By the end of December 2015, self-assess on progress with production of a report to Board relating to activities in inpatient areas and the two community teams.*
    - *By the end of March 2016, update our MaPSaF self-assessment to understand what progress has been made and report to commissioners on how safety profiles and culture has changed through intervention and critical appraisal.*

PERSONALISED

- Developing a Patient Council to ensure the service user voice and view is incorporated in to our everyday business (by June 2015).
- We will develop a strategy to ensure that the newly developed Service User Standards are embedded as part of the expected culture and behaviour of our staff (by September 2015).
- Implementing the Health Equality Framework (HEF) to capture how interventions have resulted in improvements for people with learning disabilities.
- The HEF provides an objective assessment of how the systems around service users are ensuring that needs are being identified and that appropriate support is being given, based on the five determinants of health inequalities set out by the Public Health Observatory (social determinants, genetic and biological determinants, communications and health literacy, behaviour and lifestyle, deficiencies in access to and the quality of healthcare). We will report to our commissioners on a quarterly basis and aim to hit the following targets.
    - *By the end of June 2015:*
        - 75% of staff in the Community Learning Disabilities Team, 50% of staff in the Intensive Support Service and 50% of staff in the inpatient unit will have received HEF awareness training.
        - All CLDT duty staff and 50% of all registered inpatient staff will have completed a HEF assessment.
        - We will have evidenced links with other services to identify areas of best practice.

- *By the end of August 2015:*
  - HEF will be used for all new admissions and referrals.
  - An electronic database will record HEF assessments and key related information.
  - We will have worked with our two Local Authorities to identify potentials for shared learning and information exchange.
- *By the end of December 2015:*
  - Report on areas of low scoring against the HEF and confirm what interventions have been implemented to address these issues, using 25 case studies as evidence.
  - 50% of all referrals to CLDT will receive a HEF review at the point of discharge from the service.
- *By the end of March 2016 provide a report to commissioners to demonstrate how care plans for service users are informed by lower scoring domains on the HEF, the interventions that have been implemented, and the improvement post-intervention.*

THE LAUNCH OF OUR PATIENT COUNCIL...

ACCESSIBLE

- Embedding routes of access to services by reconfiguring our Crisis Response and Access Team to deliver a 24 hour, 7 day service with a single point of contact, continuing work started in January 2015.
- Developing a caseload management system use and embed this across all teams. Undertake a skills mix review in community teams (by September 2015).
- Developing a Transition policy for Children & Young People to Adult & Adult to Older People's services, and review transitions between learning disabilities and mental health services. Review systems and inter team working to identify issues and improve the pathway for patients (by September 2015).
- Reviewing the Bed Management processes to identify blockages in the system and also undertake a capacity and demand exercise. Establish and embed the bed management and establish metrics for success in relation to out of area bed usage, length of stay and readmission rates.

RECOVERY FOCUSSED

- Using 5 W (Who? What? When? Where? Why?) Methodology as a focus on measuring outcome and recovery for service users in selected community teams within the CQUIN quality improvement framework (embedded by July 2015).
- Identifying key areas to improve in relation to Mental Health Act & Record Keeping, which could be case file responsibility, Section 17 leave, Section 132 Patient rights and Section 58 Consent to treatment (by September 2015).
- Embedding the Short Warwick and Edinburgh Mental Well Being Scale (SWEMWBS) for all new referrals in care clusters 4 to 7, delivered at initial assessment or first appropriate appointment by our Access team or through our Community Mental Health Teams (CMHTs), at the time of review (by CMHTs) and at exit from the service (by CMHTs).
- The following indicators will be measured:
    - *Implementation of SWEMWBS to all CMHTs.*
    - *Proportion (%) of service users that found the tool helpful in measuring their wellbeing.*
    - *Proportion of service users receiving SWEMWBS at an appropriate time, i.e., not at time of crisis.*
    - *Proportion of services users receiving SWEMWBS at review or exit from the service.*
    - *Proportion of service users reporting an improvement in their wellbeing over a defined period of time, with case studies to evidence.*
    - *Increase and decrease in wellbeing with evidence to demonstrate an understanding of what has worked well, what has contributed to decreased wellbeing, and what has been done to offer additional supporting packages of care.*
- We will report to our commissioners on a quarterly basis and aim to hit the following targets.
    - *By the end of August 2015, >90% of service users at first appropriate appointment are offered the chance, where it is clinically appropriate, to complete the tool.*
    - *At the end of December 2015, an audit of 100% of the case notes of service users who reached a review point or were discharged from the service in the preceding three months to demonstrate the implementation and efficacy of the tool. The aim is that no more that 10% of service users will report deterioration in score and a poor experience.*
    - *At the end of March 2016, re-assessment of the previous two targets.*

2.3 STATEMENT OF ASSURANCE FROM THE BOARD

HOW PROGRESS WILL BE MEASURED AND MONITORED

This section is provided to offer assurance that the Trust is performing well as assessed internally via the Trust's 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.

HOW PROGRESS WILL BE MEASURED AND MONITORED

The majority (89%) of clinical services provided by North Staffordshire Combined Healthcare NHS Trust in 2014/15 were commissioned by the two local Clinical Commissioning Groups, NHS North Staffordshire (38%) and NHS Stoke on Trent (51%).

NHS Staffordshire and Lancashire CSU were the lead agent acting NHS North Staffordshire Clinical Commissioning Group operated as the Co-ordinating Commissioner during 2014/15.

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

The Trust has signed the Standard National Contract covering service delivery in 2015/16. The contract is largely block in nature with the two local CCGs, although the Associate element of the contract is cost and volume with thresholds. The contract contains specific targets on a range of performance measures.

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

COMPLIANCE WITH THE HEALTH & 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. We worked hard in 2014/15 to maintain compliance with the quality standards across all of the services we provide.

However the Trust received a follow up unannounced inspection visit from the CQC in December 2014 to review compliance with staffing and how the Trust monitors the quality of its service provision. The CQC found that the Trust was meeting the requirement to monitor the quality of service provision appropriately but it did not demonstrate there were sufficient numbers of staff with the right skills and experience to support the delivery of care in two of the three teams visited. The teams were Stoke Older People's community mental health team and the Home Treatment Team.

The Trust developed a comprehensive action plan to ensure improvements were implemented and is now confident that it is meeting this regulation and submitted its progress to the CQC in March 2015 prior to publication of the final report.

Following this inspection the Trust has developed a new quality assurance programme; through this it will ensure that learning from all CQC visits is shared across services and the action plans for the two teams visited will be monitored to ensure the improvements are sustained.

The CQC has changed the way it inspects all health and social care services through a new operating model. It has introduced new fundamental standards as of 1 April 2015 replacing the 16 essential quality and safety outcomes.

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 by quantitative and qualitative information. This includes reporting experience and data regarding the impact of services on patients. The clinical audit programme is developed to reflect these needs and the national priorities. Further information is contained below.

NATIONAL PROJECTS AND INITIATIVES

This section includes reference to the national projects and initiatives that we are applying to improve the quality of our services. Some areas are mandatory and others we have chosen to apply to allow us to scrutinise our processes and services and compare our outcomes to other providers:

QUALITY GOVERNANCE ASSURANCE FRAMEWORK

The Trust is committed to the continual improvement of its quality and safety to ensure patients receive the best possible care.

The Trust uses Monitor's Quality Governance Framework to assess the robustness of its quality governance arrangements. During the year we asked external auditors KPMG to undertake an independent assessment of our arrangements.

This work, considered the Trust's position against the four domains of Strategy, Capabilities & Culture, Processes & Structures and Measurement and ten questions that form Monitor's Quality Governance Framework.

The auditors interviewed Executive and Non-Executive Board members and senior staff from corporate and clinical Divisions. In addition, a staff focus group capturing staff views from various services was held and a substantial review of evidence provided by the Trust.

The audit concluded that the Trust meets Monitor's governance requirements with a favourable score of 2.5, which shows a continued improvement from the last independent assessment of 3.5. A rating of less than 4 is required to progress through the Monitor process. The Quality Committee has taken forward the findings from this audit to help further improve compliance with the framework

Litigation cases for 2014/15

The Trust has received eleven non clinical claims for 2014/15, two of which come under the Public Liability Scheme. It is still difficult to identify any clear emerging themes, however, acts of violence and aggression feature in eight of these claims.

The expenditure on non-clinical claims has reduced slightly from the previous year by the successful defence of claims where we have been able to provide clear evidence that policies and procedures have been followed. We continue to work closely with the NHS Litigation Authority to gather all appropriate evidence to support a robust defence. If this cannot be achieved, we will continue to use the intelligence learnt from these cases to identify quality improvements

National Quality Improvement Projects (Service Accreditation Programmes) - Managed by the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI)

- The Trust's one ECT Clinic is accredited
- Three wards (1, 2 and 3 at the Harplands Hospital) for working age adults are accredited
- Two rehabilitation wards (Florence House and Summers View) are accredited

National Quality Improvement Projects (Service Quality Improvement Networks) - Managed by the Quality Network for Inpatient Care (QNIC)

- Environment and Facilities 87%
- Staffing & Training 85%
- Access, Admission and Discharge 94%
- Care & Treatment 86%
- Information, Consent & Confidentiality 69%
- Young People's Rights & Safeguarding Children 96%
- Clinical Governance 84%

Clinical Trials

Clinical trials are a research priority for the Trust, they are the means by which treatment outcomes are most accurately determined and protocols reflect best practice standards thus providing clinical staff with the opportunity to transfer knowledge into clinical practice additionally they are a valuable source of income generation through commercial sponsorship.

During 2014/15 the Trusts' research portfolio included four NIHR and commercially sponsored clinical trials; ENGAGE HD, ATTILA, PATTERN and ATLAS, a significant increase from previous years. The Trust adopted an international Huntington's disease clinical trial, ENGAGE HD. Co-ordinated by the R&D team, delivery of the trial was undertaken by the Neuropsychiatry clinical team. Research nurses and research support staff embedded within the Neuropsychiatry clinical team delivered the clinical trials alongside clinical practice; introducing research at routine clinical appointments, consenting and completing assessments alongside current practice and delivering interventions which complimented existing practice.

This model of working is what the R&D envisages as a future model of delivering evidence-based clinical trials - embedding research into clinical practice, to close the gap between clinical research and clinical practice.

The Trust's Learning Lessons framework has been further strengthened over the past 12 months following the LIA initiative to improve learning from both incidents, and more lately has joined with complaints. The LIA project facilitated identification of Learning Lessons Leads in 43 Teams to date, with ongoing work to identify the remaining Teams. These Learning Lessons Leads act as a conduit between the POST Team and Complaints/PALS team to share learning, with a view to also collecting opinions and ideas for future learning events.

Following a 2nd staff learning lessons survey in January 2015, additional areas of improvement have been actioned, The Communications Team have assisted in developing posters for the Learning Lessons events in order to greater publicise events, and paper copies of the bulletin have additionally been circulated to the Harplands areas.

A learning lessons session is now also included in the NSCHT Preceptorship programme and Year 3 student Nurse programme with Keele University, which the Patient Safety Manager delivers.

2015/16

- *Plans for learning lessons are using web based medias to further share learning, for example 2 minute YouTube clips of learning from complaints.*
- *The Complaints Team is looking at devising new leaflets and posters for how to raise concerns or appreciations which will detail the LL programme specifically, the new leaflets (draft) will be shared with NSUG prior to completion for opinion of the style of engagement.*

2.4 REVIEW OF SERVICES

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

During the period from 1 April 2014 to 31 March 2015, 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 2014/15 represents

100% of the total income generated from the provision of NHS services by the North Staffordshire Combined Healthcare NHS Trust for 2014/15.

The Trust's six main services as referred to above are listed in the introductory section of this Quality Account – see section 'Services Covered by This Quality Account'.

2.5 PARTICIPATION IN CLINICAL AUDIT

NATIONAL CONFIDENTIAL INQUIRIES AND NATIONAL CLINICAL AUDITS

'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 2014/15, one national audit and one national confidential inquiry covered NHS services that North Staffordshire Combined Healthcare NHS Trust (NSCHT) provides.
During that period, NSCHT participated in both (100%) the national clinical audit and the national confidential inquiry, which it was eligible to participate in. The national clinical audits and national confidential inquiries that North Staffordshire Combined Healthcare NHS Trust was eligible to participate in during 2014/15 are listed below and those that the Trust did participate in during 2014/15 are shown with ✔

- Prescribing Observatory for Mental Health (POMH) ✔ 100%
- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH) ✔ 100%

The national clinical audits and national confidential inquiries that the Trust participated in, and for which data collection was completed during 2014/15, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or inquiry:

TITLE	% of cases submitted	% of cases required to be submitted #
Prescribing Observatory for Mental Health (POMH): Prescribing Topics in Mental Health Services:		
• Prescribing for people with personality disorder (Topic 12b)	87.5%	100%
• Prescribing for substance misuse: Alcohol detoxification on acute, adult psychiatric wards (Topic 14a)	68%	100%
National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)	100%*	100%

**This data is collected centrally on a rolling basis as part of the NCI process # It should be noted that for POMH Audits, there is no minimum requirement of cases to be submitted. For topics 12b and 14a, an adequate sample size was obtained without the need to submit 100% cases relevant to the sample population, therefore the Trust still met the 100% requirement for POMH.*

The reports of 2/2 national audits, (as specified above) were reviewed by the provider in 2014/15.

Prescribing for people with personality disorder (POMH 12b)	Action Completed
• To congratulate the Sutherland Centre on good results. To suggest that clinicians from other areas liaise with staff at the Sutherland to share best practice	✔
• To congratulate staff on positive results around crisis planning and to remind them of the importance of referring to service user involvement in the medical record, via *Newsround*	✔
• To review the standard "antipsychotic drugs should not be prescribed for more than four consecutive weeks in the absence of a comorbid psychotic illness" against the evidence base and recent research.	Ongoing
• The agreed action plan will be presented to the Trust Clinical Effectiveness Group.	✔
• The Executive Summary and agreed action plan will be circulated appropriately as determined by the Medical Lead.	✔
• The data will be presented at one of the Trust's educational sessions.	✔

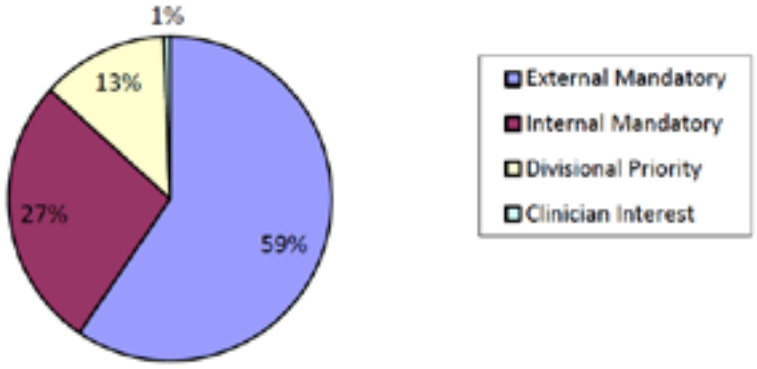
Prescribing for substance misuse: Alcohol detoxification on acute, adult psychiatric wards	Action Completed
• The audit results will be discussed at the acute wards forum.	Ongoing
• Staff members will be reminded of the standards and the need to document actions undertaken.	✔
• The agreed action plan will be presented to the Trust Clinical Effectiveness Group.	✔

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

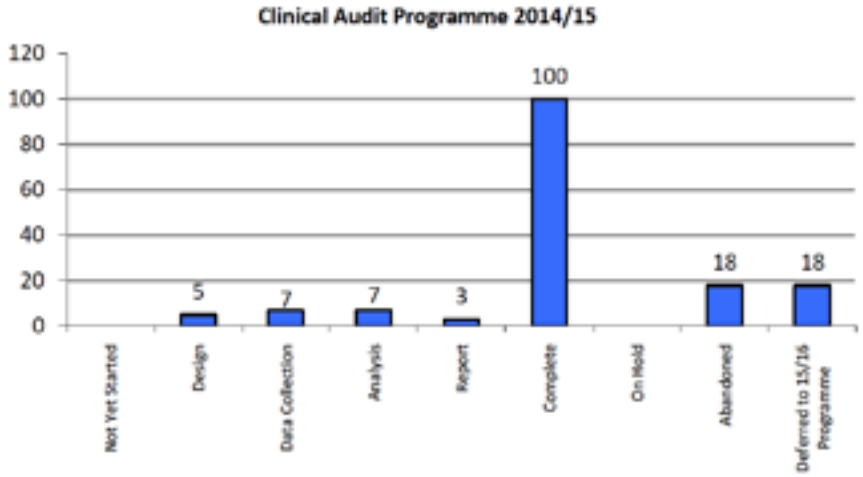
LOCAL CLINICAL AUDIT PROGRAMME 2014/15

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

The chart below reflects the total number of projects identified for 2014/15 split by the four priority areas:



During the year a total of 95 projects were completed by the Clinical Audit Department and all 95 reviewed by the provider in the reporting period. All completed audits contained a comprehensive action plan agreed by the Trust and all stages of the audit cycle undergo a robust validation exercise to ensure the reliability and quality of data reported. The graph below outlines project status for the 158 projects registered on the Clinical Audit Programme for 2014-15:



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

Further information on completed clinical audits and the clinical audit programme can be obtained from the Trust's Clinical Audit Department.

2.6 PARTICIPATION IN RESEARCH

Research is concerned with establishing what best practice is by creating new knowledge, knowledge about whether new treatments work and whether certain treatments work better than others.

During 2014/15 the Research and Development (R&D) teams' key focus was to shape the direction that the Trust takes to enable the delivery of high quality portfolio, commercial and home-grown research. The number of patients receiving NHS services provided or sub-contracted by the Trust in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee within the National Research Ethics Service was 81.

R&D's aspiration has been to develop a research culture within the Trust, however in defining our vision we had to consider what this means and how it will look and feel to our patients, staff and stakeholders:

- Our patients and carers will have an expectation that research will be discussed with them during their routine clinical appointments and that the care that they received will be based upon best available evidence;
- Individual staff electively opt to become engaged in research. Their motivation from recognition of the value of the evidence generated, and the fact that there is sufficient support throughout the process to enable them to overcome barriers and sustain the study momentum;
- There is ownership of the research agenda throughout the Trust;
- Commissioners of our services are influenced by the value of the evidence produced through our research activities;
- A reputation for delivering high quality research, with knowledge and skills recognised externally.

Research Engagement

As a Trust we aim to ensure that both our staff and service users have opportunities to engage in research and are informed about our commitment to clinical research. During 2014/15 the R&D team undertook a range of activities to increase research capabilities across the Trust, engaging with staff, service users and carers as well as partnership organisations. Key campaigns can be seen below and further information is available in the Clinical Audit and R&D Annual Report.

NIHR "OK to Ask about Clinical Research"

Consent 4 Consent (C4C) campaign for staff, patient and carers/families.

May 2014 the R&D team promoted Innovation Week

Trust staff were invited to take a tasty treat, however instead of paying by cash, paying with an innovative idea

The R&D team challenged Trust staff to a 28 day patient recruitment drive, with a goal to recruitment 10+ patients a week into currently running genetic research studies.

The R&D department throughout 2014/15 also expanded engagement work:

- Development of the Research Engagement Project: Supported by the Research Assistant Apprenticeship in collaboration with Keele University. The aim of this project is to identify and understand NSCHT clinician's perceptions of and attitudes towards research-related activity, as well as present and future engagement;
- Taking on board and implementing the results from the NIHR Mystery Shopper report, the R&D team ensured the Research was visible throughout the Trust. Research displays, attending Trust and external events to promote research and regularly contact
- clinicians and care coordinators with research updates and information has become a core activity;
- Development of wider working in research: The R&D team jointly collaborated on the Research Liaison Officer bid with the University Hospital North Midlands (UHNM). The bid was successful and the R&D team are now in the process of developing the post with UHNM;
- Working collaboratively with our partners/ organisations to deliver research and disseminate research outputs and innovation:

  - West Midlands Local Clinical Research Network (LCRN);
  - West Midlands Academic Health Science Network (WM AHSN);
  - Universities (e.g. Keele University);
  - NHS Organisations (e.g. UHNM, SSSFT).

Research Activity

During 2014/15 the R&D team has continued to increase research capabilities across the Trust, engaging with staff, service users and carers as well as partnership organisations. The Trust adopted and supported a number of national and international research projects of varying size and complexity. Research themes during 2014/15 have focused around schizophrenia, dementia, suicide, alcoholism, learning disability and Huntington's disease, with the main focus throughout 2014/15 on portfolio research on Genetic Research.

The adoption of portfolio and commercial studies during 2014/15 was limited. The Trust participated in 12 portfolio and four commercial studies, with a total accrual for 2014/15 of 81 participants. The research programme for 2014/15 included four out of the six Directorates, with no active studies in the Adult Inpatient and Children and Young People's Directorates. Adult Community Directorate continues to hold the highest proportion of studies of the portfolio (n= 8, 50%) and participant accrual (n= 41, 53%).

A core activity for the Trust is participation in projects supported by the NIHR. The Trust has developed excellent links with specialities, i.e. Division 4, NIHR CRN West Midlands: Children's speciality and continue to aim to expand the breadth of portfolio research to include services and topic areas outside of our current remit i.e. Primary Care, Physical Health, Prison research

Benefits to Quality of Care / Benefits to the Service User

Our research relies on the support of patients, carer and healthy volunteers. For patients and carers many recognise, by participating in research, they are able to take a more active role in their care, enhancing a positive and rewarding experience. The rigour of research protocols can provide an enhanced quality of care and participation in research has shown to lead to improved patient outcomes.

For staff, research provides an opportunity for personal and professional development, enhancing skills and knowledge leading to a higher standard of care delivery and enhanced job satisfaction.

The Trust recognises and values the important contribution that research makes in many areas of its activities. For the Trust, research activity is a means of improving standards and quality of care, promoting efficiency and innovation and in some cases income generation.

2.7 GOALS AGREED WITH COMMISSIONERS

COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN) FRAMEWORK

A proportion (2.5%) of the total potential income from CCGs in 2014/15 was conditional on achieving quality improvement and innovation goals agreed with Commissioners through the CQUIN Framework.

As an incentive 2.5% of the Trust's total, potential income from CCGs for 2015/16 has been linked to delivery of CQUIN targets and the Trust has agreed five CQUIN indicators with the Commissioners.

The CQUIN indicators for 2015/16 are included as the Trust's key priorities going forward and are shown in section 2.2.

The CQUIN indicators for 2014/15 were identified as the Trust's key priorities last year and as such are reported on in section 3.1.

2.8 STATEMENT FROM THE CARE QUALITY COMMISSION

REGISTRATION

North Staffordshire Combined Healthcare NHS Trust is required to register with the Care Quality Commission and its current registration status is Registered - Registration Number CRT1-1467551366 The Trust is registered to carry out the following regulated activities:

- Accommodation for persons who require nursing or personal care
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury.
- At the following registered locations:
- Trust Headquarters
- Harplands Hospital
- Dragon Square
- Summer View
- Florence House
- The Bungalows Chebsey Close*

* The Trust's registration was amended in 2015 to reflect the closure of Chebsey Bungalows so this has been removed as a location in the Trust's registration.

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 website at www.cqc.org.uk

CARE QUALITY COMMISSION ENFORCEMENT ACTION

The Care Quality Commission has not taken any enforcement action against North Staffordshire Combined Healthcare NHS Trust during 2014/15

CARE QUALITY COMMISSION COMPLIANCE REVIEW

In 2014 the CQC changed its inspection system as it introduced a new operating model. This means that every NHS Trust should expect to receive a major announced inspection at least every 3 years as well as unannounced annual Mental Health Act compliance visits. In addition the CQC can still inspect an organisation where it has any concerns or issues arise. The Trust has not yet received an inspection under the new process but is expecting this will happen during 2015/16. However as already outlined there was a follow up CQC visit in December 2014 in relation to a couple of concerns that had been raised during a CQC inspection in 2013.

There have been a number of Mental Health Act compliance visits.

North Staffordshire Combined Healthcare NHS Trust has not participated in any special reviews or investigations by the CQC during 2014/15, other than the scheduled visits referred to.

2.9 STATEMENT ON DATA QUALITY

NHS Number and General Medical Practice Code Validity

The Trust submitted records during 2014/15 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 patients' valid NHS number, was:

- 99.8% for admitted patient care; and
- 99.8% for outpatient care.

NB the Trust does not provide accident and emergency care

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

- 99.9% for admitted patient care; and
- 99.9% for outpatient care.

NB the Trust does not provide accident and emergency care

Information Governance Toolkit Attainment Levels

The Trust's score for 2014/15 for Information Quality and Records Management assessed using the national NHS Information Governance Toolkit was 72% (from 75% in 2013/14), and was graded green as all requirements achieved a minimum score of Level 2 resulting in a Satisfactory result (the only results achievable are Satisfactory or Not Satisfactory).

Clinical Coding Error Rate

North Staffordshire Combined Healthcare NHS Trust was subject to the Payment by Results clinical coding audit during 2014/2015 by the Audit Commission and the error rates reported in the latest published audit for that period for diagnosis and treatment coding (clinical coding) were:

- 0% error rate for Primary Diagnosis (4% in 2013/14)
- 34% error rate for Secondary Diagnosis (24.2% in 2013/14)
- 0% error rate for Primary Procedures (0% in 2013/14)
- 0% error rate for Secondary procedures (0% in 2013/14)

The services reviewed in the sample were Adult Mental Health, Child & Adolescent Mental Health, Elderly Mental Health and Substance Misuse.

The audit was undertaken by D&A Clinical Coding Consultancy Ltd who are NHS Classifications Service Approved auditors. The increased error rate for secondary diagnosis coding was mainly due to associated co-morbidity information not being provided to the clinical coding team for inclusion in the electronic system, although it should be noted that this information was recorded in the patients' paper notes. A robust action plan has been put in place to address this and thereby improve electronic data quality.

Relevance of Data Quality and actions to improve Data Quality

Data quality is central to understanding, delivering and managing safe services. Accuracy and timeliness underpins a high standard of collection, reporting and submission; we are taking the following actions to further improve data quality:

- Increasing the involvement of clinicians in the validation of data held in the IT systems
- Refocussing and strengthening the effectiveness of our Data Quality Forum
- Continuing to actively manage data Key Performance Indicators
- Continuing to focus on accurate and consistent patient clustering as part of readiness for Payment by Results

The Data Quality Forum continues to operate effectively with a data quality improvement plan in place which is endorsed by our Commissioners and forms part of the 2015/16 contract.

The group provides direction on which areas of data quality the Trust will focus, maintains robust reporting procedures and communicates data quality issues to the wider Trust as appropriate.

The group's membership consists of corporate and clinical representatives; also a representative from our commissioners is invited to attend each meeting. Work was undertaken towards the end of 2014/15 to ensure that the Forum has a stronger focus than ever on directly enhancing our services through improved data quality.

Part 3

REVIEW OF QUALITY PERFORMANCE FOR 2013/14 (LOOKING BACK) and STATEMENTS FROM PARTNERS

This section is in three parts:

Section 3.1 - Reviews performance against the key priorities defined in the 2013/14 Quality Account, which were aligned with the Commissioning for Quality Innovation Scheme (CQUINS), agreed with our local Commissioners.

Section 3.2 – Adds to the information provided in section 3.1 and provides a summary of our performance against a range of quality indicators / metrics, which are of interest to people who use our services. Each quality indicator / metric is linked to one or more of the following three headings: Patient Safety; Clinical Effectiveness; and Patient Experience.

Section 3.3 – Includes reference to those involved in the development of this Account and statements from key partners.

3.1 PERFORMANCE AGAINST THE KEY PRIORITIES FOR 2014/15 AS CONTAINED IN THE 2013/14 QUALITY ACCOUNT

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.

For 2014/15, therefore we identified six priority areas in total, which contribute to improved safety; clinical effectiveness; patient experience and innovation. Each section below describes the area being reviewed; the metric used to measure performance; and the overall Trust performance.

Against the CQUIN financial framework, in total we achieved 99% of the schemes.

PRIORITY AREAS

SPECIAL REVIEWS / INVESTIGATIONS

100% Achievement

Less than 100% Achievement

Non-Achievement

Priority	CQUIN Area	Patient Safety	Clinical Effectiveness	Patient Experience	Innovation	Achievement (%)	Financial Value £
1 	**NHS Safety Thermometer** Reducing medication errors and harm to patients from medication errors	✔	✔			100%	130,000
2 	**Friends and Family Test** Using the Friends and Family Test to monitor patient and staff experience			✔		100%	65,000
3 	**Physical Health** Improving physical healthcare to reduce premature mortality in people with Severe Mental Illness (SMI)	✔	✔			78%	49,000
4 	**AIMS for Inpatient Rehabilitation Units** Accreditation for two Trust inpatient rehabilitation services	✔	✔	✔	✔	100%	390,000
5 	**Closing the Loop – Improving Quality by Using Feedback** Aspiring to be an organisation which has a culture of openness and transparency and is able to demonstrate use of a wide range of different resources to improve care		✔	✔	✔	100%	325,000
6 	**Effective Team Leadership – Staff Engagement and Empowerment** Aston Effective Team Leaders Development Programme	✔	✔	✔	✔	100%	325,000

A high level of performance has been achieved as part of the 2014/15 CQUIN scheme with a significant amount of work undertaken in addition to the milestones agreed with local Commissioners which has contributed to improving the quality of services provided.

FRIENDS AND FAMILY TEST

Why was this selected as a priority?

The Friends and Family Test asks how likely it is that an individual would recommend a service to their friends and/or family and is a key tool in helping us to understand what patients really think of our services. For this year, North Staffordshire Combined Healthcare NHS Trust has been required to collect this information from staff members and service users accessing inpatient and community services. This asks whether staff would recommend the Trust to family and friends if they needed care or treatment and also how likely they would be to recommend the Trust to friends and family as a place to work. It is essential that the results of the Friends and Family Test are used to drive improvements across NSCHT services.

Our goal

To present a regular report detailing the results of the Friends and Family Test obtained from service users in both inpatient and community services, and from staff.

How did we monitor and report on progress?

Quarterly reports detailing the results of all three surveys (inpatient, community and staff) were produced. Results were shared with teams on a quarterly basis to highlight areas for action and to share comments received. Monthly results of the inpatient survey were also published on the public NSCHT website.

What did we achieve?

As required by the CQUIN, the Working Group used the results of the Friends and Family Test to monitor patient experience of NSCHT services and facilitated the rollout of the Friends and Family Test to all staff.

CARDIOMETABOLIC SIDE EFFECTS AND COMMUNICATION WITH GENERAL PRACTITIONERS

2a: Cardiometabolic Side Effects

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 cardio-metabolic risk factors in 90% of 100 randomly selected patients. National guidance stated that the selected patients should fall into the following categories (based on ICD 10 diagnostic 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 in implementing processes across the Trust. The data collected for the Quarter 4 audit was sent to the Royal College of Psychiatrists for central analysis and reporting.

What did we achieve?

As a result of this CQUIN the Trust has now implemented the screening for cardio-metabolic risk factors for all inpatient service users. Considerable progress has been made in assessing the physical health of our service users and we will continue to build on the progress made during this CQUIN.

2b: Communication with General Practitioners

Why was this selected as a priority?

This was a national CQUIN priority as determined by NHS England.

Our goal

In accordance with this CQUIN, we aimed to ensure that key information relating to service users' mental and physical wellbeing was communicated from the Trust to the service user's GP, focusing on the following aspects of healthcare:

- Primary mental health diagnosis
- Secondary mental health diagnosis
- ICD-10 codes
- Physical health diagnoses
- Prescribed medications
- Medication monitoring requirements
- Physical health status
- Physical health needs
- Physical health monitoring needs
- Physical health treatment needs

How did we monitor and report on progress?

An initial audit was undertaken in Quarter 2 and the results reported to Commissioners and discussed within the Working Group. As a consequence, a responsive action plan was put in place to develop a process for recording and communicating healthcare information. Results of a subsequent re-audit were reported in Quarter 4.

What did we achieve?

In order to address the results of the baseline audit, the Working Group devised a Healthcare Information Communication Form for completion at CPA, which included all the required information in a simple one-page format. Staff were asked to send completed forms to GPs and the Clinical Audit Department, with a third copy being filed in the notes.
This resulted in considerable improvements at Quarter 4 and the Working Group is currently reviewing its use going forward.

MEDICATIONS SAFETY THERMOMETER

Why was this selected as a priority?

The Medication Safety Thermometer is a national tool that supports trust in measuring error and harm from error related to the administration of medicines. Data collection focuses on medication reconciliation, allergy status, omitted medicines and assessment of harm from high risk medicines including antibacterial, opioids, insulin and anticoagulants.

Our goal

The aim of this CQUIN was to establish a baseline of performance on the four harms and identify areas for improvement in patient care. The objective of the Medication Safety Thermometer is to enable wards, teams and organisations to understand the burden of medication error and harm, to measure improvement over time and to connect frontline teams to the issues of medication error and harm, enabling immediate improvements to patient care.

How did we monitor and report on progress?

A rollout plan was developed in order for all inpatient services to be submitting data by the beginning of Quarter 4. Data were collected on one day each month by ward staff with support from the pharmacy team and entered onto the national database by the PA to the Chief Pharmacist. Monthly meetings were also scheduled to support staff. Quarterly reports gathering the results of the data collection were produced, which included lessons learned and changes made as a result of issues identified from the monthly audits.

How did we monitor and report on progress?

Results were positive and showed high numbers of patients who had had medicines reconciliation within 24 hours of admission and completed allergy status and low number of omitted doses and administration of high risk medicines. Teams have used the thermometer to improve safe use of medicines, including:

- Some teams have focused on ensuring medicines reconciliation is completed, including accessing GP data routinely.
- Results are routinely shared at team meetings.
- Any omitted medicines are followed up on the day of data collection and problems discussed to prevent recurrence.
- Teams have discussed importance of accurate documentation including completion of allergy status and clear prescribing to minimise risk of omitted doses.

Overall the thermometer has been well received and enabled the trust and teams to monitor medicines used in in-patients areas in real-time. We are now planning to roll out the thermometer to community teams who administer medicines.

AIMS ACCREDITATION FOR REHABILITATION SERVICES

Why was this selected as a priority?

In 2005, a position statement from the Executive Committee of the Royal College of Psychiatrists' Faculty of Rehabilitation and Social Psychiatry described rehabilitation as the "forgotten need within contemporary mental health services". Though the principles of rehabilitation and recovery have generally been accepted throughout inpatient services, there is still a pressing need for specialised services. Achievement of AIMS-Rehab Accreditation (co-ordinated by a collaboration between the Royal College of Psychiatrists' Centre for Quality Improvement and the Faculty of Rehabilitation and Social Psychiatry) would give assurance that the services provided by Florence House and Summers View were clinically effective.

Our goal

The ultimate intention of this CQUIN was for services at both Florence House and Summers View to be accredited under the AIMS-Rehab scheme. In addition, an internal peer review exercise undertaken by the Hillcrest Unit and Community Rehabilitation services aimed to highlight areas for improvement within these services.

How did we monitor and report on progress?

The internal peer review exercise was very successful and resulted in a shared learning and engagement event being held on 9 September 2014, which was attended by staff from all four services, together with members of the Clinical Audit Department and Commissioners. An implementation plan, developed by the Working Group, reported on progress throughout the accreditation process. The final report at Quarter 4 described actions agreed in order to address matters raised during accreditation.

What did we achieve?

Both Florence House and Summers View were accredited under the AIMS-Rehab scheme in February 2015; a fantastic achievement for which all staff involved are to be congratulated. Action plans have subsequently been developed to address areas identified for improvement and Trust representatives will be taking part in peer reviews of other Trusts in the near future, which we anticipate will enable us to learn from best practice.

LISTENING AND RESPONDING TO FEEDBACK

Why was this selected as a priority?

This CQUIN sought to ensure that in 2014-15 North Staffordshire Combined Healthcare NHS Trust had a responsive and accessible system for responding to feedback and that opportunities were taken to use the lessons from feedback to make improvements to the system and improve patient and carer experience.

Our goal

The ethos behind this CQUIN was to move the Trust towards a high functioning learning organisation which has a culture of openness and transparency and is able to demonstrate that a wide range of different resources are used to improve the care we deliver.

How did we monitor and report on progress?

Quarterly reports were produced to highlight progress made in specific areas and in regard to the CQUIN in general.

What did we achieve?

As part of this CQUIN the Trust reviewed and ratified the Whistleblowing Policy (now renamed the 'Raising Concerns' Policy), which aims to enable staff to raise any concerns they have and be supported by the organisation without any adverse effects on their well-being in the workplace and employment. In conjunction with this, there has also been the launch of the 'Dear Caroline' website, which is a secure anonymous website where staff can raise any concerns they may have. Themes raised through this channel are discussed by the Executive Team for actions and are also shared with staff via the internal website.

The Trust now has on display a series of "You said, we did" boards in inpatient areas to demonstrate that what service users are saying is being listened and responded to. A patient newsletter has also been developed to provide information and highlight how individuals can contact the Trust.

We are also in the process of incorporating complaints information into our Learning Lessons monthly bulletin. We have identified Learning Lessons leads who are responsible for displaying the bulletins to improve the way that this information is distributed following feedback received from staff members.

Going forward, the Trust has launched a patient, service user and carer council which aims tolisten to views on how patients, service users and carers can be better represented in the day-to-day delivery of Trust services and how those who use these services can more effectively influence the development of local substance misuse, learning disability and mental health care.

ASTON TEAM LEADERSHIP PROGRAMME

Why was this selected as a priority?

Several key reports published between 2013 and 2014 highlighted common areas for quality improvement such as staff empowerment, leadership effectiveness and the importance of developing a culture of engagement, openness and continuous learning. There is now a strong evidence-base linking improvements in the effectiveness of team leaders to improvements in patient health and wellbeing, safety and experience, staff health and wellbeing and experience, and a range of measures of organisational performance.

Why was this selected as a priority?

Several key reports published between 2013 and 2014 highlighted common areas for quality improvement such as staff empowerment, leadership effectiveness and the importance of developing a culture of engagement, openness and continuous learning. There is now a strong evidence-base linking improvements in the effectiveness of team leaders to improvements in patient health and wellbeing, safety and experience, staff health and wellbeing and experience, and a range of measures of organisational performance.

Our goal

The aim of this CQUIN was to roll out Aston Team Leadership to teams across the Trust, with 25 teams having completed the Final Survey which evidences change in "teamness" score from baseline. The intention was to improve "teamness" score through clarifying the unique team purpose and objectives, ensuring team members have role clarity and developing inter- and intra-team dynamics.

How did we monitor and report on progress?

Reports detailing progress, team performance, areas of strength and weakness and including team specific improvement plans were produced on a quarterly basis.

What did we achieve?

The Quarter 4 report demonstrated that, of the 25 teams who had completed the Final Survey, 21/25 (84%) showed an improvement in "teamness" score from baseline. This programme is still ongoing, with 91 teams actively pursuing the team journey at present.

3.2 PERFORMANCE IN 2014/15 AS MEASURED AGAINST A RANGE OF QUALITY INDICATORS

This section of the Quality Account provides a summary of our performance as measured against a range of quality indicators / metrics, which are of interest to people who use our services, indeed most were selected for inclusion by key stakeholders. The information is presented under the three main headings of: Patient Safety; Clinical Effectiveness; and Patient Experience. Each section describes the area being reviewed; the metric used to measure performance including the unique reference code; and the overall Trust performance.

Target/outcome achieved

Target/outcome not fully achieved

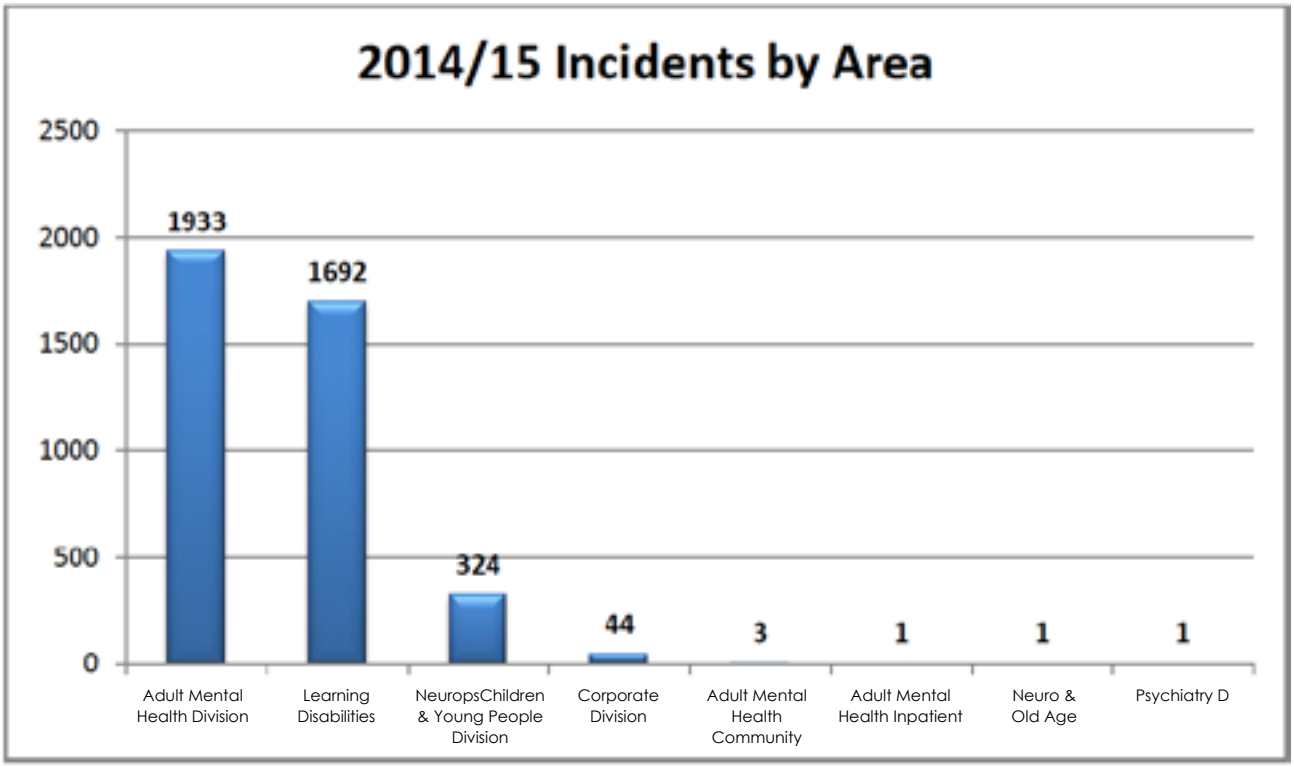
Target/outcome not achieved

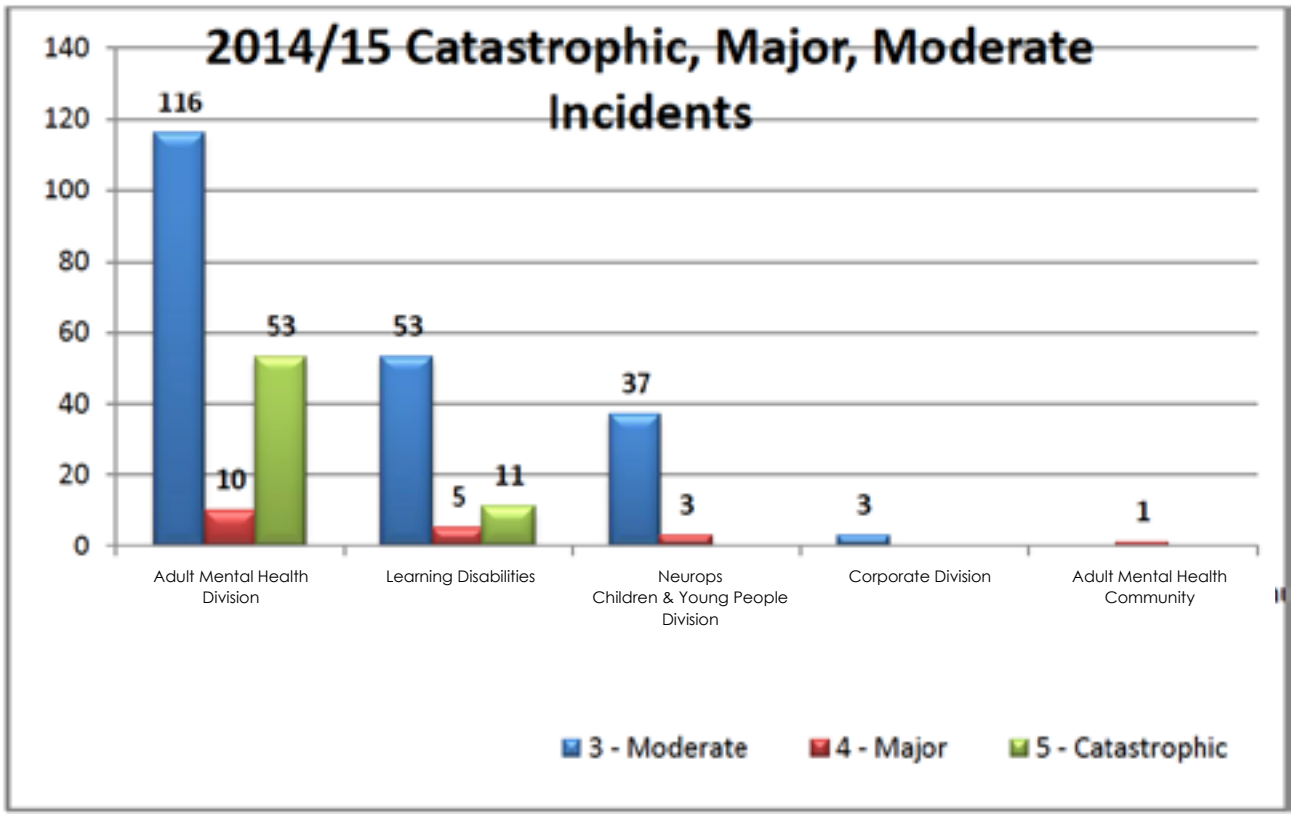
PATIENT SAFETY

Area of Performance	Environments & Cleanliness		
Metric - Method of Calculating Performance:	Trust Metric: KPI / 5 Environments / cleanliness as assessed by the Patient Led Assessment Care Environment Team (PLACE)		
Performance		We are proud of our cleanliness standards and in 2014/15 the Trust's PLACE overall score for cleanliness was 98.99%. Each PLACE inspection team included 50% patient representation and an independent validator.	
PLACE 2013/2014	Cleanliness including hand hygiene	Privacy, Dignity and Wellbeing	Condition, Appearance and Maintenance
HARPLANDS HOSPITAL	98.83%	92.59%	94.59%
DRAGON SQUARE COMMUNITY UNIT	100.00%	88.46%	94.29%
LEARNING DISABILITIES UNIT HILTON ROAD	98.57%	96.45%	89.83%
THE BUNGALOWS, 1 - 6 CHEBSEY CLOSE	100%	89.15%	94.83%
DARWIN - FKA CLYDESDALE CENTRE	99.36%	94.10%	96.05%
FLORENCE HOUSE	98.67%	87.07%	98.72%
SUMMERS VIEW	99.69%	81.94%	94.87%
TRUST OVERALL SCORE	98.99%	91.86%	94.16%

Area of Performance:	Incidents (Clinical and Non-clinical)		
Metric - method of calculating performance:	Trust Metric: QI PS 5 Incidents (to Feb 2015)		
		2013/14	2014/15
Performance 	General Incidents	3711	3707
	Moderate	474	209
	Major	34	19
	Catastrophic	82	64
	Total	**4301**	**3999**
Incidents resulting in severe harm or death as a % of total		13.7%	7.3%

In 2013/14 the Trust implemented Safeguard, a new incident reporting system. This system is now firmly embedded in practice across all teams.The system generates weekly and monthly scheduled incident reports/trends for directorates and individual teams which allows teams to explore and introgate incidents with their areas; in order to further understand and improve patient and staff safety within each area. The table above illustrates a reduction in all categories of incidents reported across the Trust for 2014/15. All incidents reported are subject to weekly review and analysis, inorder to ensure that trends are quickly identified and actions implemented to ensure inproved delivery of care services.





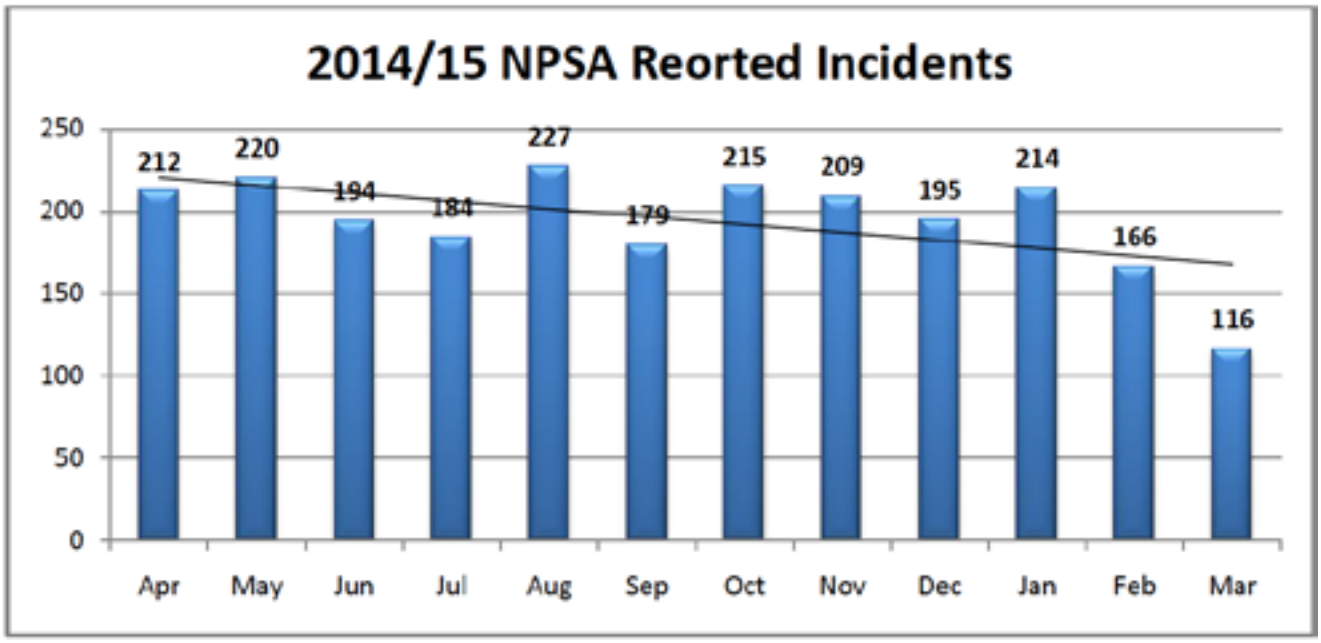
Area of Performance:	Incidents Reported to the National Patient Safety Agency (NPSA)
Metric - method of calculating performance:	Trust Metric: KPI Number of Incidents Reported to the National Patient Safety Agency – to March 2014
Performance	 There were 2331 NPSA incidents reported during 2014/15.Of these, the number of incidents resulting in severe harm or death (33) as a percentage of the total was 1.41%. In 2013/14, there were 2385 NPSA reportable incidents; the number of incidents resulting in severe harm or death (66) as a percentage of the total was 2.76%.

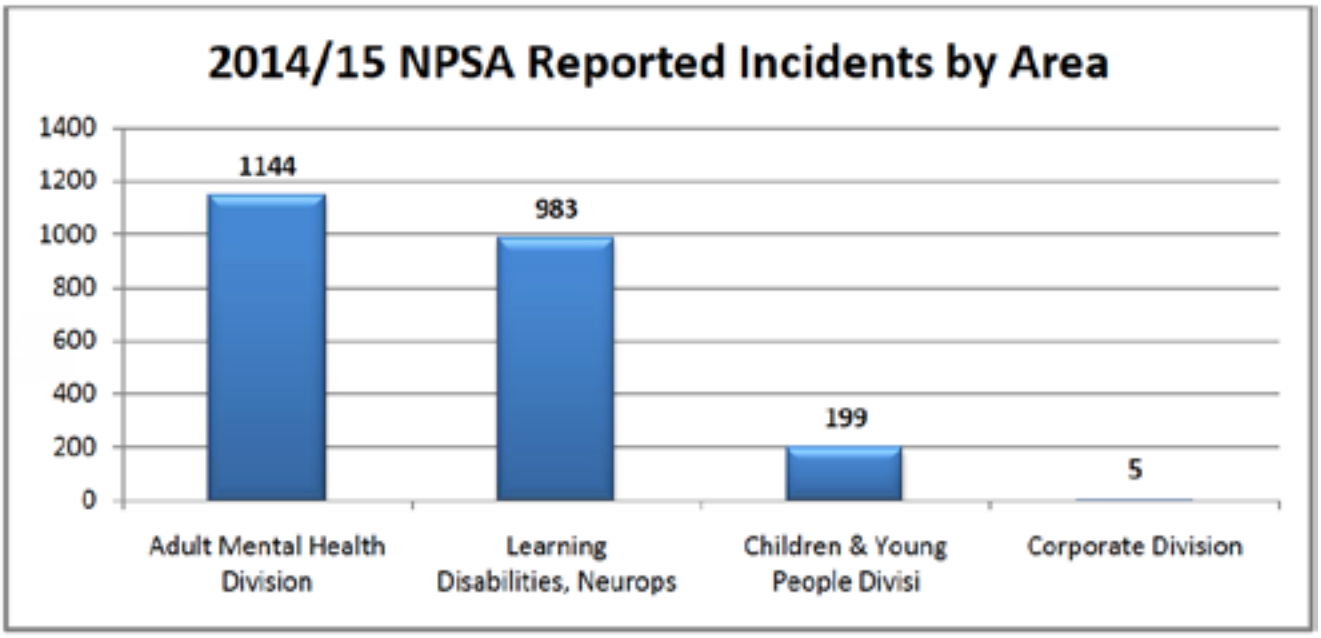
Most recent published benchmarking data (April 2013-Sept 2013):	Severe harm as % of total	Death as % of total
Trust	0.6	0.9
National average	0.4	0.9
Highest	1.6	4.7
Lowest	0	0

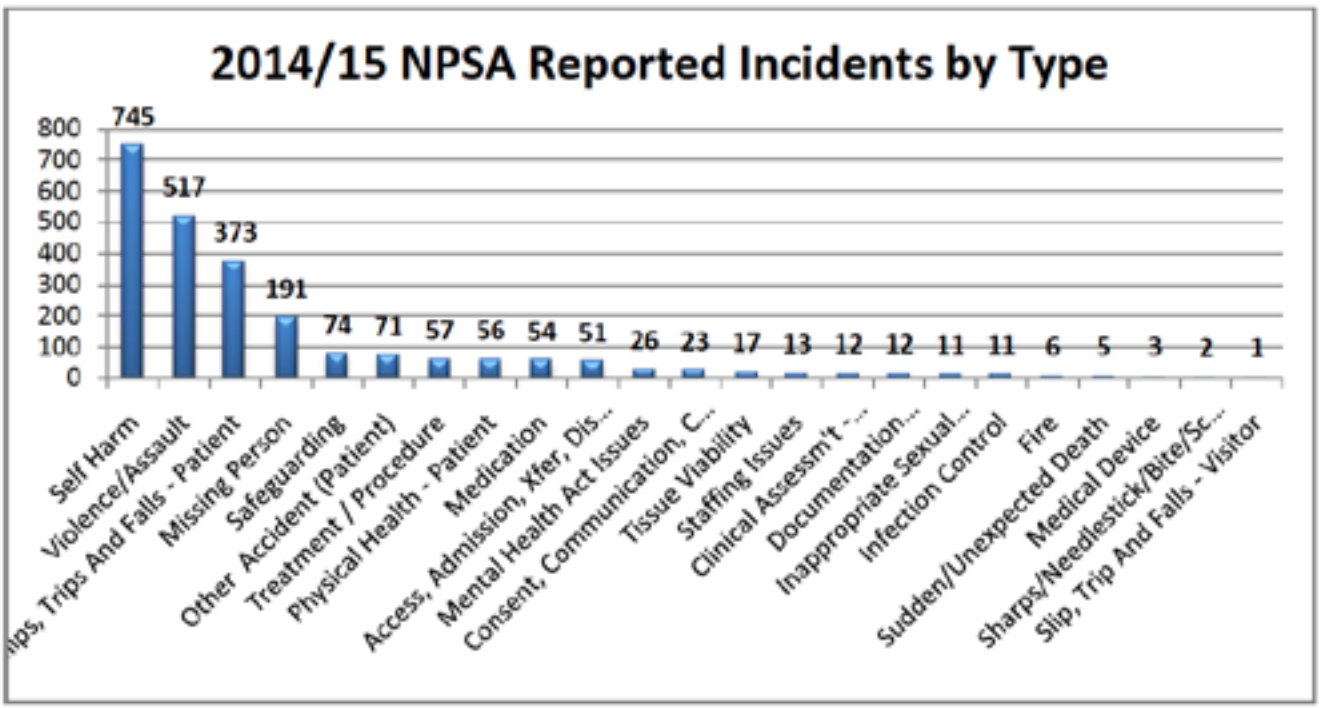
The Trust is required to report Patient Safety Incidents (PSI`s) to the National Reporting and Learning System (NRLS). This is the only data collection agency nationally and the data submitted is analysed by subject experts to provide Trusts with six monthly Organisational reports, based on data submission and will provide benchmarking data based on incidents reported by Occupied Bed Days (OBD`s), by incident type, severity and frequency of reporting. This data provides the NRLS with evidence of actual and near miss Patient Safety Incidents which in turn leads to the generation of national Patient Safety Alerts intended to highlight specific incident trends with advice on local and national actions to minimise further incidents occurring. The Trust has seen significant progress in the refinement and integrity of the submitted data to the NRLS and has noted an improvement in the quality of the submitted data. Previously the Trust noted that they appeared to have a significantly high number of catastrophic incidents in comparison to benchmarking against other Trusts. This was due to the Trust reporting all deaths, including natural cause deaths; which are not reportable patient safety incidents. Therefore following this change in understanding of data reporting requirements the Trust is confident that current Organisational reports reflect that the Trust is reporting data in line with NRLS guidance.

The NRLS describes these incidents as "Patient Safety Incidents which are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving NHS funded healthcare".

The following data shows the number of incidents and their classification by area and type which were reported to the NRLS by the Trust in 2014/15. (Previous year figures are available in our 2013/14 Quality Account, a copy of which is held on the Trust website www.combined.nhs.uk)


2014/15 NPSA Reorted Incidents
250
200
150
100
50
0
212
220
194
184
227
179
215
209
195
214
166
116
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


2014/15 NPSA Reported Incidents by Area
1400
1200
1000
800
600
400
200
0
1144
983
199
5
Adult Mental Health Division
Learning Disabilities, Neurops
Children & Young People Divisi
Corporate Division


2014/15 NPSA Reported Incidents by Type
800
700
600
500
400
300
200
100
0
745
517
373
191
74
71
57
56
54
51
26
23
17
13
12
12
11
11
6
5
3
2
1
Self Harm
Violence/Assault
Trips And Falls - Patient
Missing Person
Safeguarding
Other Accident (Patient)
Treatment / Procedure
Physical Health - Patient
Medication
Access, Admission, Xfer, Dis...
Mental Health Act Issues
Consent, Communication, C...
Tissue Viability
Staffing Issues
Clinical Assessm't -...
Documentation...
Inappropriate Sexual...
Infection Control
Fire
Sudden/Unexpected Death
Medical Device
Sharps/Needlestick/Bite/Sc...
Slip, Trip And Falls - Visitor

Area of Performance:	'Never Events'
Metric - method of calculating performance:	Trust Metric: QI PS 8 Never Events A Never Event is a serious, largely preventable, patient safety incident that should not occur if the available preventative measures have been implemented. An example would be an inpatient suicide-using curtain or shower rails.
Performance	 **Nil** - There have not been any 'never events' in the Trust

Area of Performance:	Serious Incidents (SIs) (Clinical and Non-clinical)
Metric - method of calculating performance:	Trust Metric: KPI 17.17 Investigating and Reporting of Serious Incidents
Performance	 During 2014/15there have been 66 serious incidents reported by the Trust At the time of generating this metric (27April 2014) 66 SIs have been reported of which 13 are still outstanding. Of the 66 investigations,13 are outstanding and within contractual timescales or subject to Stop the Clock or Commissioner agreed extension of deadline and, of the 53 closed, no investigation was submitted outside the contractual timescale During 2014/15, no incident breached the 40 working day deadline.

SERIOUS INCIDENTS

2014/15continues to show strong performance in respect of the timely investigation, quality of completed investigations and the approaches taken to learning from serious incident investigation. This year has seen ongoing progress with the embedding of process with positive Commissioner Review of performance.

The Trust-wide programme of learning from incident investigations was introduced and implemented with a revision of the investigation process to ensure the inclusion of all parties involved in the incident, timely feedback and involvement in agreeing appropriate actions where required.

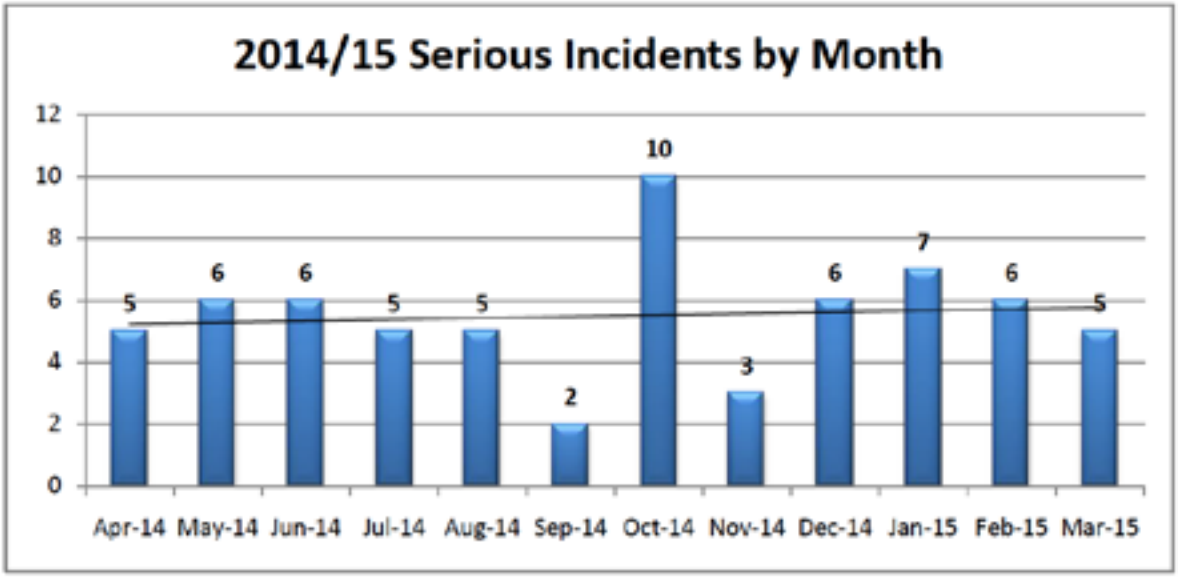
Key points learned from incident investigation are captured in a bi-monthly Learning Lessons briefing and further complimented by regular academic learning events open to all grades of staff.

We continue to work in partnership with the Directorate Governance leads to ensure trends arising from incidents are discussed at Directorate and team level meetings and are also reported to the Trust Quality Committee with a quarterly thematic review of data by serious incident type, area, and learning captured within the report.

The data reflected below illustrates serious incident reporting broken down by month and by incident type. Although there is some monthly variation, a review of the last two years data does not highlight any significant monthly or seasonal trends. The increase in October 2014 was subject of a thematic review and the results revealed that there were no trends or themes by incident type, service area or investigation recommendations.

We note that the category of Unexpected Death continues to be the highest reported serious incident type although there is a significant reduction in this category, largely in part to clarification regarding the need to no longer report deaths attributed to natural causes.

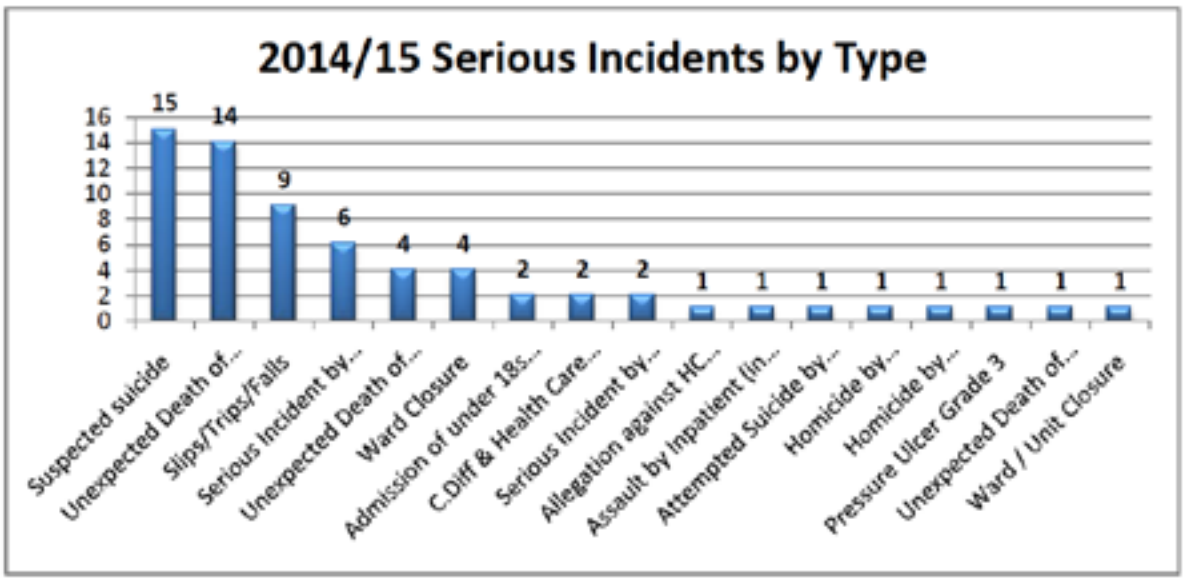
The Trust have continued to work closely with and contribute to the Public Health led Suicide Prevention strategy initiative and will continue its development in this area; the Trust Suicide Prevention group are planning to further explore the issues around patient safety and risk assessment regarding self-harm and self-neglect.



The number of unexpected deaths almost always relate to people with drug and/or alcohol issues and not all of these people were in receipt of services at the time of their death. Unexpected deaths are all categorised as serious incidents and investigated accordingly for any possible learning with regards to service delivery. The investigations are undertaken by experienced staff, who have a thorough understanding of the Trust processes and policies, in order to be able to identify areas of no-compliance, gaps in service delivery etc. However the Trust is able to report that these investigations have repeatedly revealed examples of good practice from the teams involved.

Other incidents of unexpected deaths have been natural cause deaths; where the person has been found to have died of physical health causes unrelated to their mental health issues.

It should also be noted that SI investigations are undertaken for people who have had contact with mental health services in the previous 12 months; therefore there are a number of people who are not currently under the care of the Trust at the time of their death.



Metric - method of calculating performance:	Trust Metric: KPI 17.7 MRSA Bacteraemia (numbers)
Performance	 **Nil** - We are delighted to report that we have had no Meticillin resistantStaphylococcus Aureus (MRSA) bloodstream infections since 2007 which is, in part, due to the introduction of the MRSA screening programme for all admissions to hospital inpatient wards and units, staff awareness, training and education.

Area of Performance:	Healthcare Associated Infection (HCAI): MRSA Screening
Metric - method of calculating performance:	Trust Metric: QI 17.7i MRSA Screening (%). Elective and emergency hospital inpatient beds.
Performance	 **Overall 100%** as an average for 2014/15 (to Feb 2015). We are very proud to achieve a high level of screening throughout 2014/15

Area of Performance:	Healthcare Associated Infection (HCAI): Clostridium Difficile
Metric - method of calculating performance:	Trust Metric: KPI 17.8 Clostridium Difficile (numbers)
Performance	 **No cases** of Clostridium Difficile were identified in year The Trust's target was in excess of the NHS England in reported Clostridium Difficile (CD) cases compared to the equivalent period last year

There has been no Methicillin resistant Staphlococcus aureaus (MRSA) blood stream infections, and no Methicillin sensitive Staphylococcus aureaus (MMSA) blood stream infections reported.

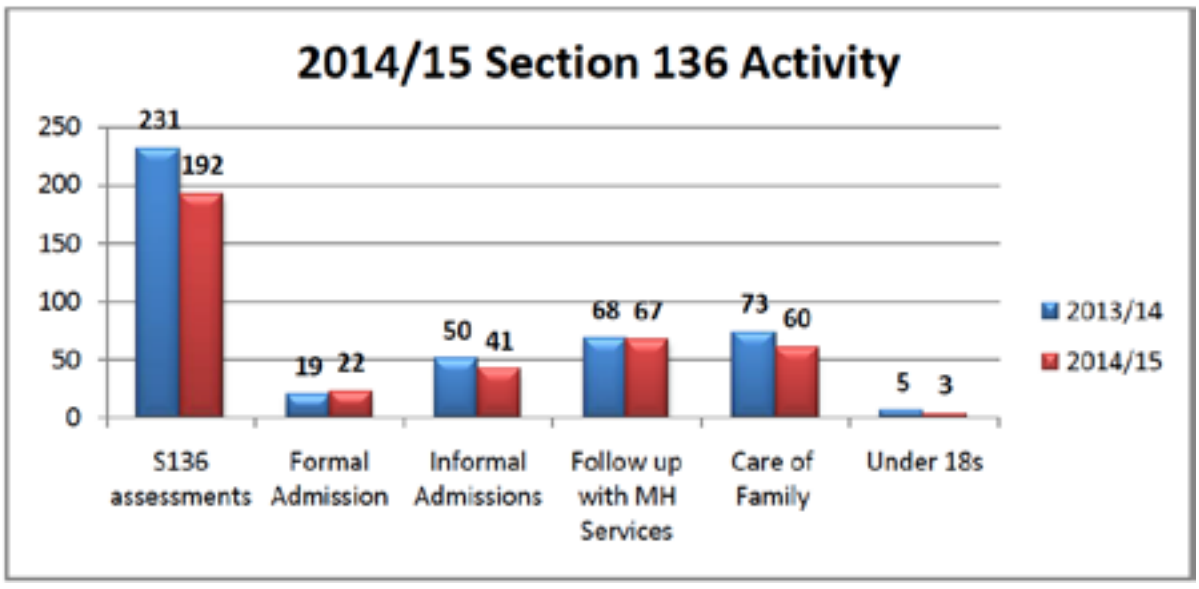
There have been no reported cases of Esterichia coli (E. coli) blood stream infection reported in 2014/15.

There has been four outbreaks reported and managed as norovirus and all were successfully contained within the affected area.

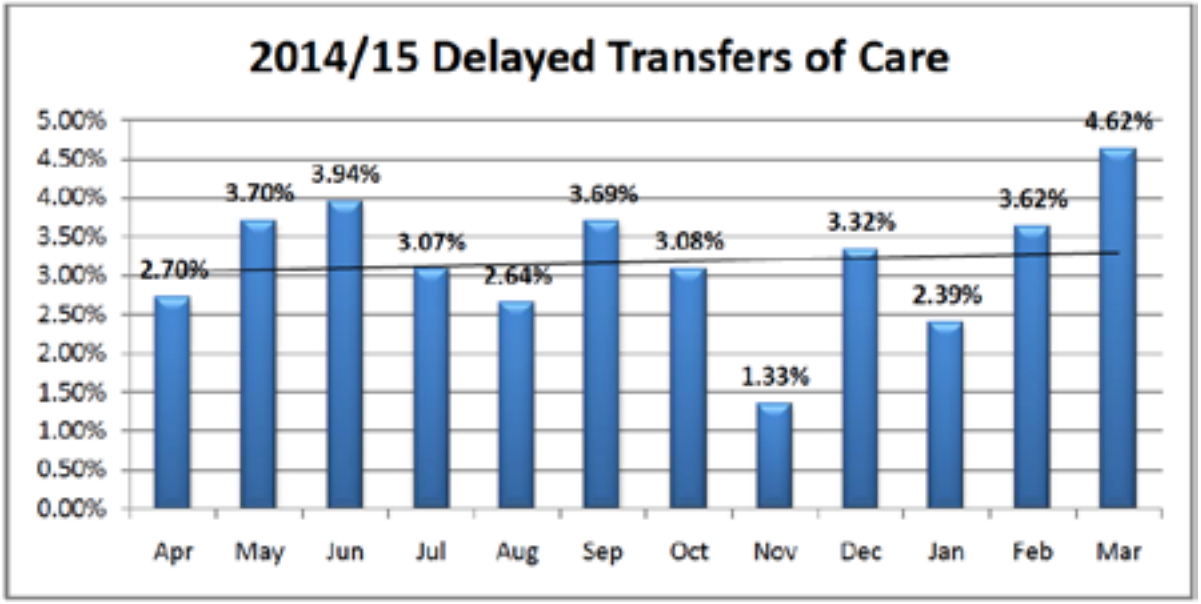
We are pleased to report consistent year on year reductions in healthcare associated infections over a significant number of years and are looking forward to the challenge of reducing the number of infections still further.

Area of Performance:	Mental Health Activity
Metric - method of calculating performance:	QG.43 Mental Health Activity
Performance	 192 assessments under Section 136 of the Mental Health Act took place at Harplands Hospital Place of Safety. The outcome of these assessments is as follows: • 11.97% - Formal admission to hospital under the Mental Health Act. • 21.35% - Informally admitted to hospital. • 34.90% - to be followed-up by mental health / social care services. • 31.25% - Other / care of family / own GP. Of all assessments 1.56% - Assessed were under the age of 18. From the above data, it can be seen that the vast majority of people assessed under Section 136 of the Mental Health Act are not admitted to hospital.

This data shows the number of assessments carried out under Section 136 of the Mental Health Act (police power to remove a person to a place of safety). The Harplands Hospital Section 136 Assessment Suite is the first choice designated place of safety and all service users are assessed here or at the second choice designated place of safety, which is currently the Northern Area Custody Facility at Etruria. This data shows the outcome of the assessments in terms of admission to hospital and the number of cases where the person was under the age of 18 years.



Area of Performance:	Delayed Transfers of Care
Metric - method of calculating performance:	KPI 17.12 Delayed Transfers of Care
Trust Performance:	Overall, for 2014/15 the Trust's rate for delayed transfers of care is 3.18% against a target of 7.5%. Significant progress has been made in maintaining the reduction in the number of people whose transfer was delayed from 3.58% in 2013/14 to 3.18% in 2014/15 resulting in the Trust achieving and maintaining the target of less than 7.5%.



Area of Performance:	Staff Satisfaction
KPI 11.1: **Staff satisfaction as measured by the annual national staff satisfaction survey**	

The national Staff Survey took place in September–December 2014. For the first time, the Trust was able to offer a mixed method survey, with 60% of staff being invited to take part online and the remaining 40% using the usual paper method. 512 staff took part in this survey, giving a response rate of 40%.

TRUST HIGHEST AND LOWEST SCORES

In the 2014 Staff Survey, the Trust's top five ranking scores were:

- Percentage of staff receiving health and safety training in last 12 months
- Percentage of staff receiving job-relevant training, learning or development in last 12 months
- Percentage of staff experiencing discrimination at work in last 12 months
- Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
- Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

Conversely, the Trust's lowest five ranking scores were:

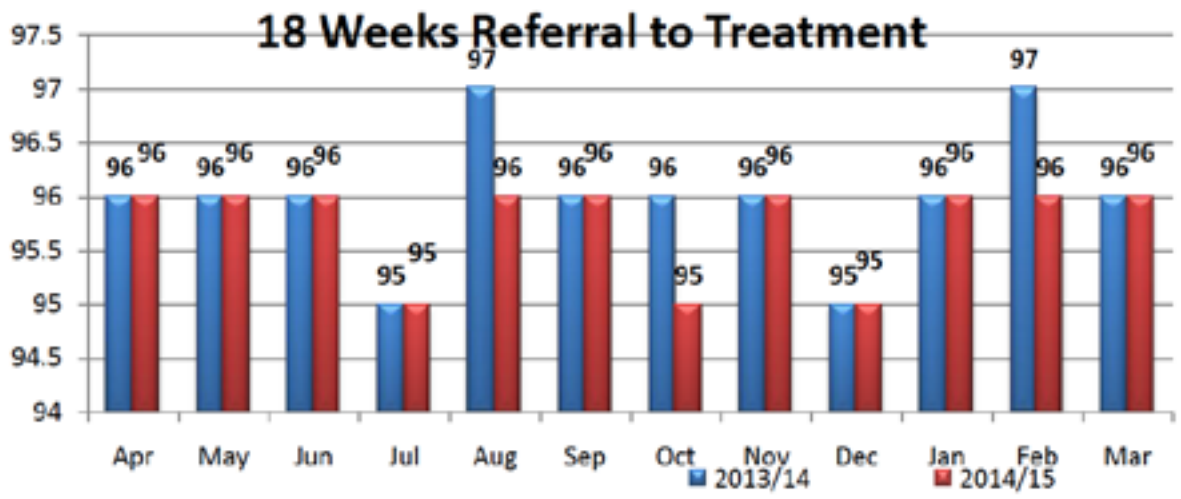
- Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver
- Percentage of staff able to contribute towards improvements at work
- Percentage of staff agreeing that they would feel secure raising concerns about
- unsafe clinical practice
- Staff motivation at work
- Percentage of staff agreeing that their role makes a difference to patients

We have identified clear priorities for action arising from the 2014 Staff Survey which include:

- To improve the response rate across the Trust
- Develop local plans at Directorate and Corporate team levels
- Maintain and continue to develop and build upon our positive culture of health and safety, a learning culture and a culture where discrimination, harassment, bullying or abuse is rare.
- Continue to invest in further development of strong patient service culture whereby staff have confidence in the quality of care/service they are able to deliver and in which they feel able to contribute to improvements at work.
- Understanding and addressing issues around staff motivation and staff engagement across the Trust. Tackling root causes and sharing information openly and honestly where the Trust has limited capacity to make changes (such as around service funding issues) will be important here.
- Have a strong campaign highlighting the importance of staff feeling secure to raise concerns and clear communication about how to report unsafe or inappropriate care or behaviour should they observe or have reason to suspect it.
- Turnaround the Trust's performance in relation to appraisal (PDR) quality of the appraisal discussion.
- Continue to implement and further develop the Trust's Stress Less approach to tackle the causes and symptoms of excessive work pressure and work-related stress.
- Continue to seek to understand staff perceptions and preferences about what they consider to be effective communications between senior managers and staff and continually develop our processes in respect of this based on this feedback and understanding.
- Explore the issues of effective leadership across the Trust to support all of the above.

Area of Performance:	Physical Health Checks			
Metric - method of calculating performance:	Physical health checks			
Trust Performance:		**Quarter 2014/15**	**Response Rate**	**Outcome for % of Physical Health Checks**
		Quarter 1	89%	67%
		Quarter 2	81%	69%
		Quarter 3	52%	71%
		Quarter 4	70%	84%
				The outcomes shown are the percentage of physical health checks completed which included<u>all</u> necessary elements which form a full physical health check

Area of Performance:	Waiting Times
Metric - method of calculating performance:	KPI 17.7 18 week RTT(Referral To Treatment) waiting time targets
Performance	 96.3% (to Feb 2015) The Trust monitors the waiting time for outpatient appointments which show the proportion of people on the waiting list for a service who have been waiting for their first appointment for treatment for more than 18 weeks. The Trust target is for no one to have to wait over 18 weeks although the Trust has not yet achieved this target. Significant improvements have been made during the year reducing the percentage waiting



Area of Performance:	7 Day Follow Up of CPA Patients
Metric - method of calculating performance:	**KPI 17.5 Follow up of patients within 7 days of discharge – (Mar 2014)**

Trust Performance:

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	100%	100%	100%	100%	100%	95%	100%	100%	100%	100%	100%	100%
2013/14	100%	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Most recent published benchmarking data:	Q3 2013/14 (%)	Q4 2014/15 (%)
Trust	100	100
National average	97.4	97.2
Highest	100	100
Lowest	93.3	93.1

Area of Performance:	Crisis Resolution Gate kept Admissions – Acute
Metric - method of calculating performance	KPI 17.14 Acute Admissions Gate kept by Crisis Resolution Teams (Mar 2014)

Trust Performance:

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%	100%	98.5%
2013/14	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Most recent published benchmarking data:	Q3 2013/14 (%)	Q4 2014/15 (%)
Trust	100	99.0
National average	98.3	98.1
Highest	100	100
Lowest	75.2	59.5

Area of Performance:	Service Users on Care Programme Approach (CPA) Care Review
Metric - method of calculating performance:	KPI 17.4 Number of patients on CPA who have received a care review in the past 12 months (2014/15 Trust & Monitor Target 95%)

Trust Performance:

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	96%	96%	96%	95%	95%	94%	96%	95%	97%	96%	96%	95%
2013/14	96%	95%	96%	97%	95%	93%	92%	93%	95%	96%	96%	96%

Area of Performance:	Patients in Settled Accommodation
Metric - method of calculating performance:	KPI 17.16i Percentage of patients who are in settled accommodation

Trust Performance:

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	92%	92%	92%	92%	92%	91%	91%	91%	91%	91%	91%	91%
2013/14	90%	90%	97%	98%	90%	91%	91%	92%	92%	92%	92%	92%

The Trust is pleased to have maintained the increase achieved in 2013/14 and continues to work closely with all parties to improve still further.

Area of Performance:	Patients in Employment
Metric - method of calculating performance:	KPI 17.16ii Percentage of patients who are in employment

Trust Performance:

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	13%	13%	15%	15%	13%	13%	13%	13%	13%	13%	13%	13%
2013/14	13%	13%	15%	15%	13%	13%	13%	13%	13%	13%	13%	12%

The Trust has worked hard to increase numbers year-on-year in this very well received local programme and will continue to support patients whenever possible.

PATIENT EXPERIENCE

Area of Performance:	Patient Experience
Metric - method of calculating performance:	KPI 16.1 Patient experience as measured by the annual national patient survey in relation to community based care – the most recent survey results were published in September 2014
Trust Performance:	We are pleased with our most recent survey results 

Questions relating to	Score out of 10	How this score compares with other trusts
Health and Social Care Workers	8.0	

"The man I am able to talk to is kind and shows great patience."

National Mental Health Survey Respondent 2014

Questions relating to	Score out of 10	How this score compares with other trusts
Organising care	8.4	
Planning care	7.2	
Reviewing care	7.6	

"My CPN is excellent. I have utmost faith in the support given."

National Mental Health Survey Respondent 2014

Questions relating to	Score out of 10	How this score compares with other trusts
Changes in who you see	6.8	
Treatments	7.7	
Other areas of life	5.1	
Crisis Care	6.0	

"The staff are fantastic – my psychiatrist is great. Speaks to me like an adult and provides me with all the information I need."

National Mental Health Survey Respondent 2014

Questions relating to	Score out of 10	How this score compares with other trusts
Overall	7.4	

"In a crisis I have been able to speak on the phone or talk face to face within 24 hours..."

National Mental Health Survey Respondent 2014

"I am extremely grateful for the help you have given me and I would not be where I am now if I did not receive support.."

National Mental Health Survey Respondent 2014

'My care is superb..'

National Mental Health Survey Respondent 2014

"In a crisis I have been able to speak on the phone or talk face to face within 24 hours..."

National Mental Health Survey Respondent 2014

Area of Performance:	**Complaints**			
Metric - method of calculating performance:	KPI 15.1 Complaint Acknowledgements, Responses and Trends			
Performance			**2012/13**	**2013/14**	2014/15
		Number of complaints	78	95	65
		Number acknowledged within timescale	98%	100%	100%
		Number responded to within timescale	85%	100%	100%
		There have been a total of 65 complaints received (to Feb 2015) for 2014/15, a reduction of30 compared to 2013/14. In 2014/15 only one complaint was referred to the Ombudsman by a complainant who was not satisfied with the response provided by the Trust.			

Area of Performance:	Patient Advice and Liaison Service (PALS) & Compliments
Metric - method of calculating performance:	QI 1.8 Numbers and types of contacts via PALS and Compliments

Performance specific to the services covered by this Quality Account:

During the course of the year the patient experience coordinator (PALS) dealt with a wide range of issues raised by service users and carers following contacts, requests and issues were received and addressed from clients within the services detailed in this Quality Account:

Comments	Compliments	Liaison / Help	Information	Signposting / onward referral	Other
30	78	124	18	9	0

There are no specific timescales attached to the PALS service, however, the ethos is person-centred and service users are kept informed with progress against agreed timeframes in resolving their desired outcomes. There is a high degree of satisfaction with the service indicated by both open and anonymous feedback.

Area of Performance:	Same Sex Accommodation
Metric - method of calculating performance:	QI 3.15 Shared Bedrooms QI 3.16 Shared Bathrooms QI 3.18 Overall Compliance

Trust Performance:

We are proud to confirm that mixed sex accommodation has been eliminated in our trust.

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. We are committed to deliver care with privacy and dignity of which providing every patient with gender appropriate accommodation is an integral element, because it helps to safeguard their privacy and dignity when they are often at their most vulnerable.

3.3 ENGAGEMENT AND STATEMENT FROM KEY PARTNERS

ENGAGING OUR PARTNERS AND STAKEHOLDERS - '3 STEPS TO ENGAGEMENT'

North Staffordshire Combined Healthcare NHS Trust remains committed to working collaboratively with a range of partners and as such has included three key steps in the development and publication of this Quality Account. As in previous years, all three steps have been successful and have resulted in key changes in the development and content of this Quality Account.

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

Step 1: Development Stage:

We have again developed a survey to seek 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 retained and what should be changed. We sent copies of the survey to all of these groups and included references to the survey in a public Trust Board meeting. All feedback received was responded to and reviewed as part of the engagement and design process for this Quality Account

Step 2: Agreeing Priorities:

The survey referred to above included a section about the priorities that key partners, service user representative groups, local authorities and staff would expect to see reported in our 2014/15 Quality Account. In addition, we have held a number of engagement meetings including a dedicated 'drop-in' session, attended events and have received written communications from our partners to agree our key quality priorities for 2015/16 as follows:

- Commissioners – North Staffordshire CCG (NHS North Staffordshire) and Stoke-on-Trent CCG (NHS Stoke on Trent)
- Staffordshire Overview & Scrutiny Committees
- Stoke-on-Trent Overview and Scrutiny Committee
- Healthwatch Stoke-on-Trent
- Healthwatch Staffordshire
- NHS England Area Team

Step 3: Sharing the Draft Quality Account:

In line with the 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 invited each partner to provide a statement for inclusion in the Trust's Quality Account. These statements are shown below:

COMMENTS FROM KEY PARTNERS

NORTH STAFFORDSHIRE CCG AND STOKE-ON-TRENT CCG:

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

The contract and service specifications with the Trust detail the level and standards of care expected and how these will be measured, monitored, reviewed and performance managed. As part of the contract monitoring process, North Staffordshire CCG and Stoke-on-Trent CCG meet with the Trust on a monthly basis to monitor and seek assurance on the quality of services provided. In addition to the contract meetings, the CCGs work closely with Trust and undertake continuous dialogue as issues arise to seek assurance, which is also obtained via quality visits and attendance at Trust internal meetings.

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

REVIEW OF 2014/15

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

- Commissioners wish to congratulate the Trust in their successes in 2014/15 not limited to achieving Accreditation in Inpatient Mental Health Services – Rehabilitation Units at Florence House and Summers View and being awarded Placement of the Year at the Keele University School of Nursing & Midwifery's Awards Ceremony for their Parent and Baby Day Unit.
- The Trust has strengthened staff engagement during 2014/15 through implementing the Listening into Action approach and Aston Team Leadership Programme. Commissioners hope that this ongoing cultural change will be reflected in an improvement in the NHS Staff Survey in 2015.
- The Trust launched its Patient Council in February 2015 to incorporate the voice of patients, service users and their representatives into everyday business.
- The Trust reopened Ward 4 from January 2015 as a dual care environment for patients whom are medically fit for discharge and awaiting appropriate care package. The Trust has received positive feedback from patients, visiting professionals and Healthwatch Stoke following an Enter & View visit in March 2015.
- The Trust has not reported any 'Eliminating Mixed Sex Accommodation' breaches during 2014/15.

However, 2014/15 has not been without its challenges:

- Commissioners undertook an announced quality visit to Ward 4 in response to an increase in the number of falls in early 2014. The Trust took immediate actions to address areas of improvement which were monitored regularly throughout the year and completed with the exception of those relating to longer term changes to the ward infrastructure.
- We note the Care Quality Commission comments re staffing levels within the Community Mental Health Services visited. We are pleased the Trust is working with the Mental Health Institute to develop a workforce tool for Community Mental Health Services and that it routinely declares ward staffing levels in line with the national requirements. We recognise that the numbers, calibre, skill mix and continuity of staff are fundamental to providing/sustaining quality care and will be seeking assurance from the Trust over the coming year in this regard.
- Commissioners undertook an announced quality visit to the Access Team during late 2014 which identified several areas for improvement. A follow up unannounced visit alongside representatives from the Trust in early 2015 concluded that there was a need to improve commissioner and stakeholder understanding and perception of the service. We will be seeking assurance on future improvements and service developments over the coming year.
- Whilst it is disappointing that the Trust reported a case of Clostridium Difficile on Ward 4 the root cause analysis determined that the case was unavoidable and Commissioners are assured that the Trust manages infection prevention and control appropriately.

PRIORITIES FOR 2015/16

The Commissioners have worked closely with the Trust to agree quality improvements for 2015/16 using the CQUINs framework which the Trust has aligned to their priorities for improvement which will drive real improvements in quality and safety.

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

Dr Julie Oxtoby
Clinical Accountable Officer
North Staffordshire CCG

Dr Andrew Bartlam
Clinical Accountable Officer
Stoke-on-Trent CCG

STAFFORDSHIRE 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 of 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, we note the presence of a statement from the Board and the declaration that to the best the information is accurate, list of services and signatures of the CEO and Chair. The Vision is well articulated and the explanation of the Quality Account process is also present. The future plans and aspiration to achieve Foundation Trust status are noted. We suggest that further explanation of the review mentioned would give context and add clarity to this section.

Priorities, we note how and why they were chosen, the involvement of stakeholder's linkage to strategy and the means intended monitor measure and report to board level. However we would welcome more detail to include indicators and evidence on progress made since the last QA.

Statements of Assurance, we note the supplementary text explaining the relevance of the information to quality and illustrated services. The number of services reviewed is present but we feel that the report would be enhanced by the inclusion of more detail of the services provided/ sub contracted. In relation to income we believe that the report would benefit if more detail of expenditure against income and overall impact on the budget.

Participation in research, the work of the Research and Development Team is acknowledged. The number of patients recruited to take part and the subsequent outcomes of the research is available to the reader.

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. We suggest that the publication of the actual figures would be appropriate.

CQC registration, membership the absence of conditions enforcement actions and the presence of regulated activities are noted. As are the statistical records referring to information governance, the clinical coding audit and actions to improve data quality.

Review of quality performance, we are pleased note that each of the quality/metric indicators is linked or more of the three domains of Patient Safety, Clinical Effectiveness and Patient experience. An explanation of how, by whom and the rational for choice of the indicators is present.

Information is present in relation to specific services and what the patients and public have to say about them. We are of the view that it would add value to the document when addressing Priority Areas i.e. Patient Experience, Friends and Family Test if performance is measured in real figures not as a percentage. In the case of the Friends and Family Test 57% happy with service 43% may not an explanation in the narrative would be helpful.

Indicators and evidence including from complaints, patient surveys, inspection and benchmarking is present together with detail of performance against national priorities. In respect of the 2014 Staff Survey we note the inclusion of the five highest scores and the five lowest, and the effect on staff morale by the latter. The importance of the clear priorities identified to address these issues is noted.

We commend the Trust for the commitment to provide communication and support for service users and carers whose first language is not English. It is availability of the document in different languages, formats and in its original form via a designated email address.

We note that we are commenting on a draft document; our comment is based on the information available at this time with the expectation that the absent and outstanding material be added to the final draft before publication. To conclude we are of the view that the document could have been presented with the public in mind numbered pages in a more sequential and user friendly format.

HEALTHWATCH STOKE ON TRENT:

The Quality Account was presented and considered by patient representatives at Healthwatch Stoke-on-Trent on 28th May 2015 and, following the presentation and responses to the questions raised, Healthwatch Stoke-on-Trent offers the following comments.

Healthwatch Stoke-on-Trent welcomes the engagement that has taken place with partners, public and most importantly patients in producing this Quality Account. It is also pleasing to note the joint working that has been apparent with other services e.g. the collaboration with UHNM to provide the Dual Care Ward in Ward 4. Healthwatch Stoke on Trent welcomes this and was pleased to provide a positive report on its Enter and View visit to Ward 4 last month. These demonstrable links with wider health service partners will, it is hoped, help to further embed the message that there is "No Health without Mental Health".

The evident commitment to staff development through the Listening into Action programme, and the rollout of this across all directorates in the Trust is welcomed to support better outcomes for staff and, in turn, patients.

Healthwatch welcomes the significant reduction in Clinical and Non-clinical Incidents in 2014/15 and welcomes the continued prioritisation of Safety in the 2015/16 SPAR priorities. Clearly there are concerns about bed occupancy levels which remain high and a focus on improved Bed Management is welcome under the Accessible priority. Healthwatch hope we can arrive at a point where no patient travels out of area to receive in-patient care. The increase to 24/7 provision of the Crisis Response Function is also a very welcome step.

Healthwatch patient representatives unanimously welcomed the focus of work that is intended to improve transitional services for Children and Young People. This recognises the level of concern being expressed by families and young people and was also highlighted by Healthwatch in its recent work with young people. In particular the drive to provide one patient pathway which services slot into rather than the patient having to slot into different services is recognised as a very positive step. Healthwatch notes the intention to improve the pathway by September 2015 and looks forward to working with the Trust to monitor patient experience of this. Some additional focus on reducing waiting times for patients via CAMHs will be welcome as the current waiting times are unacceptable.

Healthwatch welcomes the development of the Patient Council under the Personalised priority and hopes that this will be used to keep the service user voice at the centre of service design, delivery and improvement.

We look forward to working with the Trust to support this in the coming year. Healthwatch Stoke-on-Trent, May 2015.

HEALTHWATCH STAFFORDSHIRE RESPONSE TO NORTH STAFF COMBINED HEALTHCARE TRUST QUALITY ACCOUNTS

26/05/15

The Quality Account for North Staffs Combined Healthcare Trust (NSCHT) is very well presented and laid out, which provides a useful introduction to the Trust before sections regarding statements on quality; priorities for improvement; and a review of quality performance from the previous year. This clear structure is useful for both those partners in health and social care yet also the general public. The information provided in the Account is clear and informative. Particularly helpful is the use of patient feedback and how this has been used to structure future improvements with the "you said, we did, we plan to…" approach the NSCHT has taken outlining where significant progress has been made. Additionally, the use of a 'traffic light' system whereby Trust performance is highlighted demonstrates the clear progress NSCHT has made against its Key Performance Indicators (KPIs) in 2014/15 in comparison to the previous year, 2013/14.

We are pleased that the Trust is continuing to focus on patient care and experience. Over the 4 quarters of 2014, 95% of service users were satisfied with the care they received from NSCHT. Monitoring patient experience, NSCHT measure this in relation to community based care. With respect to these scores (out of 10), overall satisfaction ranks at 7.4, which is 'about the same' as other Trusts.

The Trust has now aligned its priorities for the forthcoming year along 4 key areas, including safe; personalised; accessible; and recovery care and treatments. While these areas present a challenge to the Trust they also allow the NSCHT to focus its efforts to improve its systems, capacity and flexibility in responding to the increasing demands from those suffering with mental health conditions. These areas indicate the importance of improving patient engagement; capacity; storing information digitally; and transition points between child and adult services to prevent individuals from falling through the gaps. We welcome these areas and would like to work closely with North Staffs Combined Healthcare Trust over the next twelve months to understand how the Trust's work in each of these areas improves patients' experience.

We have raised concerns about the capacity of the access and home treatment team from patient complaints and feedback collected by Healthwatch Staffordshire and whilst we have received assurances from the Trust that several changes have been made to improve the service, the Trust have identified this as an ongoing priority. We will continue to work with the Trust to resolve patient complaints and concerns collaboratively.

Dr Stephen Axon
Senior Research and Insight Officer,
Healthwatch Staffordshire

Elizabeth Learoyd
Complaints and Advocacy Manager,
Healthwatch Staffordshire

3.4 STATEMENT OF CHANGES

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

You Said	Trust Response
North Staffordshire CCG and Stoke-on-Trent CCG	
No changes required	N/A
Healthwatch Staffordshire	
No changes required	N/A

Healthwatch Stoke-on-Trent	
No changes required	N/A
Staffordshire Health Scrutiny Committee	
Suggestion of a further explanation of the review undertaken regarding Trust future plans	More detail included
Suggestion of more detail to evidence progress against priorities described in the 2013/14 Quality Account	This data is contained in section 3 of the Quality Account
Suggestion of more detail on services provided and sub-contracted	This information is contained within the Trust's Annual Report.
The report would benefit if more detail on expenditure against income and overall impact of the budget was included.	This information is contained within the Trust's Annual Report.
Suggestion that financial figures against CQUINS were included	Financial figures included
Suggestion that real figures for friends and family test score are included	Numerator and denominators included
Suggestion that presentation of the document could be presented with public in mind in a user friendly format.	As the document reviewed was in draft format we have plans to have the final document produced in a more user friendly format. In addition, as in previous years, we commit to produce a summary version of the quality account.

3.5 AUDITOR STATEMENT OF ASSURANCE

INDEPENDENT AUDITOR'S LIMITED ASSURANCE REPORT TO THE DIRECTORS OF NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required to perform an independent assurance engagement in respect of North Staffordshire Combined Healthcare NHS Trust's Quality Account for the year ended 31 March 2015 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the following indicators:

- Percentage of patients on Care Programme Approach (CPA) followed up within seven days of discharge: and
- Percentage of admissions to acute wards gatekept by the Crisis Resolution Home Treatment Team.

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of the Directors and the auditor

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 annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy 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 is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;

- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2014 to June 2015;
- papers relating to quality reported to the Board over the period April 2014 to June 2015;
- feedback from the Commissioners dated 26 May 2015;
- feedback from Local Healthwatch dated 26 May 2015 and 28 May 2015;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey dated 18 September 2014;
- the latest national staff survey dated 2014;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 7 April 2014;
- the annual governance statement dated 4 June 2015;
- the Care Quality Commission's quality and risk profiles dated.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of North Staffordshire Combined Healthcare NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and [Name of Trust] for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;

- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by North Staffordshire Combined Healthcare NHS Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP
31 Park Row
Nottingham
NG1 6FQ

25 June 2015

3.6 GLOSSARY OF TERMS

- *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 Service*
- *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 West Midlands North Comprehensive Local Research Network*
- *CPA Care Programme Approach*
- *CPD Continuing Professional Development*
- *CPN Community Psychiatric Nurse*
- *CQC Care Quality Commission*
- *CQUIN Commissioning for Quality Innovation scheme*
- *CSU Commissioning Support Unit DOH Department of Health*
- *ECT Electroconvulsive therapy*
- *EngAGE Stoke-on-Trent Forum for people over 50 to give their views*
- *Healthwatch Local independent consumer champions created together represents the Views of the public*
- *HRG4 Health Resource Group (standard groupings of clinically similar treatments)*
- *IAPT Improving Access to Psychological Therapies team*
- *IM&T Information Management and Technology IT Information Technology*
- *KPI Key Performance Indicator*

- *Metric Method of calculating performance*
- *Mind Mental Health Charity Network*
- *MRSA Methicillin-resistant Staphylococcus Aureus*
- *NDTi National Development Team for Inclusion*
- *NHSLA NHS Litigation Authority*
- *NICE National Institute for Health and Clinical Excellence*
- *NIHR National Institute for Health Research*
- *NPSA National Patient Safety Agency*
- *NSCHT North Staffordshire Combined Healthcare NHS Trust*
- *PALS Patient Advice and Liaison Service*
- *PbR Payments by Results*
- *PIP Productivity Improvement Pathway Programme*
- *POMH Prescribing Observatory for Mental Health*
- *QIPPP Quality, Innovation, Productivity, Partnership and Prevention*
- *RAID Rapid Assessment Interface & Discharge*
- *R&D Research and Development*
- *Reach Local advocacy project supporting people with learning disabilities*
- *Rethink Mental Health membership charity*
- *SPA Single point of Access (to mental health services)*
- *SUS Secondary Users Service*
- *TDA Trust Development Authority*
- *UHNS University Hospital of North Staffordshire 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 FREEPOST address:

Freepost RTCT-YEHA-UTUU
Communications& Membership Team
NorthStaffordshire Combined Healthcare NHS Trust
Trentham Business Centre, Bellringer Road
Trentham Lakes South
STOKE-ON-TRENT
ST4 8HH

Email: qualityaccount@northstaffs.nhs.uk
Visit: www.combined.nhs.uk

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: **Open Trust Board**

Date of Meeting:	30 July 2015
Title of Report:	Integrated Quality Report Q4 2014-15
Presented by:	Dr Buki Adeyemo, Medical Director
Author of Report: Name: Date: Email:	 Glen Sargeant, Head of Performance and Information 09 July 2015 glen.sargeant@northstaffs.nhs.uk
Purpose / Intent of Report:	• For information / Assurance
Executive Summary:	Attached is a summary of the Trust's Integrated Quality Report for the period up to and including Q4 (Jan-Mar 2015). This report should have been presented to the June committee meeting but was omitted in error. Apologies for the oversight. As at Quarter 4 the Trust has delivered the majority of its key performance metrics. There are a number of areas of good practice and, where performance has been identified as needing to be improved, the Trust has put measures in place to achieve this. The summary provides key points and any exception items drawn from the 63-page report. The bulk of the detail within the overall report has already been presented to the Quality Committee in its constituent parts throughout Q4; therefore the whole report is not attached. The full Integrated Quality Report is presented on a quarterly basis to commissioners for discussion and review as a key part of the contract performance management process.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Governance Strategy Supports the effective delivery of safe and high quality services.
Relationship with Annual Objectives:	Supports the effective delivery of safe and high quality services.

Risk / Legal Implications:	Addressed by this report.
Resource Implications:	Not directly as a result of this report.
Equality and Diversity Implications:	Not directly as a result of this report.
Relationship with Assurance Framework [Risk, Control and Assurance]	Management process supports the Assurance Framework.
Recommendations:	The Trust Board is asked to receive the report for information and assurance.

Integrated Quality Report Quarter 4 (2014/15)

Summary

The Integrated Quality Report focusses on**:**

- Key trends and lessons learnt in the individual sections plus elements of integrated learning across all key processes
- Monitoring against the key priorities defined in the Trust's Quality Account
- Qualitative data to support the Performance & Quality Management Framework and reporting of performance across the range of key performance indicators

As at Quarter 4 has delivered the majority of its key performance metrics. There are a number of areas of good practice and, where performance has been identified as needing to be improved, the Trust has put measures in place to achieve this.

Key points from this report are:

Serious Incidents
During 2014/15 the Trust has successfully investigated all of the Serious Incidents within the contractual timescale of 40 working days and submitted investigation reports to Commissioners, where extensions have been agreed, within the agreed timescale.

A number of investigations will remain open and subject to Commissioner agreed "stop the clock" process which effectively places the investigation on hold until further details of cause of death are known. In these cases the Trust ensures that a briefing note detailing current and recent care including key aspects of risk assessment and management is completed by the relevant care team to assist in identifying any apparent shortfall in care and remedial actions.

The Trust continues to identify strategies to improve Trust wide learning from serious incident investigation.
A copy of the most recent Learning Lessons Update issued to support staff is included in this report.

Incidents
The trend line on page 11 illustrates the total number of incidents reported on a monthly basis over the last 24 months. The data shows that, with the exception of high reporting months in April and August 2013, there has been no unusual variation in the overall monthly totals. Narrative explaining these increases has been detailed in previous Integrated Quality Reports. Incident reporting monthly totals remain variable but have not significantly reduced or increased other than where noted. It is important to note that overall, incidents are being reported by a wider range of teams and that, despite the closure of the Chebsey Close bungalows and resettlement of all but one service user, and that this service accounted for over 50% of all incidents reported, the monthly totals have not reduced as a result. This is detailed further in the NRLS reporting section.

Commissioning for Quality Improvement Scheme (CQUIN)
Milestones have been delivered to quarter 4; and other than two elements of the Physical Health CQUIN valued at £10k all other monies have been secured.

Patient Experience AMH Inpatient Discharge Questionnaire

The quarter 4 2014/15 results of the Trust's Adult Mental Health in-patient discharge questionnaire are:

The overall results in terms of satisfaction levels confirm that 117/125 (94%) of service users rated the care they had received at North Staffordshire Combined Healthcare NHS Trust as excellent, very good or good.

Complaints

In accordance with Complaint Regulations, all of the complaints (100%) were acknowledged no later than 3 working days after the day on which the Trust received the complaint. During Quarter 4, there was 1 complaint (number 277) that was being assessed by the Parliamentary and Health Service (Ombudsman) from October 2014; we were advised in January 2105 that they are now looking to further investigate.

During Quarter 4, there were no complaints referred to the Parliamentary and Health Service. The Trust received the response from the Ombudsman relating to the complaint referred to them in June 2014. A number of issues were raised with the Ombudsman and following independent investigation one of the points was upheld, meaning that overall their findings were that the complaint was partially upheld. Given that information relating to this upheld point was included in the responses, there were no further actions required by the Trust.

Patient Experience

The Trust continues to promote the Patient Experience Team and its functions, including the PALS service, through external and internal awareness raising sessions.

Service user and carer stories are being collated as part of the on-going process to improve their overall care experience; learning points from these stories are shared throughout the Trust and improvement actions taken if needed.

CQC Compliance monitoring framework

The Trust established a new quality assurance programme in February 2015 in response to the need to continually improve quality and safety within services and in relation to the establishment of the CQC's new operating model and inspection regime effective from 1 April 2015.

Statutory & Mandatory Training

At month 12 the Trust is reporting 87% compliance overall.

Areas for improvement against the 95% compliance target are:

Information Governance (77%), Manual Handling – Object (88%), Manual Handling – Patient (77%), Safeguarding Adults (90%) and Safeguarding Children (89%) Health & Safety (95%) Infection Control (94%)

A **full copy** of the Integrated Quality Report Quarter 4 (2014/15) is available via **this link**.

Recommendations

1. The Trust Board is asked to receive the report for information and assurance.

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: Trust Board (open)

Date of Meeting:	30 July 2015
Title of Report:	Progress update regarding the Service User and Carer Council
Presented by:	Mark Dinwiddy, Interim Director of Nursing and Quality
Author of Report: Name: Date: Email:	 Mark Dinwiddy Mark.Dinwiddy@northstaffs.nhs.uk
Purpose / Intent of Report:	• For discussion and approval
Executive Briefing :	This paper has informed the Quality Committee and subsequently the Trust Board of the work undertaken to develop a Service User and Carer Council (The Council). It is envisioned that The Council will serve as a rich source of consultation, advice and feedback for the Trust. It will enable and enhance the Quality of services that we provide and significantly broaden co-production as the Trust develops and grows new and innovative business. It demonstrates the Trust's commitment to engaging with service users, partners and carers and reflects the Trust's objectives as set out in the Operating Plan 2015/16
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Customer Focus • Clinical • Governance
Relationship with Annual Objectives:	Improve patient experience and pathways Being a high quality health and social care provider
Risk / Legal Implications:	
Resource Implications:	Patient experience lead, post (funded). Director of Nursing, (Existing). Meeting space, (available at Lawton House) Administration, (funded)
Equality and Diversity Implications:	Where necessary, through advocacy, provision has been made to ensure that all members have an equal voice. The voice of children and young people will be supported through The CYP Directorate.
Relationship with Assurance Framework [Risk, Control and Assurance]	The Council provides an additional layer of assurance with Quality initiatives, CIP plans and Business Plans
Recommendations:	The Trust Boad is asked to note and agree the progress and plans to develop The Service User and Carer Council

Report to Quality Committee & Trust Board

Report Title:	Progress report on Service User and Carer Council
Date:	21 July 2015
Presented by:	Mr M Dinwiddy

1. Background

Since January 2015, the Nursing and Quality Directorate has been developing broader patient and carer involvement through all Directorates. Involving people who have used services and those who serve as carers through two engagement events, which have taken place in the Trust Headquarters at Lawton House. Developing a Service User and Carer Council will help to ensure the service user voice and view is incorporated into our everyday business.

The first event served to listen to the patients and carers and gather their views and ideas about how they would wish to engage closer with the Trust. The second event served to crystallise the opinions and share a Terms of Reference for a regular planned Service User and Carer Council meeting.

The Inaugural meeting of The Council is due to take place on the 20th August 2015. Full Patient and Carer involvement from each of the Directorates is anticipated. The meeting will agree a Chair and Terms of reference.

Board representation of The Council chair is anticipated at the September Board of Director's meeting

2. The planned outcomes and purpose of The Council

- The Council will meet every month and will represent all Directorates with one patient and one carer from each of the directorates
- The Council will elect a Chair who will hold position for one year
- The Chair of The Council will be a standing (non voting) member of the Trust Board and it is proposed that they attend both open and closed sessions of The Trust Board
- The Council will be empowered to discuss and comment on Quality issues, Business and financial (Cost Improvement Plans) plans
- The Council will be asked to drive The *Service User Standards* and to hold The Trust accountable for the implementation of *The Service User Standards*
- The Council will be actively engaged in developing assurance for actions arising from Patient audits, surveys and Friends and Family test etc
- The Council will be actively involved in developing new methods to gather customer feedback
- The Council will be empowered to drive co-production in Directorates
- The Council will drive patient participation in all interviews for Trust staff
- The Council will be empowered to recommend ideas and innovations for the use of charitable funding

3. Governance

- The Council will have no delegated authority (as part of the Trust's Standing Orders) or be considered as a subcommittee of the Trust Board
- The Council will be a conduit of information regarding patient and carer issues which can be shared informally through Directorate reporting arrangements through to the Senior Leadership Team and Board Committee meetings.
- The Council will be administered and assisted by The Patient Experience lead

- Members of The Council will be subject to standard Trust Disclosure Barring Service (DBS)

4. Recommendations

The Quality Committee and Trust Board are asked to note the progress made to date and to support the on-going development of greater patient and carer engagement.

Appendix 1 Draft Terms of Reference
Appendix 2 Role description – Expert by Experience Representative
Appendix 3 Feedback from event 2 June 2015
Appendix 4 Introducing the Service User Standards

North Staffordshire Combined Healthcare NHS
NHS Trust

EXPERTS BY EXPERIENCE COUNCIL

TERMS OF REFERENCE

Membership	The membership of The Council will comprise: ▪ 2 Experts by Experience (1 carer and 1 service user or representative of wider group) for each Clinical Directorate. ▪ Healthwatch Staffordshire ▪ Healthwatch Stoke-on-Trent ▪ Representation from Service User and Carer Groups or open membership from Service Users, Carers, advocates, local community and voluntary sector groups. ▪ nominee for each Clinical Directorate ▪ Executive Director of Nursing or Deputy ▪ Non Executive Director ▪ Trust Service User and Carer Experience Lead ▪ As required – representation from Communications Department, Audit Department and others.
In Attendance	Only the Council Chair and relevant members are entitled to be present at a meeting of the Council, but others may attend by invitation of the Council.
Frequency of Meetings	Monthly for the initial first six months and then review with a view to decreasing to bi monthly.
Reporting Arrangements	▪ Reports to the Trust Board ▪ Minutes of meetings shall be formally recorded and submitted to the Trust Board. The Council Chair will draw to the attention of the Trust Board any issues that require disclosure to the Trust Board or require Executive action. ▪ The Board will report back to The Council via the Council Chair and Director of Nursing who will both have a seat on the Board. ▪ Relevant papers will also be distributed accordingly. ▪ Annual report to the Trust Board on actions taken to comply with terms of reference.
Review Date	▪ Initial six month review with a view to reducing to annually.

EXPERTS BY EXPERIENCE COUNCIL

TERMS OF REFERENCE

1. Constitution

The Trust Board hereby resolves to establish an Experts by Experience Council (hereafter referred to as The Council).

2. Membership

The membership of The Council will comprise:

1. Experts by Experience including Service User & Carer representation for each Clinical Directorate
2. Healthwatch Staffordshire and Healthwatch Stoke-on-Trent
3. Representation from Service User and Carer Groups or open membership from Service Users, Carers, advocates, local community and voluntary sector groups and other people interested in the work of the Trust.
4. Nominee for each Clinical Directorate
5. Executive Director of Nursing or Deputy
6. Non Executive Director
7. Trust Service User and Carer Experience Lead
8. As required representation from Communications Department, Audit Department and others.

In the absence of The Council Chair and Vice Chair members present will elect one of themselves to chair the meeting.

All members appointed to The Council must undergo a Disclosure and Barring Service screening via the Trust's Human Resources Department. Due consideration will be given to this requirement not creating a barrier to potential members. This will require confidiential discussion with the relevant individual and Trust representatives.

All Members appointed to The Council must sign a confidentiality agreement. To support effective and appropriate sharing of information relating to both Council and Directorate meetings an information summary sheet will be produced following each meeting. This will clearly outline what information may be shared and the scope of sharing. This will be determined by the relevant meeting Chair and Council member.

The Trust's Service User and Carer Lead or their nominee will act as an administrator to The Council.

3. Frequency of Meetings and Required Frequency of Attendance

The Council will meet monthly for the initial first six months and then review with a view to decreasing to bi monthly.

Members of the Council should attend regularly.

4. Attendance

Only the Council Chair and relevant members are entitled to be present at a meeting of the Council, but others may attend by invitation of the Council.

5. Authority

The Council is authorised by the Trust Board to consider any activity within its terms of reference**.**

6. Duties

Service Users and Carers are experts by experience; equally their judgements may be informed by the care they witness others receiving. Their experiences, both good and poor empower them to be meaningfully involved in discussions around quality, experience and service improvement.

The Experts by Experience Council will:

- Promote service user and carer involvement in Trust activity at all levels.
- Seek assurance that the Trust has effective mechanisms and systems in place to capture the experiences and views of service users and carers, identifying and responding to any emerging themes or trends.
- Represent the views of service users and carers and where appropriate seek the views and feedback from other relevant local and national groups.
- Contribute to each of the Clinical Directorate meetings; offering contributions, ideas and opinions which reflect the voice of service users, carers and their families opposed to individual voices.
- To receive and monitor progress against the delivery of the Trust's Patient and Carer Experience Strategy.
- Consider the impact of Trust policies and strategies for service users and carers.
- To contribute to the development of Trust policies and strategies ensuring appropriate consideration is given to the needs of service users and carers.
- Work on projects which have been identified as an area of focus by the membership and agreed by the relevant Board or Group Chair. This may sometimes require collaborative working with other Board or Group members and at other times working autonomously.
- Receive and scrutinise information (including compliments) from the Complaints and Patient Advice & Liaison Service (PALS)
- Receive and scrutinise results of any national or local patient, carer or staff audits and surveys.
- Participate in service user led inspections of care and service reviews including Board to team visits and Patient Led Assessment of the Care Environment (PLACE).
- Participate in the recruitment and selection process for new staff appointments.
- Participate in the selection committee for the annual staff REACH awards (Recognising Excellence and Achievement in Combined Healthcare).
- The Chair of The Council will have a (non-voting) seat on the Trust Board.

7. Reporting Arrangements

The minutes of Council meetings shall be formally recorded by the Trusts Service User and Carer Lead or their nominee. Copies of the minutes of Council meetings shall be available to

all Council members, Trust Board, Clinical Directors, Head of Directorates and others accordingly on request.

The Trusts Service User and Carer Lead will prepare a report to The Trust Board after each meeting of The Council. The Council Chair will draw to the attention of the Trust Board any issues that require disclosure to the Trust Board or require Executive action.

The Board will report back to the Council via the Council Chair and the Director of Nursing who both have a seat on the Board. Relevant papers will also be distributed accordingly.

8. Compliance and Effectiveness

The Council must produce an annual report to the Trust Board on the actions taken by The Council to comply with its terms of reference. The report will also include information about Council Member's membership and attendance at any other Trust meetings.

9. Administration

The Council shall be supported administratively by the Trusts Service User and Carer Lead or their nominee, whose duties will include:

- Ensuring appropriate secretarial support is in place to take the minutes and keep a record of matters arising and issues to be carried forward. Minutes shall be recorded and circulated accordingly within 10 working days.

- Agreeing an agenda with The Council Chair and collation of papers. Items for inclusion within the agenda shall be submitted two weeks prior to a meeting. Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items for discussion shall be forwarded to each member of The Council no later than 5 working days before the date of the meeting. Supporting paper shall be sent to Council members and to other attendees as appropriate at the same time.

- Preparing reports to the Trust and relevant Clinical Directorates after each meeting of The Council.

- Offering support as required re any other areas determined by The Council.

10. Requirement for Review

The Terms of Reference will initially be reviewed after the first six months of the Council being established with a view to reviewing annually.

North Staffordshire Combined Healthcare NHS
NHS Trust

Role Description - Expert by Experience Representative

North Staffordshire Combined Healthcare NHS Trust (NSCHCT) values the unique perspective that Service Users, Carers and advocacy groups (Experts by Experience) bring to our Boards and Groups. They are experts by experience. We believe experiences; both good and poor empower individuals to be meaningfully involved in discussions around quality, experience and service improvement.

Title: Expert by Experience (Service User / Carer /Advocacy Group Representative

Time commitment: Up to three days per month (depending on level of involvement)

Venue: Will depend on which meeting

Expenses: Out-of-pocket expenses for travel and carer arrangements

Accountable to: Relevant Board or Group Chair

Supported by: Relevant Board or Group Chair and Service User and Carer Experience Lead

Tenure of office: Up to 3 years (extension/renewal will be through mutual agreement with relevant Board or Group Chair)

NSCHCT Expert by Experience (Service User / Carer Representative) Role

- Expert by Experience Representatives are invited to be involved in the Trusts Clinical Directorate meetings.
- The Chair of The Expert by Experience Council will be invited to be a (non voting) member of the Trust Board.
- Expert by Experience Representatives are invited to participate in patient led inspections of care and service reviews including Board to team visits and Patient Led Assessment of the Care Environment (PLACE).
- Expert by Experience Representatives are invited to participate in the selection committee for the annual staff REACH awards (Recognising Excellence and Achievement in Combined Healthcare).

Specific Roles and Responsibilities for Expert by Experience Representatives

Expert by Experience Representatives are valued members of the Board or Group and have the full support of the relevant Board or Group Chair. The Chair will meet with existing or

potential Representatives accordingly; should they require information or support around their role. This is in addition to the Trust's Service User & Carer Experience Lead who will be available to provide support and assistance as required.

Experts by Experience will:

- Contribute to each of the Clinical Directorate meetings; offering contributions, ideas and opinions which reflect the voice of Service Users, Carers and their families opposed to individual voices.
- Promote Service User and Carer involvement in Trust activity at all levels.
- Seek assurance that the Trust has effective mechanisms and systems in place to capture the experiences and views of Service Users and Carers, identifying and responding to any emerging themes or trends.
- Represent the views of Service Users and Carers and where appropriate seek the views and feedback from other relevant local and national groups.
- To receive and monitor progress against the delivery of the Trust's Service User and Carer Experience Strategy.
- Consider the impact of Trust policies and strategies for Service Users and Carers.
- To contribute to the development of Trust policies and strategies ensuring appropriate consideration is given to the needs of Service Users and Carers.
- Work on projects which have been identified as an area of focus by the membership and agreed by the relevant Board or Group Chair. This may sometimes require collaborative working with other Board or Group members and at other times working autonomously.
- Receive and scrutinise information (including compliments) from the Complaints and Patient Advice & Liaison Service (PALS)
- Receive and scrutinise results of national and local Service User and Carer or staff audits and surveys.
- Participate in patient led inspections of care and service reviews including Board to team visits and Patient Led Assessment of the Care Environment (PLACE). Council members may choose to develop sub committees to help support in these roles.
- Participate in the selection committee for the annual staff REACH awards (Recognising Excellence and Achievement in Combined Healthcare).
- Participate in the recruitment and selection process for new staff appointments.
- Identify personal training needs and attend training provided accordingly.
- Provide a commitment to the Board or Group, attending as many meetings as possible and acting as a representative of the Board or Group when required
- Not take on projects, which they feel are outside of their remit, beyond their skill or knowledge level, or would require a time commitment which they are unable to keep.
- Expert by Experience Representatives will be asked to sign a confidentiality agreement.

    - To support effective and appropriate sharing of information relating to both Council and Directorate meetings an information summary sheet will be produced following each meeting. This will clearly outline what information may be shared and the scope of sharing. This will be determined by the relevant meeting Chair and Council member.

- Expert by Experience Representatives will require a Disclosure and Barring Screening. Due consideration will be given to this requirement not creating a barrier to potential members. This will require confidential discussion with the relevant individual and Trust representatives.

Expert by Experience Representative Person Specification

Experience:

- A current or previous Service User of NSCHCT mental health, specialist learning disability or substance misuse services (or similar services) or member of an advocacy group representing the wider voice of a group.
- A Carer for current or past Service Users of Trust or similar services.

[In some instances Boards or Groups may seek individuals who have more recent experience of services who will present a more up-to-date view of current provision and issues. This will need to be looked at on a case-by-case basis, but in general no specific experience of being a member of a committee previously is required].

Skills and aptitude

- Good communication skills (support will be available as required)
- Ability to form and maintain positive working relationships in challenging circumstances
- Ability to distinguish between personal and representative views
- Good time management skills

Personal qualities

- Assertiveness and confidence to raise issues and challenge in meetings
- Sensitivity and compassion
- Reliability
- Flexibility
- Resilience and tenacity
- Aware of impact of own behaviour on others
- Openness and transparency
- Ability to consider the majority view
- A commitment to connecting with local representative groups including Healthwatch

Knowledge

- Knowledge of NSCHCT values

Trust Commitment

In return for their valuable contribution, NSCHCT commit to the following;

- Invite and welcome open and honest feedback from our Experts by Experience Representatives.

- Ensure Service Users & Carers have the opportunity and the time to contribute to decision making.

- Consider Service User and Carer Representatives as full members of any meetings for which they are part of the agreed membership. The Chair of the Expert by Experience Council will be invited to be a member of the Trust Board meeting.

- Ensure meetings are held at accessible locations with adequate refreshments. Meetings will be arranged at the most convenient time for the entire membership.

- Reimburse any travel and carer expenses accrued getting to and from NSCHCT meetings, in line with the Trust's reimbursement policy.

- Ensure the language used in meetings is as accessible as possible. Where necessary, terms will be explained.

- Respond to any identified training needs as and when Representatives request, this may include informal shadowing and observation.

- Respond to queries and requests from Representatives in a timely and efficient manner.

North Staffordshire Combined Healthcare NHS
NHS Trust

Patient Council Development Event 2 June 2015

Feedback Draft Terms of Reference and Representative Role Description

- **Terminology for Representative Role**: A number of people said they preferred the term 'Expert by Experience' opposed to 'Service User' or 'Carer' – it was also felt that this is a more inclusive term for potential Council members who may not have accessed services but are representing the wider voice of others e.g. Reach advocacy service for people with a learning disability and that the terms of reference reflect this.

- **Membership:** How will members of the Council be selected? Can we draw from existing forums to identify members initially?

  Outcome: A discussion followed with the agreed outcome that yes, appointment of members of the Council should be through nominations from existing forums and groups, this will include Reach advocacy group (as discussed earlier during the event). This will be with the exception of the Trust's Substance Misuse Directorate which already has a very successful and established service user group known as New Beginnings. Some members of New Beginnings are willing to become members of the wider Trusts Patient Council and Substance Misuse Directorate meeting.

- **Question:** How many Council representatives will be members of each clinical Directorate meeting?

  Outcome: It was agreed that two Council members, one service user and one carer representative will be members at each clinical directorate meeting.

- **Question**: What about individuals who are not members of a representative group or forum, can they put themselves forward to be a member of The Council opposed to being nominated via a representative group?

  Outcome: The person could contact the relevant representative group to discuss further and express their interest in being nominated.

- **Question:** Some carer/service user representative may have experience of more than one Directorate e.g. inpatient and community. Can we clarify if carers/service users will be part of the membership as well as representatives from carer / service user organisations?

  Outcome: Comments made by some people who are already members of other organisations/groups, general feeling that this is not an issue as long as the person has adequate

time commitment. Conflict of interest was not seen to be an issue as long as the person is open about their membership of other groups etc.

- **Neuro and Old Age Psychiatry Directorate (NOAP):** A number of people commented on the diversity of this directorate and suggested that there be 2 representatives for each broad speciality, i.e. Neuro Psychiatry and Older Persons Psychiatry. An example of this being the Huntington Society and Age Concern. This may also be very applicable within the Children's Directorate for the same reasons.
-
- **Outcome:** Agreement that wider representation maybe applicable for both of these Directorates, this will be fed back to the relevant Clinical Directors and Head of Directorates.
-
- **Meaningful Involvement of Young Carers**: Further discussion around the involvement of young carers via North Staffs Carers Association. It was noted that young carers maybe very involved in caring / supporting adult relatives accessing trust services or similar and that their role and contribution to the Council should not be overlooked.

  Outcome: To ensure meaningful representation of young carers on the Council, with support accordingly**.**

- **Frequency of Council Meetings:** Agreement that meetings are held monthly for the first six months until the forum has become established. A six monthly planned review of the Patient Council will include reviewing the frequency of meetings.

  Outcome: Review after six months, Council Chair and Trust Service User/Carer Lead to action.

- **Reporting Arrangements:** How does the Board feedback to Council? (Two way process of sharing information)

  Outcome: The Chair of the Council will have a seat on the Board; this should support effective two way communication alongside the Director of Nursing and Quality who will also attend both Council and Board meetings. The effectiveness of this can be included within the planned first six monthly review of the Council effectiveness. Relevant papers will also be distributed accordingly.

- **Question:** How do current forums / groups feed into The Council?

  Outcome: If the member is from an existing forum or group this will help to facilitate this. This will be revisited as part of the planned six monthly review of the Council.

- **Tenure:** A general discussion and agreement that members serve for 2/3 years opposed to one year in office (1st year grow into role, 2nd year 'doing' the role, 3rd year allowing for good succession/transition planning) The Council needs to shape and grow but there must be a balance to this with clear succession planning, if everybody leaves at the same time all knowledge and skills lost. This would also allow opportunity for adequate promotion and recruitment in to planned vacancies (supporting a rolling programme of interested parties).

Duties: How much activity are we expecting carers/service users to participate in e.g. meetings, patient led inspections of care, board to team visits etc. – can activity be shared amongst sub groups?

Outcome: The terms of reference state that The Council shall have the power to establish sub-committees for the purpose of addressing specific tasks or areas of responsibility. This will be revised to be more specific around the activities referred to.

Other Comments

- **Personal qualities / skills / aptitude:** Comments made that current draft is too specific and that a more important attribute for the council member is empathy and understanding opposed to report writing skills etc.

  Similarly it was not felt necessary to include the following section in the role description:

  Keep abreast of local and national news and developments regarding healthcare policy and patient /carer experience, considering the impact of this on the activities of The Council, Board, Committee or Group they may be members of.

  Outcome: To be withdrawn.

- **Time to plan and prepare:** Key issue re receipt of timely and accessible information (not last minute) and time to prepare work and engage (e.g. Reach service commented that up to 3 days work may be required to help adequately plan and engage in 1 meeting)
-
- **Outcome:** The trust will work in partnership with all individuals/groups to acknowledge, respect and support this.
-
- **Expenses:** Need to add opportunity for sitting service as well as out of pocket expenses for carers.

  Outcome: The Trust will work in partnership with all individuals/groups to acknowledge, respect and support this. Review of existing trust policies to ensure supportive of this and amend if required.

- **Confidentiality Agreement:** Suggestion made that following each Council or Directorate meeting a summary document be produced clearly identifying what information may be shared by Council members (including scope of sharing). Sue Batnak, Healthwatch Staffordshire kindly offered to share the protocol/initiative that Healthwatch Staffordshire currently have in place for Healthwatch meetings, this could be adapted for use by the Council.

  Outcome: The Trust will ensure that this is supported, liaise with Healthwatch Staffordshire and include in the initial six month review of the Council.

- **Disclosure and Barring Service:** (replaced former CRB check) stated as requirement on the role description, this was felt to be important and must remain but due consideration be given to not putting people off.

Outcome: Trust to discuss further with Human Resource team and feedback.

- **Involvement in staff recruitment:** Comment that this is not currently included in duties of Representative role, to be included.

  Outcome: To be included in the Terms of Reference and Role Description

- **Participatory active model required:** Comment; don't want to become professional meeting goers. People want to see action.

  Outcome: The Trust supports this and likewise wants to see action opposed to members 'just attending meetings' The Trust acknowledges that the Council needs to 'evolve and grow' over time, and that its direction of travel should be shaped by the its members. Initial six monthly will be helpful in determining this.

North Staffordshire Combined Healthcare NHS
NHS Trust

Caring for & Caring About

Care Compassion Competence Communication Courage Commitment
are
is our business

Supporting the 6 Cs

"One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient."

Peabody 1927

Introducing our **Service User Standards**



your values

valuing people as **individuals**
working together for better lives
openness and **honesty**
providing high quality **innovative care**
exceeding expectations

Contents

Introduction from our **Chairman & Chief Executive**

Ken Jarrold CBE
Trust Chairman

Caroline Donovan
Chief Executive

Introducing Our Service User Standards **'Caring for and Caring About'**

At North Staffordshire Combined Healthcare NHS Trust, we are committed to providing our local communities with safe, high quality effective care, where our service users truly feel cared for and cared about.

Doing the right thing at the right time and getting it right the first time for our service users is priceless. Solving issues before they happen, takes less time than resolving them afterwards. With that in mind we are delighted to introduce our service user standards 'Caring for and Caring About'.

Our standards are underpinned by 'The 6Cs' care, compassion, competence, communication, courage and commitment and support our commitment to every one of our service users, every day, wherever they may be accessing services, to do our best to ensure…

You feel safe, in a clean and comfortable environment, with professional staff working together and with you to ensure you are in 'safe hands'.

You feel cared about, with kind and helpful staff with a courteous and respectful attitude towards you, listening and keeping you involved and informed at every step.

You have trust and confidence in your care and treatment, provided by competent, skilled and compassionate staff

Service Standards for Everyone

These standards apply equally to all of us, every day, in everything that we do. They support us to be more consistent in what we do and say to provide a good experience for our service users, carers and colleagues, regardless of our role. The boxes below add further context to each of our standards.

You feel safe, in a clean and comfortable environment, with professional staff working together and with you to ensure you are in 'safe hands'.

You feel cared about, with kind and helpful staff with a courteous and respectful attitude towards you, listening and keeping you involved and informed at every step.

You have I trust and confidence, in your care and treatment, provided by competent, skilled and compassionate staff.

1. Cleanliness

2. Behaviour

3. Honest & Open

4. Courteous & Respectful

5. Communicate & Listen

6. Helpful & Kind

7. Informative

8. Timely

9. Compassionate

10. Continuous Improvement through listening and responding

1. Cleanliness

Supporting the 6 Cs – Care, Competence, Commitment

This means every one of us is vigilant across all aspects of safety, practices hand hygiene and shows attention to detail for a clean, safe and tidy environment wherever we work.

A safe, clean, comfortable environment…

…Instills trust and confidence

Do....	Don't....

Seen to be clean

- Practice hand hygiene; encourage colleagues/visitors to do so too.
- Let service users see/know you have washed your hands.
- Show attention to detail in cleaning
- Ensure equipment is safe & clean.

"I've just washed my hands, but I'm happy to wash them again if you want me to."

- Don't be frustrated with service users if they ask you to wash your hands again
- Don't only clean what's seen.
- Don't eat or drink in clinical areas.

"No need, I've already washed my hands."

Safe practice

- Always put service user safety first
- Follow all service user safety and infection control procedures.
- Ensure safe use of equipment, have you been trained?
- Speak up if you believe service user safety is being compromised.

"Wait, safety comes first for all of us."

- Don't tolerate unsafe practice in any circumstances e.g. to meet a target.
- Don't criticise others for speaking up on behalf of service user safety.

"Carry on, there's a lot to do."

Pride of place

- Take pride in having a clean, safe, tidy environment – not just your area but across all trust services.
- Tidy up litter and clutter if you see it, or immediately report it to the appropriate department to respond.

"We're all responsible for maintaining a safe, clean comfortable environment."

- Don't just leave rubbish in the corridor
- Don't walk passed rubbish or clutter without tidying up.
- Don't leave it for the cleaner, if you can clear it up straight away.
- Don't assume it is somebody else's responsibility

"Leave it, it's not our job."

2. Behaviour

Supporting the 6 Cs – Care, Competence, Commitment

It's important that every member of staff behaves professionally at all times. This has a strong positive impact on service user and carer experience.

Experiencing professional and considerate behaviour means feeling valued and safe…

…Professional behaviour reassures service users and their carers

Do....	Don't....

Behave professionally

- Imagine anywhere service users or carers could see or hear members of staff as a 'stage' on which we must act professionally.
- Concentrate on work at work.
- Wear smart, clean and appropriate dress/ uniform to create a professional impression.

"I'm not sure that's appropriate to discuss here, tell me later."

- Don't cause service users and carers to worry unduly through unprofessional behaviour e.g. criticising colleagues, processes or the organisation.
- Don't make service users and carers feel they don't have your full attention by talking with other staff members about your personal life.
- Don't argue in front of service users or carers.

"That team is always a problem."

Never "too busy" to care

- Ensure service users and carers feel we have time to listen & respond to their needs.
- Keep a positive & calm demeanor in front of service users and carers.

"How can I help? This can wait until later"

- Don't say you are 'busy', service users and carers may worry about quality of care, or keep quiet when they need something for fear of burdening you.
- Don't pass your stresses onto service users and carers.

"You're not my patient."
"We are all rushed off our feet."

Business away from the bedside

- Take conversations about operational matters away from service user and carer earshot, so they don't worry unduly.

"I'll just pop into the office so we can talk about this."

- Don't have conversations about work that may cause service users and carers to worry –anywhere you can be overheard.

"I'm two nurses short on the ward."

3. Honest & Open

Supporting the 6 Cs – Care, Competence, Commitment

Who is the most important person at work, your colleague, your manager or your service user?

Have courage and confidence to challenge and make a difference.

Be prepared to challenge Inappropriate staff actions and behaviour…

…Not all people have a voice

Do....	Don't....

Speak up

- Straightaway when our standards are not being met, when service user safety or experience is compromised.
- Acknowledge and be appreciative when people do a good job or go out of their way.
- Make sure care is personalised, current and in accordance with best practice, guidance and standards.

"Could that have gone differently?"

- Don't ignore any poor behaviour or practice.
- Don't assume somebody else will or is dealing with poor behaviour or practice.
- Don't inappropriately use standardised care plans – care plans should be personal and needs led.
- Don't just speak up around negative issues – it's important to acknowledge good practice too.

"She's like that, she'll never change."

Open to challenge

- Ensure service users and carers feel we have time to listen/respond to their needs.
- Keep a positive/calm demeanour in front of service users and carers.

"Thanks for the feedback. That's really made me think about my actions."

- Don't take feedback as criticism.
- Don't believe that you can't change your behaviour, or blame others when you take responsibility.

"Who are you to tell me?"
"I can't change who I am."

Apologise

- Take conversations about operational matters away from service user earshot, so they don't worry unduly.

"I'm sorry about that. I can see how it has upset you."

- Don't dismiss other people's views or feelings, when they are upset
- Don't tell people to "calm down" (it has the opposite effect)
- Don't blame others.

"It's not my fault."

4. Courteous & Respectful

Supporting the 6 Cs – Care, Compassion and Communication

Whatever our role it is often the smallest things that have the biggest impact on service user and carer experience, things like welcoming and introducing yourself to service users and carers.

"*Hello my name is…* I'm one of the doctors who will be looking after you on the ward while you are with us. How are you feeling today?"...

... A warm welcome and introduction are so important

Do....	Don't....

Positive welcome

• Give an instant welcome, make eye-contact, appropriate smile. • Introduce yourself by name and role - demonstrate a willingness to help. • Make sure people know who their Named Nurse is and how to contact Matron, PALS, how to make a Compliment or complaint.	• Don't make people wait more than 5 seconds to know you've seen them. • Don't use closed body language • Don't talk to other people about unrelated issues. • Don't assume people will understand the roles of all staff/disciplines. • Don't be dismissive of other colleagues.
"Hello, I'm …... I'm here to…"	**"What do you want? I'm busy"**

Respect for individuals

• Ask permission /consent e.g. using 'may I' before anything you do • Address them by preferred name • Talk directly with people • Use common courtesies like 'please', 'thank you' and 'after you' • Respect and be responsive towards diversity and difference.	• Don't assume you can 'do to' people without their permission or consent • Don't use belittling/over-familiar names e.g. 'duckie', 'darling', 'sweetheart' • Don't talk over service users or depersonalise them as a condition or 'an incident' • Don't assume people should be grateful.
"May I take some details from you?"	**"What do you want?"**

Privacy and dignity

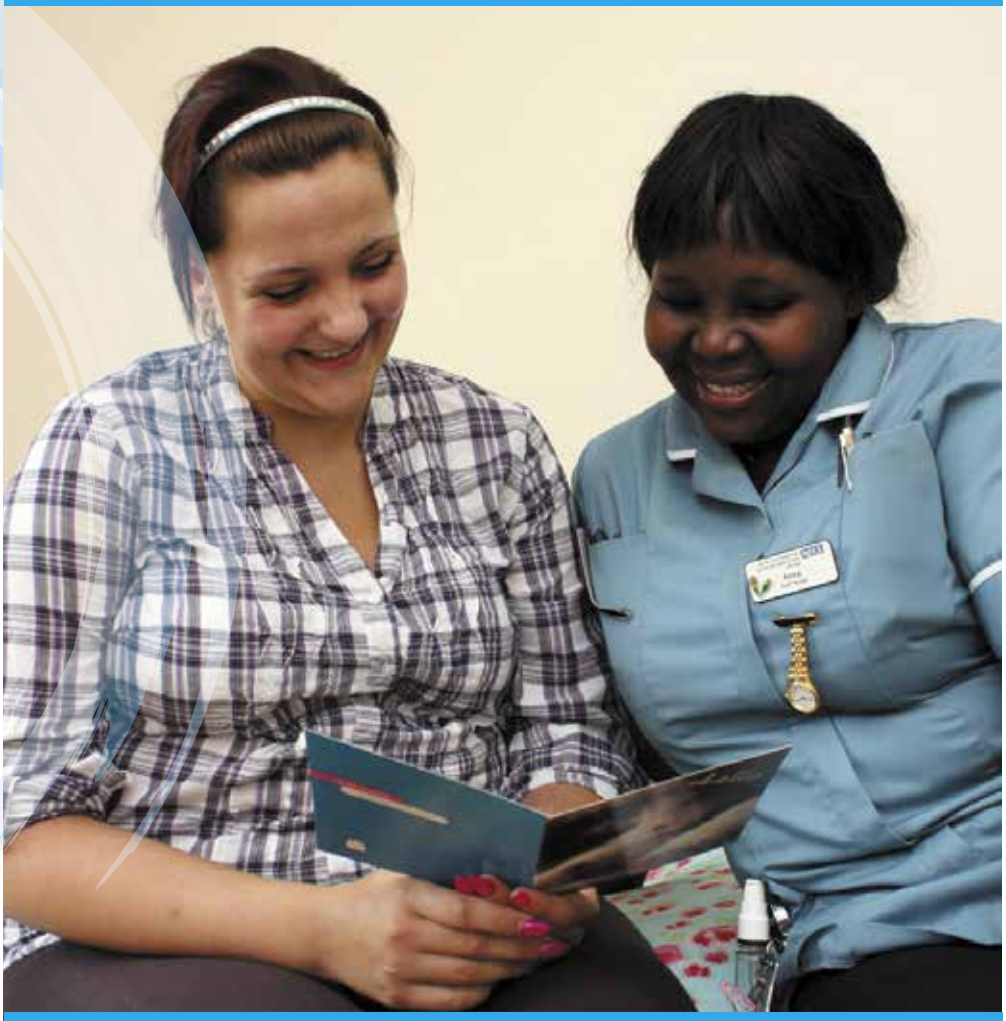
• Respect privacy and personal space; seek permission before entering bedrooms, bathrooms, etc. • Ensure bathrooms are clean tidy and stocked appropriately. • Ensure service user information is collected, utilized and stored appropriately at all times to maintain confidentiality	• Don't forget service users are all people • Don't pass the buck or blame other people. • Someone else will get a toilet roll.
"I can imagine that was upsetting."	**"Wait in there."**

5. Communicate & Listen

Supporting the 6 Cs – Care, Compassion and Communication

Communication is central to successful caring relationships and effective team working. Listening is as important as what we say and do.

Clear communication means understanding and feeling understood...



... Take time to listen and explain

Do....	Don't....

Listen and ask open questions

• Interact with service users and carers purposefully, using open questions. • Use active listening skills to check understanding and expectation. • Adapt your verbal and non- verbal communication accordingly.	• Don't ask closed questions starting with 'is', 'are', 'do', 'can' which people can answer with just 'yes' or 'no' (other than when clinically necessary) ask open questions starting with 'how' or 'what' • Don't assume you know the answer.
"How are you feeling?"	**"Are you feeling alright?"**

Keep people in the loop

• Let people know what's happening now, and what will happen next. • Keep people in the loop when they are waiting e.g. a clinic or ward round running late. • Provide timely, clear, accurate information in a meaningful format. • Where appropriate use technology and social media to improve care and access to services.	• Don't leave service users waiting or worrying without knowing what's going on. • Don't ignore service users who are out of sight.
"I'm sorry but the doctor has been delayed by ten minutes"	**"You don't need to know that"**

Smooth handovers

• Ensure good documentation and record keeping, it's essential. • Communicate/collaborate with MDT & others as required. • Ensure you are up to date, read notes, ask colleagues for an update. • Give a thorough handover to incoming staff, clarifying any questions or concerns they have. • Let service users see that staff are communicating well with each other.	• Don't expect a colleague to pick up from you without a briefing, or leave it to them to pick up the pieces • Don't make service users and carers feel worried that teams aren't communicating.
"Your nurse has updated me."	**"I didn't have time to read the notes."**

6. Helpful & Kind

Supporting the 6 Cs – Care, Compassion and Communication

Look out for and respond to people who need help.

Helpful and kind staff help to create a positive experience...

... Make a difference
Don't wait to be asked

Do....	Don't....

Be ready to help

- Look out for people who need help or a word of re-assurance
- Look out for people who seem lost, or hesitant. Be proactive and helpful; ask if you can help them.
- Attend to small details that are important to support a positive service user and carer experience.

"Is there anything I can do to help you?"

- Look the other way or avoid eye contact to avoid helping people
- Ignore service users, carers or colleagues so they feel invisible or unimportant.
- Ignore people who need your help.
- Wait to be asked.

"She'll shout if she really needs me."

Take ownership

- Take ownership to quickly address peoples practical needs
- Be responsive, if it's safe to do so
- If you can't do it, find someone who can and check later it's been done

"Leave that to me."
"I'll find someone who can help you."

- Don't assume someone else will do it
- Don't tackle a task you're not skilled to handle, or just ignore it
- Don't abdicate responsibility e.g. "she's not my patient, I can't help you"

"That's not my job."

Keep your promises

- Make promises you can keep, and keep them.
- Be someone people can rely on, who does what they say they will.
- Go the extra mile when it's important for service users and their carers.

"Leave that with me."

- Don't make empty promises, or say you 'might' be able to help, e.g. promise to 'be back in 5 mins' but never return
- Don't set unrealistic expectations

"I might be able to…."

7. Keeping People Involved & Informed

Supporting the 6 Cs – Care, Compassion, Competence, Communication and Commitment

Involve service users as partners in their own care; "no decision about me without me".

Support Carers through early identification, involvement and support.

Keeping people informed and involved...

... Leads to empowerment

Do....	Don't....

Clear explanations

• Explain things to service users and their carers in a meaningful way. • Provide timely information in a meaningful format. • Set clear service user expectations • Ensure all staff are familiar with the trust's 'Carers Charter' – early identification, involvement and support, is this clearly displayed?	• Don't assume people know what is happening to them. • Don't assume people share your expert level of understanding. • Don't assume they aren't confused, anxious or frightened.
"Let me know if there's anything at all you are not clear about."	**"I won't bore you with the details." "You don't need to know that."**

What is going to happen to me?

• Actively involve people in decisions about their care and treatment, explain & discuss the options. • Explain what will happen during treatment and the risks/benefits. • Describe how they might feel • Check service users are involved with and clear about their plan of care, including what they can do to aid their recovery.	• Don't assume you know what the service user will want to include/do. • Don't assume because you've said it, the person has to understood, as they may be too ill, stressed, and anxious to take it in.
"You may feel nauseous, if you do let us know and we will help you with this."	**"You will feel nauseous."**

Any other questions?

• Give people the chance to ask all the questions: e.g. 'What other questions do you have?' • Give service users an opportunity to talk about their fears and worries.	• Don't cut service users off before they have asked all their questions e.g. 'any questions?' (looking at your watch). • Don't dismiss patients fears (you may see this every day, but they don't).
"What other concerns do you have?"	**"No questions then?"**

8. Timely

Supporting the 6 Cs – Care, Compassion, Competence, Communication and Commitment

For service users to engage with their treatment it has to fit into their lives. Offering choice and flexibility around appointments and visiting time's increases engagement.

"When would be best for you?"

...Choice and flexibility increases engagement

Do....	Don't....

Prompt attention

- Respond as quickly as you can to service users' needs, provided it's safe to do so.
- Prioritise service user needs over admin that could wait for a few minutes.
- Arrive on time for meetings/clinics.

"How can I help you? I can finish up this filing later."

- Don't waste other people's time by being late for meetings or appointments
- Don't leave phones unanswered

"I'll finish this typing before I look up."

Value patients' time over our own convenience

- Engage in proactive planning
- Strive to continuously reduce waiting time for appointments.
- Look for ways to reduce unnecessary waiting.

"If we start planning now you'll be able to go home sooner."

- Don't arrange things around the services convenience.
- Don't tackle the symptom without addressing the cause e.g. double booking patients rather than reducing DNA rates

"You'll just have to wait."

Choice and flexibility

- Recognise that for service users to engage with their treatment it has to fit into their lives
- Offer a choice of appointments and visiting times to suit service users and their carers.

"When would be best for you?"

- Don't expect service users to go out of their way to fit into our processes.

"You have to fit in to our timetable."

9. Compassion

Supporting the 6 Cs – Care, Compassion, Competence, Communication and Commitment

Compassion helps create a meaningful caring relationship, paving the way for the development of trust.

This is how I would want my Gran to be treated...

...Feeling respected means being valued as a unique individual

Do....	Don't....

Dignity of the whole person

- Consider service users and their carer's feelings, especially when people are facing difficult situations/news.
- Imagine how you would want one of your loved ones to be treated.
- Ensure that all care environments protect the privacy and dignity of service users.

"How can I help you? I can finish this filing later."

- Don't treat people as just a condition
- Don't assume people would feel the same as you.
- Don't just think compassion applies to service users and their loved ones; we need to support our colleagues too.

"I know exactly how you feel."

Considerate

- Let people know you are caring e.g. "I'll close the door to give you some privacy"
- Show empathy "I understand this is difficult for you"
- I'll make sure nobody disturbs you.
- Be ready to be sensitive and supporting.

"May I spend some time with you to talk about your treatment options?"

- Don't talk unnecessarily to someone else whilst supporting a service user.
- Don't allow operational issues to be an excuse for being rushed and short with service users.

"You'll have to wait".

Pain is personal

- Acknowledge that the pain people feel is real to them.
- Reduce service user's pain as quickly as you can and without fuss.

"Let's help with your pain now."

- Don't trivialise service user's pain.
- Don't let processes be an excuse for leaving a service user in pain (but do remember to put safety first)

"Your pain can't be that bad."

10. Continuous Improvement through Listening and Responding

Supporting the 6 Cs – Care, Compassion, Competence, Communication, Courage and Commitment

We are all responsible and accountable for service improvement.
Listen, respond and make a difference.

Improvement is everyone's responsibility...

...Keep listening
...Keep responding

Do....

Don't....

Make sure

- All staff are fully aware of the Trust's Patient Advice and Liaison Service (PALS), complaints procedure and any other local and national feedback systems (i.e. NHS Choices, North Staffs User Group, service user & carer groups/ meetings, local support networks etc.
- Supportive information is available to distribute to service users and carers.
- All staff have attended 'Listening & Responding' training.
- Service users know who to speak to and how to contact them re any concerns they may have etc.
- You make time to listen to service user and carer feedback.
- All feedback is acknowledged shared and actioned accordingly within the team, celebrate and share positive feedback.

- Dismiss or ignore service user feedback as being irrelevant.
- Fail to respond to feedback when you have told a service user you will.
- Blame other colleagues or teams
- Rely solely on others to devise and implement feedback systems.
- Assume one feedback mechanisms will suit everyone.
- Let supplies of supportive information leaflets become depleted/out of stock.

"Let me provide you with a copy of our feedback leaflet".

"What do you expect, we can't do everything".

Getting it Right - Service User / Carer Compliments

Getting it right not only supports a positive experience for our service users and carers but also helps to promote a positive working environment for our staff. Below are some examples of compliments received:

"I feel safe"

"I was given full information about what was going to happen during my stay on the ward".

"It has been an enormous comfort for the way that I have been treated during this time. I have been looked after in such calm, tranquil surroundings and by such dedicated and caring people".

I have been impressed with the standard of cleanliness at the Harplands; it is the cleanest hospital I have ever seen".

"I feel cared for and about"

"I was scared and I will never forget one of the nurses coming to me and giving me a poster that said 'Because you're worth it' - it was a silly little thing but it really lifted my spirits and made me feel worthwhile".

"A massive thank you, you have cared, helped and at the same time made me find my smile again".

"It's nice to have X back on reception, she is always friendly when we come for our appointments. We feel welcome."

"I have trust and confidence"

"Just knowing that you have that level of trust and support is everything; they listen, understand and always take the right action. We have every confidence in them."

"We had total trust in the service; we always felt involved and listened to, the staff were interested in what we had to say."

"Whilst my husband was on the ward he went through some bad occasions, with his illness but I always felt that he was totally looked after and treated with respect, nothing was ever too much trouble."

Notes

North Staffordshire Combined Healthcare NHS
NHS Trust

Introducing Our Service User Standards
'Caring for and Caring About'

These standards apply equally to all of us, every day, in everything that we do. They support us to be more consistent in what we do and say to provide a good experience for our service users, carers and colleagues, regardless of our role.

Designed and printed by Impressions Design & Print • Tel: 01270 767661 • www.impressionsprint.co.uk

North Staffordshire Combined Healthcare NHS
NHS Trust

General Enquiries
Email: **communications@combined.nhs.uk**
Phone: **01782 273510**
Trust Headquarters, Bellringer Road, Trentham, Stoke-on-Trent, ST4 8HH
www.combined.nhs.uk

your values

valuing people as **individuals**
working together for better lives
openness and **honesty**
providing high quality **innovative care**
exceeding expectations

Enclosure 10

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: Trust Board

Date of Meeting:	30 July 2015
Title of Report:	Kate Lampard Report into the Actions of Jimmy Savile
Presented by:	Dr Buki Adeyemo, Medical Director Mark Dinwiddy, Interim Director of Nursing
Author of Report: **Name:** **Date:** **Email:**	Annie Roberts & Vicky Baxendale
Purpose / Intent of Report:	~~• For Decision~~ ~~• Performance monitoring~~ • For Information
Executive Summary:	Kate Lampard's review of Jimmy Savile's actions was published at the beginning of March. The review has made a number of recommendations for NHS trusts to take forward, the majority of which impact on our organisation, particularly those highlight in red.
Which Strategy Priority does this relate to: **How does this impact on patients or the public?**	• Customer Focus Strategy ~~• Clinical Strategy~~ ~~• IM and T Strategy~~ ~~• Governance Strategy~~ ~~• Innovation Strategy~~ • Workforce Strategy ~~• Financial Strategy~~ • ~~Estates Strategy~~
Relationship with Annual Objectives:	1 - Delivery of high quality evidence based services 3 – Stakeholder engagement 6 – Improve culture of Staff engagement
Risk / Legal Implications:	Reputation management
Resource Implications:	None identified over and above current resource
Equality and Diversity Implications:	None identified
Relationship with Assurance Framework [Risk, Control and Assurance]	Risk relating to reputational damage
Recommendations:	The Trust Board is asked to note the contents of this report and receive a progress update in six months.

Our Ref: **CD/PS**
Date: 29 May 2015

Chief Executive's Office
Trust Headquarters
Bellringer Road
Trentham Lakes South
Trentham
Stoke-on-Trent
ST4 8HH
Direct Line: 01782-441632
Email: Caroline.Donovan@northstaffs.nhs.uk

Mr Bob Alexander
Chief Executive Designate
NHS Trust Development Authority
Southside
105 Victoria Street
LONDON SW1E 6QT

Dear Mr Alexander

Re: NHS Investigations into Jimmy Savile and the Kate Lampard Lessons Learnt Report.

Thank you for the letter dated 11 March 2015 regarding the above drawing our attention to the very important learning lessons overarching report by Kate Lampard.

We have read the report and accept the recommendations and review and in response, please find enclosed our Trust`s action plan to identify where additional action is needed.

We would like to assure you that action has been taken and is in progress and trust you will find the enclosed satisfactory.

Yours sincerely

Caroline Donovan
Chief Executive

Annex A: REPORT ON TRUST PROGRESS IN RESPONSE TO KATE LAMPARD'S LESSONS LEARNT REPORT

NAME OF TRUST:	North Staffordshire Combined Healthcare

Recommendation	Issue identified	Planned Action	Progress to date	Due for completion
I. All NHS hospital trusts should develop a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors.	Draft Policy completed, awaiting ratification.	Trust Board for Ratification	Policy to be forwarded through due process for Trust board sign off	31st July 2015
II. All NHS trusts should review their voluntary services arrangements and ensure that: • They are fit for purpose; • Volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision; and, • All voluntary services managers have development opportunities and are properly supported.	The processes to recruit volunteers are reflective of how we recruit paid staff. They are subject to interviews, references, DBS checks and occupational health checks routinely. Volunteers attend the trust induction day (which includes mandatory training) and receive local induction to their placements; however there has historically not been a monitoring system to ensure volunteers fulfil their mandatory training requirements on a regular basis. Volunteers are also required to complete the Care Certificate as with all of our staff who have not had previous care experience.	Ensure Volunteers receive all mandatory training appropriate to their role.	1. Training plan completed May 2015. 2. Volunteer coordinator is ensuring all Volunteers are receiving Safeguarding Training by 31st July 2015.	31st July 2015

	The Volunteer Service Manager is part of the Patient Experience Team therefore receives regular appraisal, supervision and training opportunities applicable to their role.			
III. All NHS hospital staff and volunteers should be required to undergo formal refresher training in safeguarding at the appropriate level at least every three years.	All Staff to continue receive Mandatory Safeguarding Training Volunteer staff have not been historically routinely monitored with regard to compliance of regular training.	Training is available for Volunteers using blended approach of distance learning or attendance at Trust training sessions. System is devised for Training Team to monitor volunteer training and will be implemented to ensure compliance. In addition to this Volunteers can access formal Safeguarding Supervision as part of the normal team supervision processes, monthly drop in supervision held at Harplands Hospital or via individual supervision with the Safeguarding Named Nurse.	Training Team have identified all Volunteers requiring training and have developed a system to monitor compliance	30th June 2015.
IV. All NHS Hospital trusts should undertake regular reviews of: • Their safeguarding resources, structures and processes (including their training programmes); and, • The behaviours and responsiveness of management and staff in relation to safeguarding issues. • To ensure that their arrangements are robust and operate as	1.Safeguarding processes/arrangements for children are already audited annually in line with Section 11 of the Children Act to ensure they are meeting national standards. 2.Training attendance is	Complete	Complete	Complete and ongoing. 30th April 2015

	effectively as possible.	monitored, quality is assured via peer review within Safeguarding Board Partners. 3.Supervision provided by Safeguarding Lead is monitored both for frequency, availability and quality (quality is monitored by Designated nurse at CCG).			
V.	All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers.	This is already in place.	complete	complete	Complete and ongoing. April 30th 2015
VI.	All NHS hospital trusts should devise a robust trust-wide policy setting out how access by patients and visitors to the internet, to social networks and other social media activities such as blogs and Twitter is managed and where necessary restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary.	Policy already in place.	complete	complete	Complete and Ongoing. 30th April 2015
VII.	All NHS hospital trusts should ensure that arrangements and processed for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own internal HR processes and standards and are subject to monitoring and oversight by their own HR managers.	This is already in place.	complete	complete	Complete and Ongoing. 30th April 2015
VIII.	NHS hospital trusts should review their recruitment, checking, training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions and that overall responsibility for these matters rests with a single executive director.	This is already in place.	complete	complete	Complete and Ongoing. 30th April 2015.

IX. NHS hospital trusts and their associated charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a result of their associations with celebrities and major donors, and whether their risk registers adequately reflect this.	Guidance on Fundraising Activities already in place. Procedure For Recording Charitable Donations already in place.	Complete, however will be reviewed to include fundraising involving VIPs	Deputy Director for Finance in process of reviewing procedures.	Review of procedures will be complete by 30th June 2015.

I confirm that this Trust Board has reviewed the full recommendations in Kate Lampard's lessons learnt report:

SIGNED: DATE:

CE NAME:

Return to Natalie Dixon, Senior Policy Advisor, NHS TDA – Natalie.Dixon7@nhs.net

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: Trust Board

Date of Meeting:	30 July 2015
Title of Report:	Summary Report - Board to Team Visits Q1 2015/16
Presented by:	Mark Dinwiddy, Executive Director of Nursing & Quality
Author of Report: Name: Date: Email:	 Val Stronach 15 July 2015 ValerieA.Stronach@northstaffs.nhs.uk
Purpose / Intent of Report:	• For Decision • Performance Monitoring • For Information√
Summary of Report:	This report provides a summary of Board to Team visits conducted during Q1 2015/16.
Which Care Quality Commission domain does this relate to:	• Safe √ • Effective√ • Caring √ • Responsive to People's needs√ • Well led √
Which Annual Objective does this relate to:	• Delivery of high quality evidence based services • Integrated models of care • Stakeholder engagement √ • Use of technology as an enabler • Robust plans delivering quality and sustainable services • Improve culture of staff engagement √
Risk / Legal Implications:	Not assessed
Resource Implications:	Executive Director time
Recommendations:	The Board is requested to receive and note the content of the report.

Quarter 1 Summary Report - Board to Team (B2T) Visits 2015/16

Introduction

Several High profile inquiries into serious failings at NHS Hospitals have reported Boards being insufficiently concerned about patient safety and their understanding of patient and staff experience. Board members did not engage with service users or staff on the frontline, consequently Board members were not known outside of the Boardroom or Committee circuit.

Background

A recommendation of the Francis Inquiry into Mid Staffordshire Hospital NHS Trust was that "the Trusts make Board members visibility across the organisation a priority". The Trusts Chairman has made it a requirement for all board members to carry out planned visits across the trusts frontline clinical areas. This initiative strengthens the Boards visibility and ability to see and hear about the everyday experiences of service users, carers and staff.

The board to team visits are also a key component of the Trust's commitment to monitoring and improving quality, service user and staff experience. Key outcomes associated with the board to team programme will be:

- To raise the profile of the board with service uses and staff so that they can understand the Board's role and how it exists to ensure effective quality.
- To ensure that service users, carers and staff have the opportunity to meet and discuss services with board members those who are responsible for them
- To increase engagement with service users, carers and staff
- To enhance board members connection from Board to 'ward/team'
- To provide board members with a range of experience of services that is provided
- To provide board members with one perspective of service quality that compliments the other information that is routinely reported to board meetings
- To report on and escalate any issues that service users or staff have raised with board members for action.

Method

In March 2015 a revised scheduled programme of visits to all clinical areas was devised, pairing an Executive Director and a non-Executive Director to undertake allocated visits throughout the year.

This report provides a summary of visits undertaken during Q1, 2015/16.

A total of 21 visits were scheduled during Q1, each to different trust services, of these 6 visits were completed and a written summary report was submitted.

The following table summarises visits undertaken during Q1 2015/16

Date	Service / Department	Announced or Unannounced Visit
15/04/15	Dragon Square	Announced visit
23/04/15	Darwin Centre	Announced visit
24/04/15	Ward 7, Harplands Hospital	Announced visit
06/5/15	Ashcombe Centre	Announced visit
08/05/15	Ward 3, Harplands Hospital	
14/05/15	Pharmacy, Harplands Hospital	Announced visit
09/06/15	Florence House	Announced visit
09/06/15	Sutherland Centre	Unannounced visit
15/06/15	Ward 5, Harplands Hospital	Announced visit
26/06/15	Ward 5, Harplands Hospital	Unannounced visit

However, it should be acknowledged that at times it has been difficult to maintain the planned schedule of visits for various reasons; visits have been re-scheduled to ensure that 'backlogs' do not occur. It should also be noted that members of the incoming Service User and Carer Council, August 2015, may wish to be involved in the visits providing an additional dimension of 'patient/carer led' inspection of the care environment.

The two unannounced visits to Ward 5, Harplands Hospital, and the Sutherland Centre were additional visits to the planned programme, both of which were completed by the Chief Executive Officer.

Summary of Feedback

- **Dragon Square Specialist Short Break Service (visit 15/04/15)**

Background

This is a specialist service for children and young people (aged 5-18 years), with a diagnosed severe learning disability and additional complex health needs, which require Registered Nursing Care whilst the child is away from home. These needs may include either severe and significant challenging behaviour, which could not be managed in other respite settings, or medical/physical conditions requiring regular and frequent nursing interventions.

Warmly welcomed by the Matron Sue Laird and met both children and a parent.

Immediate Actions

None identified.

Positive Practice

- The environment appeared very caring, the staff appeared to be totally focused on the children's needs. They were highly motivated, compassionate and had low turn-over and many of them had worked at Dragon Square for a long time.

Challenges

1. The challenges we discussed were the impending review by Commissioners. I encouraged the Matron to be open and honest with staff about the review and make sure Commissioners were firmly reading any consultation process.

- **<u>Darwin Centre (visit 23/04/15)</u>**

Background

The Darwin Centre is a regional 15-bedded inpatient unit, providing specialist mental health services for young people and their families. The centre is open seven days a week. The primary function of The Darwin Centre is to provide assessment and treatment facilities for youngsters with mental health disorders (including deliberate self harm, acute psychosis and eating disorders). The Service had recently undergone a MHA compliance visit.

We were welcomed and shown round the centre by Mel Hart, the Matron. She showed us around the clinical environment. The young people were in a group session, so we were unable to talk to them. Quite a few staff were in the office.

Immediate Actions

None identified.

Positive practice

- Met with the Consultant Psychiatrist who was very positive about the service.

Challenges

1. No WI-Fi available for service users – request that this is followed up as soon as possible.
2. Sitting rooms for families inaccessible due to no bell – Requested that this is followed up as soon as possible – Director of Operations to support.
3. Lack of restraint room, the Matron was not aware that an architect had visited the service re potential adaptations to enhance the environment. I have asked the Director of Operations to ensure the matron is made aware of this.
4. Need to do work around child centred philosophy – Simon Wilson appointed to provide support and supervision in the improvement of the service post recent CQC compliance visit and QUNIK review.

5. Staff had not been appointed into the new posts supported by SLT, ? 6-8 weeks ago. JD's still being developed. Discussed concerns re this with Matron who will take forward as a priority action.

- **<u>Ward 7 Harplands Hospital (visit 24/04/15)</u>**

Background

Ward 7 is a specialist Older People's ward, supporting people with complex mental health illness and/or dementia. The Inpatient Ward works closely with the Day Hospital and Community Teams

Immediate Actions

- None identified, it was felt to be a positive visit.

Positive Practice

- The ward environment was clean.
- Staff were friendly and welcoming.
- We observed positive interaction between staff and patients.
- We observed a gentleman with dementia involved in a friendly conversation with one of the staff members.
- It was nice to see older people being able to walk around the ward. There were different activities going on in the ward.
- All the interactions we observed between staff and patients/ relatives were supportive and helpful.

Challenges

1. Difficulty with patient mix on the ward as there was a mix of individuals with functional and organic disorders.
2. In addition, younger patients were admitted who were sometimes not appropriate to the ward environment.
3. Issues with some junior doctors completing discharge summaries on time
4. Senior nurses feel that they can't refuse request for admission from Royal Stoke so sometimes responsible for the patient mix on the ward
5. Availability of admission room – in the process of getting this sorted
6. Garden area – not enough room – solution found to remove wire fence to allow for more room to be created.

- **<u>County Integrated Community Mental Health Team – Ashcombe Centre (visit 06/05/15)</u>**

Background

The Integrated Community Mental Health Team provides mental health and social care services to adults across North Staffordshire. The services provided are based upon a recovery orientated model.

Although the Executive Director and Non Executive Director visited the service as planned, the visit did not proceed due to operational issues at the time and staff availability. The visit has been re scheduled.

- **Ward 3 Harplands Hospital (visit 08/05/15)**

Background

Ward 3 is an acute admission ward for women based on the Harplands site. Staff work closely with the Access and Acute Home Treatment Teams as well as with other therapy teams based within the hospital, to support people in their recovery.

The visit took place as an announced visit on the 8th May 2015 at 9.00am and lasted for around two and a half hours.

At the time of the visit there were 24 patients using a possible 22 beds with 1 patient on leave and a further patient having slept on Ward 1 the previous night.

A number of staff and service users were spoken with on the visit including Ward Manager, Deputy Ward Manager, Activity Worker, Staff Nurses and the Nurse Practitioner.

Positive Practice

- The service users looked supported and well cared for
- The ward environment at the time of the visit was clean, happy, relaxed and well managed – however some of the furniture, particularly chairs, are in need of replacement as they are tatty and in cases thread bare.
- The ward was appropriately staffed for the shift
- There was evidence that staff were utilising time in suitable occupation with service users with activities taking place and a VE 70th Anniversary celebration taking place from 11.00am
- Information was displayed on the wall relating to incidents, length of stay, staff sickness etc. which was used to a limited degree and would have benefited from greater triangulation being undertaken for the benefit team so that it was more easily utilised to inform decisions and help the ward team – the establishment is currently recorded at 5:5:3 but the acuity of users of the service necessitates a ratio of 6:6:4. Recruitment for these posts has commenced and HCSW interviews had taken place with the Ward Manager taking an active part.
- The Ward Manager also had a good approach to the use of technology to enable occupation, communication but also to encourage positive feedback to be left on the NHS Choices website when Service Users express their positive experiences. There was also a good approach to ensuring that technology is enabled for all unless there is a clinical/safeguarding need to restrict it
- The Ward manager spoke of the very good links that are in place with the community services too and how they support MDTs.

Challenges

1. From discussions it was clear that there are challenges in relation to staffing. Nurse staffing had been an issue at times with the use of Bank.
2. There is also an issue with Medical Consultant recruitment

3. The Ward Manager was clearly passionate about her team and service users. She spoke well about the ongoing work they are undertaking to ensure that there is meaningful occupation for service users which was having a positive impact on the use of medication. She also spoke of the challenges of supporting people with Personality Disorders on the ward and the education work they are undertaking with the Director of Psychology to support staff in this difficult area
4. There was an issue with admission to a leave bed with a Service User who went on leave and had to return early having to sleep on Ward 1 for the night which she found to be distressing. The Ward Manager expressed concerns

    - That the ward clinical staff were seemingly not listened to about the fact they expected the return of this service user as the home visit was not going well
    - The experience of sleeping away from the ward may deter efforts to support further home visits as she may not have a bed to return to.

5. The introduction of the Activity Workers had been a real success and the feedback books were a testimony to that success. There was a query which had yet to be answered which concerned cover for the current Activity Worker who was about to go on Maternity Leave.
6. There is also a member of staff who undertakes Complimentary Therapy 1 day per week which again received good feedback. There was a question as to what had happened to the previous substantive post when the previous post holder left some months ago.
7. There was a discussion on the impact of the Duty senior Nurse role and the fact that it had removed over 1000 hours from the ward at a cost in excess of £38k. There were concerns expressed about the impact on continuity and leadership on the ward

Actions agreed following the visit

- Recruitment - Director of Workforce and Leadership (conducting the visit) to feedback on current position regarding vacancies Nursing and Medical 16 May 15.
- Furniture replacement - Director of Workforce and Leadership to ask for potential funding from Charitable Funds or elsewhere to enable the replacement of many of the chairs and other furniture end of May
- Admission to Leave Beds - Director of Workforce and Leadership stated it was not appropriate to sleep patients out. Director of Workforce and Leadership take to SLT (12 May) to ensure clarity in ensuring clinical engagement in decision making and to feedback to Ward Manager and Managers on Call.
- Activity Worker Maternity Leave Cover and Complimentary Therapist - Director of Workforce and Leadership to check where this is in the system and feedback to the Ward manager by 16 May.
- Duty Senior Nurse - Director of Workforce and Leadership to raise at SLT by the end of June.
- Shadowing - Director of Workforce and Leadership to Shadow the Ward Manager for a shift.

Overall

The visit provided good insight in to the issues facing the ward and some of the challenges presented to staff. The ward at the time of the visit was appropriately staffed and staff were relaxed and calm as were service users. There were a number of suggested areas for review/consideration that will be fed back to the Ward Manager and appropriate leads within the Trust.

- **Pharmacy Service Harplands Hospital (visit date 14/05/15)**

Background

The Pharmacy Team provides a very wide range of services, including; dispensary service, dispensing on average 6,000 items a month, inpatient and outpatient dispensing, clinical and technician and senior assistant support, advice around new treatment usage and ward stock control.

Immediate Actions

None identified.

Positive Practice:

- Dispensing 6000 items per month. Chief Pharmacist shared the quality assurance process in place. Discussed and understood production process six months per prescription.

Challenges

1. Shared care for Paloperidone and Rispiridone costs, we are not recovering costs from the GPs, and neither do we seem to have a commissioning framework to enable us to change our activity.
2. Shared Care - what is happening to resolve?
3. Blood testing for Clozapine - why can`t we do it on Harplands site - one stop shop for patients? Where has this been discussed?
4. Doctor`s repeat prescriptions - what are we doing to resolve the issue of late or non-completion?
5. Electronic prescription needs to be linked to Digital by Choice.
6. Estates issues goods in and out - need to have better access – To be followed up.
7. Omitted doses – Director of Nursing & Quality to raise with Modern Matrons.
8. Wards to alert Pharmacy when patient will be collecting drugs from Pharmacy – Director of Nursing to follow up.
9. Fridge Temperatures – recording, maintaining within safe ranges, auctioning accordingly.

- **City Integrated Community Mental health Team - Sutherland Centre (visit 09/06/15)**

Background

The Integrated Community Mental Health Team provide mental health and social care services to adults across North Staffordshire. Services are based upon a recovery orientated model.

Immediate Actions

None identified

Positive Practice

- The Team Manager was very welcoming and friendly. She appeared enthusiastic and motivated.
- Team Manager discussed the busy caseloads that staff had and the structure for team leadership.
- Team Manager described the impending move of the Assertive Outreach and Rehabilitation Teams into the community teams and commented that they had been preparing and actively thought through as a team how to best ensure integration.
- Commented that the role of the Nurse Practitioner as being key in providing clinical leadership alongside her own role.

Challenges

1. Waiting for computers to arrive – requested that the Team Manager escalates this issue with Head of Directorate and Director of Operations if the delay continues.
2. Visibility of managers – comment made that that it would be good to see the management team more often i.e. Head of Service and Clinical Director.
3. Plenary – negative impact of senior staff using iphones and iPads, this has subsequently been fed back to the Executive team.
4. Succession planning – Consultant Psychiatrist will be retiring later this year – plan to be in place to appoint to post as soon as possible – this has subsequently been raised with the Medical Director.
5. A key issue discussed was the out of hour's service, currently operates Monday – Friday 5pm – 8pm and weekends 9am – 5pm. The Team Manager does not think that this is a particularly efficient way of providing service user support. She suggested that rationalisation across the teams probably providing support via the Access team would be a better option. – This has subsequently been raised via the CEO's blog, SLT and arranged for a Listening into action conversation with all of the out of hour's services in august 2015. The Director of Operations is leading on this.

- **Florence House – Rehabilitation Inpatient service(visit 09/06/15)**

Background

Rehabilitation is defined as a whole systems approach to recovery from mental illness that maximizes an individual's quality of life and social inclusion by encouraging their skills, promoting independence and autonomy. The service works with a client group experiencing long-term complex mental health problems, the services is structured to offer an extended period of engagement to help individuals maximise their potential.

I visited Florence house on my own on the afternoon of the 9th June announced visit.

Immediate Actions

None identified.

Positive Practice

- I was welcomed by the Ward Manager Carolyn Wilkes.
- I had a walk round Florence house and was really impressed with the team. It was clean, well organised and well led. I was introduced to service users and staff who spoke really

positively about their experiences. I was particularly impressed with the increased Psychology input on the unit and enjoyed my discussion with the new psychologist and Carolyn who were able to talk about the length of stay of service users and their recovery pathway.

- The staff and service users explained the daily routine and how they made their own breakfast and lunch and helped to make dinner. I was introduced to service users who spoke very positively about their experiences
- Overall I was very impressed, particularly with the ward leadership.

- **<u>Ward 5, Neuropsychiatry Harplands Hospital (visit 15/06/15)</u>**

Background

Ward 5 is a 15 bedded adult specialist Neuropsychiatry ward which supports people who develop mental health problems following an acquired brain injury. This may be through an accident or a hereditary illness such as Huntington's disease.

Patient average length of stay is estimated at 4 months.

Ward staffing rotas were 5 : 5 : 3, these have now been increased to 6 : 6 : 4.

Immediate Actions

None identified.

Positive Practice

- Patient (non emergency) call via buzzer answered within 1 minute.
- Activity worker involved in the gardening project.
- Patients appeared well cared for in a clean and comfortable environment.
- Staff friendly and welcoming.

Challenges

1. One highly complex acquired brain injury patient still being treated but with less complexity now UHNM were very keen to move the patient to the Trust because of the Mental Health issues. It was reported that up to 5:1 staffing ratio was required to treat the patient. The staff were unsure if the Commissioners were funding additional costs (Director of Finance following this up)
2. The staff felt that 1 hour per week psychologist input was insufficient and a full time practitioner would be more appropriate.
3. Additionally more O/T input would benefit the patients.

The above points have been raised with the Matron who will take forward.

- **<u>Ward 5, Neuropsychiatry Harplands Hospital (unannounced visit by CEO 26/06/15)</u>**

<u>Background</u> **-** As above

Immediate Actions

None identified.

Positive Practice

- Staff were warm and friendly, I was shown around by 2 staff nurses who had worked on the ward for many years and were clearly committed and motivated to provide high quality patient care. They shared a few patient stories with me which was really helpful.
- I met a few patients and more staff. I was shown around the garden by one of the activity workers and a patient and was proudly shown the work they had done in the garden.

Challenges

1. One of the main issues identified was the environment. A lack of enough office space, storage facilities and limited day room space. I was shown around the ward and discussed how they could use the space they had better e.g. clear out the equipment rooms and rationalise the space which may allow for a larger office if the current store room was knocked through to create a bigger space. I asked them to discuss the possibility with their Ward Manager and Matron. Also some of the offices were used by different professional groups e.g. therapists or doctors and could be use in a broader way for the team.
2. I discussed with them use of wireless internet access by service users and they weren't aware this was available, I asked them to discuss as a team and raise awareness of this with service users, also to consider buying some iPads for service user use.
3. The showers it was shown were too small for wheelchairs to go in them - this is urgent and needs responding to. I have raised this with the Matron.
4. We discussed the clinical pathway particularly with the Neuro Community team, the staff described how this was not as strong as when the team were co- located. I have requested that the Ward Manager and Matron discuss this and ensure we are maximising opportunities and too consider the option and feasibility to co- locate the team again on Ward 5.
5. There also appears to be an opportunity for the 2 matrons from adult inpatient and older people's inpatient services to pull together a learning lessons and improvement group for nurses working on Harplands site. I have discussed this with the Matron.

General Conclusions

In summary there are many positive observations and comments made by the visiting Board members particularly around cleanliness, staff engagement with service users and positive feedback from service users about their experiences. It was good to note the activities that were ongoing on the inpatient areas. Staff members welcomed the visits and valued the opportunity to talk to Board members.

It is very pleasing to see that where challenges were identified suggested improvement actions were discussed during the visit, or have subsequently been followed up with relevant staff to take forward. It remains imperative that actions identified during Board visits are communicated to the

relevant clinical team and Directorate management team to ensure improvements are made in a timely manner. This is the responsibility of the visiting Board members but the responsibility for implementing actions rests with the Clinical Directorates. As the rolling programme of visits progresses during 2015/16 actions identified during previous visits must be followed up accordingly.

Our next Q2 report will include feedback about our new service user and carer standards 'Caring for and Caring About'.

A further quarterly summary report will be completed at the end of Q2, this will also include a review of the efficiency and effectiveness of the current approach to the B2T visits.

Recommendation

The Board is requested to:

Receive the Q1, 2015/16 summary report of Board to Team visits.

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO TRUST BOARD (OPEN)

Date of Meeting:	30 July 2015
Title of Report:	Monthly Finance Reporting Suite – June 2015
Presented by:	Ann Harrison, Interim Director of Finance
Author of Report: Name: Date: Email:	 Andy Turnock 22 July 2015 andrew.turnock@northstaffs.nhs.uk
Purpose / Intent of Report:	Performance monitoring
Executive Summary:	The attached report contains the financial position to 30 June 2015. The Trusts financial performance is a retained deficit of £0.343m against a planned deficit of £0.368m, a favourable variance of £0.025m. The in-year cost improvement target is £2.66m with a year to date performance of £0.04m ahead of plan. The cash balance as at 30 June 2015 was £7.13m. The capital expenditure is £0.04m, which is slightly behind the Plan of £0.14m. The Continuity of Service risk rating is reported as 3 in line with the plan.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	Financial Strategy
Relationship with Annual Objectives:	Financial Reporting
Risk / Legal Implications:	n/a
Resource Implications:	As above.
Equality and Diversity Implications:	n/a
Relationship with Assurance Framework [Risk, Control and Assurance]	

Recommendations:	***The Board is asked to:*** • ***note that the financial performance to date is on plan, with a favourable variance reported of £0.025m*** • ***note the in-year cost improvement target is £2.66m and a year to date performance slightly ahead of plan*** • ***note the cash position of the Trust as at 30 June 2015 of £7.13m*** • ***note the capital expenditure position as at 30 June 2015 is an under spend against plan*** • ***note the year to date Continuity of Service risk rating of 3***

DRAFT FINANCIAL OVERVIEW as at 30 June 2015

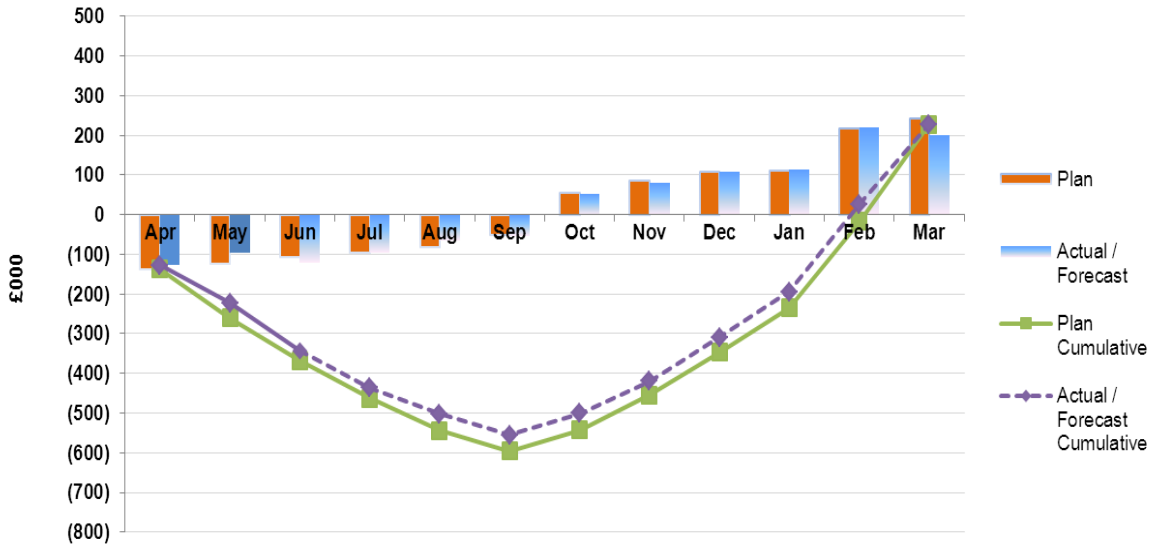
Income & Expenditure - Retained Surplus / (Deficit)

£000	Plan	Actual	Var	%	RAG
YTD	(368)	(343)	25	7	G
Forecast	227	227	0	0	G

Net Capital Expenditure

£000	Plan	Actual	Var	%	RAG
YTD	140	40	(100)	(71)	A
Forecast	1,530	1,530	0	0	G

Retained Surplus / (Deficit) Run Rate 2015-16



Cash Balances

£m	Plan	Actual	Var	%	RAG
YTD	7.0	7.1	0.1	2	G

Continuity of Service Risk Rating

	YTD Plan	YTD Act	FOT
Overall Risk Rating	3	3	3
Metrics:			
Liquidity Ratio	4	4	4
Capital Servicing Capacity	1	1	2

Notes

Risks:

- Non achievement of income targets
- Non delivery of CIP requirement
- Managing cost pressures
- Under performance against activity targets

Assumptions:

- Clinical income targets are predominately achieved.
- Charges against provisions provided for last year do not exceed the value provided.

1. Financial Position

1.1 Introduction

The Trusts financial Plan submission to the National Trust Development Authority (NTDA) showed a retained surplus position of £0.227m.

The Trust's 'Adjusted Financial Performance' for 2015/16 is a surplus of £0.750m (£0.227m plus IFRIC 12 adjustment of £0.523m). This is in line with the requirement to deliver a 1% surplus on the Trust's turnover.

This report details the Trust's performance against the Plan for the period ending 30 June 2015.

1.2 Income & Expenditure (I&E) Performance at Month 3

At the end of Month 3, the Trusts budgeted plan was a retained deficit of £0.368m (£0.237m deficit at adjusted financial performance level). The reported retained position is a deficit of £0.343m, giving a favourable variance of £0.025m against plan.

Table 1 below shows this position in the Statement of Comprehensive Income (SOCI) for the Trust. A more detailed SOCI is shown in Appendix A, page 1.

Table 1: Statement of Comprehensive Income

Detail	Full Year Annual Budget £000	Current Month £000			Year to Date £000		
		Budget	Actual	Variance	Budget	Actual	Variance
Income	75,664	6,158	6,292	133	18,277	18,524	248
Pay	(56,002)	(4,777)	(4,604)	173	(14,282)	(13,680)	602
Non pay	(16,131)	(1,214)	(1,529)	(315)	(3,537)	(4,361)	(824)
EBITDA	**3,530**	**167**	**158**	**(9)**	**458**	**484**	**27**
Other Costs	(2,780)	(231)	(235)	(4)	(695)	(697)	(2)
Adjusted Financial Performance	**750**	**(64)**	**(76)**	**(12)**	**(237)**	**(212)**	**25**
IFRIC 12 Expenditure	(523)	(44)	(44)	0	(131)	(131)	0
Retained Surplus / (Deficit) prior to Impairment	**227**	**(108)**	**(120)**	**(12)**	**(368)**	**(343)**	**25**
Fixed Asset Impairment	0	0	0	0	0	0	0
Retained Surplus / (Deficit)	**227**	**(108)**	**(120)**	**(12)**	**(368)**	**(343)**	**25**

Contained within non-pay budgets are the CIP targets for directorates, many of have been reduced following the transacted in budgets of the various schemes across the Trust.

Also contained within non-pay, specific budgets have been set and held centrally. Table 2 shows these central reserves forecast budgets which equate to £2.333m, against which the Trust is forecasting expenditure of £0.501m. This highlights that the Trusts achievement of the forecast retained surplus of £0.227m is predicated on the support to the operational position from reserves of £1.832m.

Table 2: Reserves Held Centrally

Description	Forecast Annual Budget (£000)	Committed within FOT (£000)
Contingency	191	112
Cleanliness in Hospitals	15	15
Quality & Reform	374	374
QNIC	46	0
Other Earmarked reserves	1,708	0
Total	**2,333**	**501**

1.3 Forecast Year End Performance

Following the finalisation of the month 3 position, a worked up forecast outturn has been undertaken which supports the retained surplus of £0.227m (£0.750m at adjusted financial performance level) which is in line with Plan. This outturn position is dependent on achieving the cost improvement programme as well as managing cost pressures, existing or arising, during the financial year. The Trust's forecast position has been shared with the NTDA as part of their financial monitoring regime.

1.4 Cost Improvement Programme

The in-year target for the year and reported to the NTDA is £2.66m and takes into account the requirement to deliver the 1% surplus referred to above.

As at month 3, the performance against the planned schemes on a year to date basis is slightly behind plan, with £0.382m being achieved against the target of £0.402m. However, additional schemes have been identified which have delivered £0.06m on a year to date basis resulting in an overall performance of £0.442m, and therefore a £0.04m over achievement. This is shown in table 3 below.

Table 3: CIP Delivery – Year to Date

	Plan £000	Delivered £000	Variance £000
Original schemes	402	382	(20)
New schemes	0	60	60
Total schemes	**402**	**442**	**40**

2. Summary of Financial Position

A Statement of Financial Position is shown in Appendix A, page 2.

2.1 Fixed Assets

Property, Plant & Equipment and Intangible assets balances of the Trust have remained relatively static.

2.2 Cash

As at 30 June 2015, the Trust's cash position was £7.13m which represents a decrease during the month of £0.613m. A monthly cash flow forecast is shown in Appendix A, page 3 which demonstrates the cash movements.

2.3 Other Working Balances

There has been little change in the working balances during the month, with an overall net increase of circa £0.6m. This is a result of an increase in creditors of £0.5m (predominately deferred income) and an increase of debtors of £1.1m. The increase in debtors is due to the following:

£0.48m Section 75 – both City and County

£0.34m NHS debtors – numerous increases

£0.27m ADS/One Recovery re Substance Misuse

It is worth noting that there is minimal or no risk associated with the above increases in debtor values.

Within the overall debtors value, £1.0m relates to invoiced debt. Invoiced debt is summarised by age in Appendix A, page 4, along with the analysis of the stage of recovery.

3. Capital Expenditure and Programme

The Trust's permitted capital expenditure in 2015/16 is £2.3m; this is the combination of the Trust's £1.53m Capital Resource Limit (CRL) and its asset sales of £0.77m. The capital expenditure for the year as at 30 June 2015 is £0.04m which represents an under spend against the profiled capital expenditure of £0.140m shown in the Plan submitted to the NTDA.

Appendix A, page 5 details the expenditure to date and the forecast outturn including a graph to show both the actual and projected performance against Plan.

4. Continuity of Services Risk Rating Risk Rating

As reported in the Plan, the Trust is planning to achieve a Continuity of Service Risk Rating of 3 by the end of the financial year. As at month 3, this is calculated as 3. The forecast outturn rating is also 3, in line with the planned rating previously mentioned.

Appendix A, page 6 shows in detail the separate metrics, the outputs, and the various components used to calculate the specific metrics.

5. Recommendations

The Board is asked to:

- ***note that the financial performance to date is predominately on plan, with a favourable variance reported of £0.025m***
- ***note the delivery of CIP and the overall favourable variance against plan on a year to date basis***
- ***note the cash position of the Trust as at 30 June 2015 of £7.13m***
- ***note the capital expenditure position as at 30 June 2015 is an underspend against plan of £0.1m***
- ***note the year to date Continuity of Service Risk Rating of 3 and also a forecast rating of 3.***

Appendix A – Page: 1

Statement of Comprehensive Income including Forecast Outturn – Trust Wide

	Full Year	< < < Current Month > > >			< < < Year to Date > > >			< < < Forecast Outturn > > >		
	Budget	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Income:										
Revenue from Patient Care Activities	67,070	5,563	5,443	120	16,179	16,018	161	68,613	68,533	80
Other Operating Revenue	8,594	728	715	13	2,346	2,259	87	8,343	8,594	-252
	75,664	6,292	6,158	133	18,524	18,277	248	76,956	77,127	-171
Expenses:										
Pay										
Medical	-6,765	-509	-566	57	-1,450	-1,690	240	-6,221	-6,787	565
Nursing	-25,752	-2,176	-2,229	53	-6,512	-6,642	131	-26,734	-26,710	-24
Other clinical	-13,649	-993	-1,137	144	-3,047	-3,430	383	-12,802	-13,814	1,012
Non-clinical	-9,395	-691	-777	85	-2,090	-2,342	251	-8,813	-9,395	582
Non-NHS	-442	-234	-68	-166	-580	-177	-402	-1,766	-911	-855
Cost Improvement	0	0	0	0	0	0	0	0	0	0
	-56,002	-4,604	-4,777	173	-13,680	-14,282	602	-56,335	-57,616	1,280
Non Pay										
Drugs & clinical supplies	-1,870	-204	-162	-42	-570	-477	-93	-2,333	-1,898	-435
Establishment costs	-1,765	-125	-152	27	-360	-442	82	-1,417	-1,765	348
Premises costs	-1,947	-235	-165	-70	-683	-537	-146	-2,718	-1,947	-771
Private Finance Initiative	-3,865	-332	-322	-10	-997	-966	-30	-3,981	-3,865	-116
Other (including unallocated CIP)	-5,139	-633	-413	-220	-1,751	-1,115	-636	-6,256	-4,244	-2,013
Central Funds	-1,546	0	0	0	0	0	0	-501	-2,333	1,833
	-16,131	-1,529	-1,214	-315	-4,361	-3,537	-824	-17,207	-16,051	-1,155
EBITDA *	**3,530**	**158**	**167**	**-9**	**484**	**458**	**27**	**3,414**	**3,460**	**-46**
Depreciation (excludes IFRIC 12 impact and donated income)	-827	-73	-69	-4	-211	-207	-4	-797	-797	0
Investment Revenue	12	2	1	1	5	3	2	16	12	4
Other Gains & (Losses)	0	0	0	0	0	0	0	42	0	42
Local Government Pension Scheme	0	0	0	0	0	0	0	0	0	0
Finance Costs	-1,364	-114	-114	0	-341	-341	0	-1,364	-1,364	0
Unwinding of Discounts	0	0	0	0	0	0	0	0	0	0
Dividends Payable on PDC	-601	-50	-50	0	-150	-150	0	-561	-561	0
Adjusted Financial Performance - Surplus / (Deficit) for the Financial Year **	**750**	**-76**	**-64**	**-12**	**-212**	**-237**	**25**	**750**	**750**	**0**
IFRIC 12 Expenditure ***	-523	-44	-44	0	-131	-131	0	-523	-523	0
Retained Surplus / (Deficit) for the Year	**227**	**-120**	**-108**	**-12**	**-343**	**-368**	**25**	**227**	**227**	**0**

* EBITDA - earnings before interest, tax, depreciation and amortisation

** NTDA expected surplus or deficit against w hich the Trust is measured

*** Additional costs in respect of the Trust's PFI scheme follow ing the introduction of IFRS, classed as technical adjustments.

Statement of Financial Position – including forecast

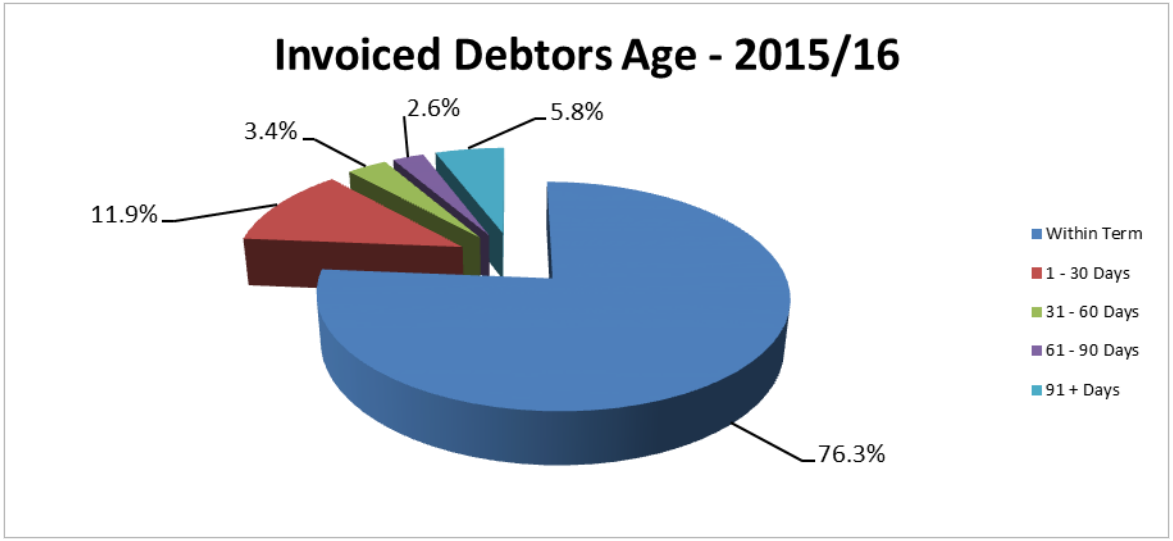
Detail	Period End Dates 31/03/2015 £000	30/04/2015 £000	31/05/2015 £000	30/06/2015 £000	Forecast 31/03/2016 £000
NON-CURRENT ASSETS:					
Property, Plant and Equipment	30,863	30,762	30,668	30,573	31,799
Intangible Assets	52	52	52	40	66
Trade and Other Receivables	0	0	0	0	0
TOTAL NON-CURRENT ASSETS	30,915	30,814	30,720	30,613	31,865
CURRENT ASSETS:					
Inventories	86	77	84	82	86
Trade and Other Receivables	3,017	3,675	4,469	5,570	3,298
Cash and cash equivalents	6,805	7,956	7,743	7,130	6,416
SUB TOTAL CURRENT ASSETS	9,908	11,708	12,296	12,782	9,800
Non-current assets held for sale	2,520	2,520	2,520	2,520	1,750
TOTAL ASSETS	**43,343**	**45,042**	**45,536**	**45,915**	**43,415**
CURRENT LIABILITIES:					
NHS Trade Payables	-864	-823	-1,047	-1,065	-676
Non-NHS Trade Payables	-4,374	-6,272	-6,680	-7,222	-5,757
Borrowings	-351	-351	-351	-351	-346
Provisions for Liabilities and Charges	-1,682	-1,679	-1,667	-1,636	-882
TOTAL CURRENT LIABILITIES	-7,271	-9,125	-9,745	-10,274	-7,661
NET CURRENT ASSETS/(LIABILITIES)	5,157	5,103	5,071	5,028	3,889
TOTAL ASSETS LESS CURRENT LIABILITIES	**36,072**	**35,917**	**35,791**	**35,641**	**35,754**
NON-CURRENT LIABILITIES					
Borrowings	-12,992	-12,963	-12,934	-12,904	-12,647
Trade & Other Payables	-558	-558	-558	-558	-558
Provisions for Liabilities and Charges	-604	-604	-604	-604	-404
TOTAL NON- CURRENT LIABILITIES	-14,154	-14,125	-14,096	-14,066	-13,609
TOTAL ASSETS EMPLOYED	**21,918**	**21,792**	**21,695**	**21,575**	**22,145**
FINANCED BY TAXPAYERS EQUITY:					
Public Dividend Capital	7,998	7,998	7,998	7,998	7,998
Retained Earnings	814	687	591	471	1,041
Revaluation Reserve	13,664	13,664	13,664	13,664	13,664
Other reserves	-558	-558	-558	-558	-558
TOTAL TAXPAYERS EQUITY	**21,918**	**21,792**	**21,695**	**21,575**	**22,145**

Cash-flow Forecast

Statement of Cash Flows (CF)	Actual Apr 15 £000	Actual May 15 £000	Actual Jun 15 £000	Forecast Jul 15 £000	Forecast Aug 15 £000	Forecast Sep 15 £000	Forecast Oct 15 £000	Forecast Nov 15 £000	Forecast Dec 15 £000	Forecast Jan 16 £000	Forecast Feb 16 £000	Forecast Mar 16 £000	2015/2016 Full Year £000
Cash Flows from Operating Activities													
Operating Surplus / (Deficit)	35	66	42	67	95	111	216	242	263	265	314	378	**2,094**
Depreciation and Amortisation	113	112	117	110	110	110	109	109	109	107	107	107	**1,320**
Impairments and Reversals	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Interest Paid	-114	-114	-114	-114	-114	-114	-114	-114	-113	-113	-113	-113	**-1,364**
Dividend Paid	0	0	0	0	0	-300	0	0	0	0	0	-261	**-561**
Inflow / (Outflow) prior to Working Capital	**34**	**64**	**45**	**63**	**91**	**-193**	**211**	**237**	**259**	**259**	**308**	**111**	**1,489**
(Increase) / Decrease in Inventories	0	-7	2	0	0	-2	0	0	0	0	0	7	**0**
(Increase) / Decrease in Trade and Other Receivables	-658	-794	-1,101	271	-95	529	297	486	-267	382	290	402	**-258**
Increase / (Decrease) in Trade and Other Payables	1,817	581	509	-41	137	217	-11	-595	-315	-444	-390	-222	**1,243**
Provisions (Utilised) / Arising	-3	-12	-31	-15	-25	-446	-25	-25	-25	-275	-213	-533	**-1,628**
Increase/(Decrease) in Movement in non Cash Provisions	0	0	0	0	0	0	0	350	0	0	0	280	**630**
Inflow / (Outflow) from Working Capital	**1,156**	**-232**	**-621**	**215**	**17**	**298**	**261**	**216**	**-607**	**-337**	**-313**	**-66**	**-13**
Net Cash Inflow / (Outflow) from Operating Activities	**1,190**	**-168**	**-576**	**278**	**108**	**105**	**472**	**453**	**-348**	**-78**	**-5**	**45**	**1,476**
Cash Flows from Investing Activities													
Interest Received	2	2	2	2	1	1	1	1	1	1	1	1	**16**
(Payments) for Property, Plant and Equipment	-12	-18	-10	-72	-75	-25	-80	-20	-100	-350	-550	-988	**-2,300**
Proceeds of disposal of assets held for sale (PPE)	0	0	0	312	0	0	0	0	458	0	0	0	**770**
Net Cash Inflow / (Outflow) from Investing Activities	**-10**	**-16**	**-8**	**242**	**-74**	**-24**	**-79**	**-19**	**359**	**-349**	**-549**	**-987**	**-1,514**
NET CASH INFLOW / (OUTFLOW) BEFORE FINANCING	**1,180**	**-184**	**-584**	**520**	**34**	**81**	**393**	**434**	**11**	**-427**	**-554**	**-942**	**-38**
Cash Flows from Financing Activities													
Capital Element of Payments in Respect of Finance Leases PFI	-29	-29	-29	-29	-29	-29	-29	-29	-29	-30	-30	-30	**-351**
Net Cash Inflow/(Outflow) from Financing Activities	**-29**	**-29**	**-29**	**-29**	**-29**	**-29**	**-29**	**-29**	**-29**	**-30**	**-30**	**-30**	**-351**
NET INCREASE / (DECREASE) IN CASH AND CASH EQUIVALENTS	**1,151**	**-213**	**-613**	**491**	**5**	**52**	**364**	**405**	**-18**	**-457**	**-584**	**-972**	**-389**
Cash and Cash Equivalents (and Bank Overdraft)	**7,956**	**7,743**	**7,130**	**7,621**	**7,626**	**7,678**	**8,042**	**8,447**	**8,429**	**7,972**	**7,388**	**6,416**	

Aged Debtor Analysis

Analysed as	Within Term £000	1 - 30 Days £000	31 - 60 Days £000	61 - 90 Days £000	91 + £000	Overall Balance £000
NHS	566	81	15	27	29	**718**
Local Authorities	41	27	0	0	1	**69**
Other Debtors	198	17	20	1	31	**267**
Total	**805**	**125**	**35**	**28**	**61**	**1,054**

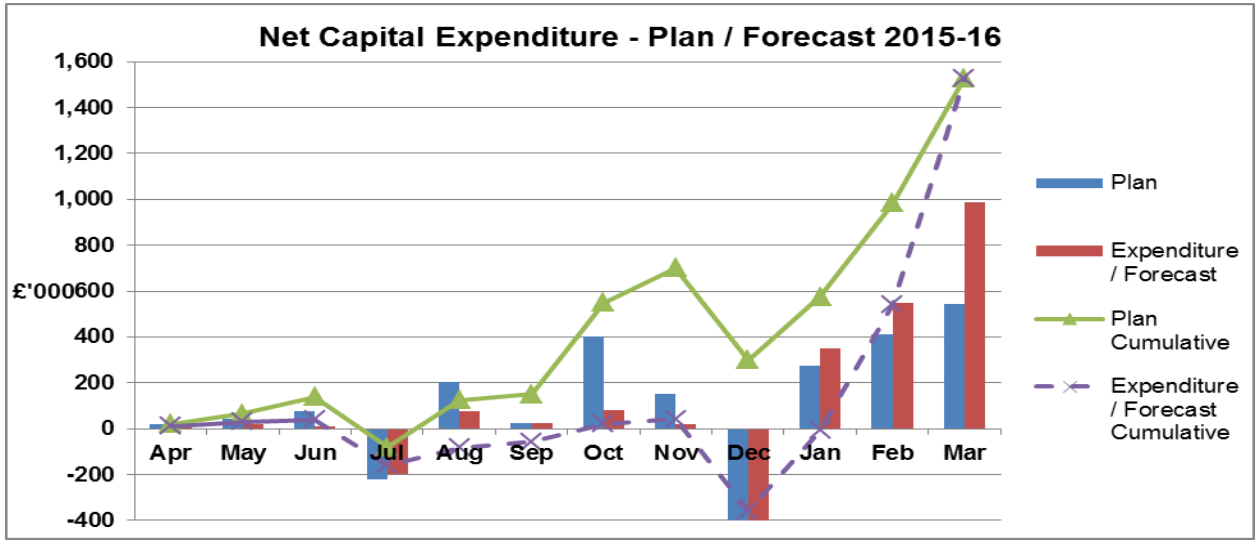


Analysed by Credit Control Stage	Within Term £000	1 - 30 Days £000	31 - 60 Days £000	61 - 90 Days £000	91 + £000	Overall Balance £000
No formal dispute received - full payment anticipated	805	125	35	28	29	**1,022**
Routine credit control processes activated	0	0	0	0	22	**22**
Resolved - Awaiting Credit Note to be issued	0	0	0	0	0	**0**
Escalated to Management / Solicitors	0	0	0	0	10	**10**
Total	**805**	**125**	**35**	**28**	**61**	**1,054**

Capital Programme and Expenditure

Scheme	Detail	2015/16 Original Scheme Value £000	Year to Date £000	Forecast Outturn £000
Psychiatric Intensive Care Unit	awaiting business case approval	400	0	400
Low Secure unit with rehabilitation	awaiting business case approval	500	0	500
Assessment & Treatment and Telfold Unit	awaiting business case approval	600	0	600
Dragon Square Upgrade		250	3	250
Information Technology	various	100	0	100
Equipment	various	80	0	80
Other		270	37	270
Environmental Improvements	numerous sites	100	0	100
Total Expenditure		**2,300**	**40**	**2,300**
Disposals				
Former Learning Disability property	Meadow View	-270	0	-270
Bucknall Hospital (part)	staged receipts	-500	0	-500
Net Expenditure		**1,530**	**40**	**1,530**

Capital Allocations	£000
Initial CRL (per NTDA Plan submission)	**1,530**
Revisions to Plan:	
None	-
Final CRL	**1,530**
Value of Schemes Forecast Outturn as at 30/06/15	**1,530**
Potential (Over) / Undershoot against CRL	**0**



Continuity of Service Risk Rating

Continuity of Services Risk Rating		YTD Actual £000	Forecast Plan £000	Forecast Actual £000
Liquidity Ratio	**Working Capital:**			
	Total Current Assets	15,302	11,550	11,550
	Total Current Liabilities	-10,274	-7,661	-7,661
	Inventories	82	86	86
	Non Current Assets Held for Sale	2,520	1,750	1,750
	Working Capital Balance	**2,426**	**2,053**	**2,053**
	Annual Operating Expenses:			
	Operating Expenses	18,382	72,680	74,862
	Add back:			
	Depreciation & Amortisation	-342	-1,350	-1,320
	Impairments	0	0	0
	Annual Operating Expenses:	**18,040**	**71,330**	**73,542**
	Liquidity Ratio (Working capital balance / Annual operating expenses)	12.2	10.4	10.2
	Liquidity Ratio Metric	**4.0**	**4.0**	**4.0**
Capital Servicing Capacity	**Revenue Available for Debt Service:**			
	EBITDA	485	3,486	3,414
	Interest Receivable	-5	-16	-16
	Revenue Available for Debt Service	**490**	**3,502**	**3,430**
	Annual Debt Service:			
	Finance Costs (including interest on PFIs and Finance Leases)	341	1,364	1,364
	Dividends	150	561	561
	Capital element of payments relating to PFI, LIFT Schemes and finance leases	88	351	351
	Annual Debt Service	**579**	**2,276**	**2,276**
	Capital Servicing Capacity (times) (Revenue available for Debt Service / Annual Debt Service)	0.8	1.5	1.5
	Capital Servicing Capacity metric	**1.0**	**2.0**	**2.0**
Continuity of Services Risk Rating for the Trust		**3.0**	**3.0**	**3.0**

Risk Assessment Framework Parameters					
Liquidity Ratio (days)					50% Weighting
Rating	4	3	2	1	
Tolerance	0	-7	-14	<-14	
Capital Servicing Capacity					50% Weighting
Rating	4	3	2	1	
Tolerance	2.5	1.75	1.25	<1.25	

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: Trust Board – Open Section

Date of Meeting:	30 July 2015
Title of Report:	Finance and Performance Committee Report – Committee Meetings 18 June & 23 July 2015
Presented by:	Tony Gadsby – Committee Chairman
Author of Report: Name: Date: Email:	 Steve Blaise 23 July 2015 Steve.blaise@northstaffs.nhs.uk
Purpose / Intent of Report:	• For Decision ✔ • Performance monitoring ✔ • For Information ✔
Executive Summary:	The attached reports provides a summary of the Committee meetings held on the 18 June & 23 July 2015 and provides assurance to the Board over the level of review and challenge provided by the Committee of financial and other reporting as well as forecasting.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Customer Focus Strategy • IM and T Strategy ✔ • Governance Strategy ✔ • Workforce Strategy ✔ • Financial Strategy ✔ Helps ensure appropriate resources are directed to and protected for appropriate patient care services.
Relationship with Annual Objectives:	Supports achievement of financial targets, the monitoring of CQUIN requirements and the delivery of efficiency programmes
Risk / Legal Implications:	Principle risk register reviewed via committee and reported separately to the Board
Resource Implications:	
Equality and Diversity Implications:	None
Relationship with Assurance Framework [Risk, Control and Assurance]	Provides assurance over the Trust's arrangements for sound financial stewardship and risk management.
Recommendations:	The Trust Board are asked to: • Note the contents of the report and take assurance from the review and challenge evidenced in the Committee.

North Staffordshire Combined Healthcare NHS Trust

Assurance Report to the Trust Board – Thursday, 30 July 2015

Finance and Performance (F & P) Committee Report to the Trust Board – 18 June 2015

This paper details the issues discussed at the Finance and Activity Committee meeting on 18 June 2015.

The meeting was quorate, approved the minutes from the meeting on the 28 May 2015 and reviewed the progress and actions taken from previous meetings.

The Committee received the financial update for month 2 (May 2015) 2015/16. This was the first month of the 2014/15 year to include the full set of supporting schedules.

The income and expenditure position to Month 2 was ahead of plan at a deficit of £0.223m (£0.136m deficit at "adjusted financial performance" level) against a plan deficit of £0.260m, a favourable variance of £0.037m against plan. The paper also reported that the year-end forecast was in line with the planned position of £0.227m surplus, equating to a £0.750m surplus at adjusted financial performance level although it was noted that this forecast figure was support by Trust reserves.

The Trust's cash balance at the end of May was £7.7m (against the plan balance of £7.3m at the same period), but which is £0.3m lower than the position at the end of April 2015.

The Capital Resource Limit (CRL) for 2015/16 is £1.5m. The planned capital expenditure for the year is £2.3m funded by £1.3m depreciation, £0.8m of asset sales and cash in hand. At the end of May 2015 the Trust was £0.035m behind plan having incurred capital spend of £0.030m against a plan of £0.065m.

The report also noted that the Trust was reporting a Continuity of Service overall risk rating of level 3 at May 2015. Additionally, the Trust is reporting a forecast year end overall rating of level 3. It was also note that Appendix A - page 6 of the report provided a more detailed breakdown of the Risk Rating calculation

The Committee also received papers summarising the base case Long Term Financial Model (LTFM) key metrics for the period 2015/16 to 2019/20 together with the LTFM metrics following the application of downside and mitigations assumptions over the same period.

Other Reports and Updates

The Committee received additional reports and verbal updates as follows:

- The verbal report from the Director of Finance verbal report included an update on a number of issues which included an update of the Quality Impact Assessment of the Trusts Cost Improvement Plans and the sharing of that detail with the Trusts main Commissioners. The Director of Finance also outlined the current proposals and timescales for the production and distribution of Service Line Reports.

- The minutes and report from the Trusts Capital Investment Group (CIG) were not available as the group had not met. However, it was noted that a meeting was due to take place on 29 June 2015. The Business cases linked to the Trusts capital programme were discussed during the closed section of the meeting.

- A brief verbal update on the completion and agreement of the Trusts Non Clinical Service Level Agreements (SLA's) and, in particular, the Estates Shared Service SLA's with SSOTP and NHS Property Services.

- A Performance Management report including TDA metrics, agreed targets, trends and a revised RAG rating. The reported noted that, at month 2, there were 7 metrics rated as Red and 4 as Amber. The Committee were briefed on the issues within these areas.

- A report was tabled and discussed updating the Committee on the Trust's current tender activity. Particular reference was made to the current Substance Misuse inpatient tender where notification had been received notifying the Trust of a delay in awarding this tender.

- Key Risks to finance and performance. A schedule was provided which described the key risks appertaining to the 2015/16 financial plan.

- The Committee received a report detailing the Trusts costing processes and systems used in the production of the Trusts Reference Cost return. The Committee took assurance that a robust process is in place as evidenced by the quality and data checks detailed within the paper.

North Staffordshire Combined Healthcare NHS Trust

The Board is asked to note the contents of this report and take assurance from the review and challenge evidenced in the Committee.

On Behalf of Tony Gadsby – Chair of Finance and Performance Committee

Steve Blaise – Deputy Director of Finance

1ST July 2015

North Staffordshire Combined Healthcare NHS Trust

Assurance Report to the Trust Board – Thursday, 30 July 2015

Finance and Performance (F & P) Committee Report to the Trust Board – 23 July 2015

This paper details the issues discussed at the Finance and Activity Committee meeting on 23 July 2015.

The meeting was quorate, approved the minutes from the meeting on the 18 June 2015 and reviewed the progress and actions taken from previous meetings.

The Committee received the financial update for month 3 (June 2015) 2015/16.

The income and expenditure position to Month 3 was ahead of plan at a deficit of £0.343m (£0.212m deficit at "adjusted financial performance" level) against a plan deficit of £0.368m, a favourable variance of £0.025m against plan. The paper also reported that the year-end forecast was in line with the planned position of £0.227m surplus, equating to a £0.750m surplus at adjusted financial performance level although it was noted that this forecast figure was support by Trust reserves. This position would represent a breakeven performance against plan.

The Trust's cash balance at the end of May was £7.1m (against the plan balance of £7.0m at the end of June), but which is £0.6m lower than the position at the end of May 2015.

The Capital Resource Limit (CRL) for 2015/16 is £1.5m. The planned capital expenditure for the year is £2.3m funded by £1.3m depreciation, £0.8m of asset sales and cash in hand. At the end of June 2015 the Trust was £0.1m behind plan having incurred capital spend of £0.040m against a plan of £0.140m. The Trusts Capital programme and forecast capital spend profile was discussed in greater detail under the closed section of the meeting.

It was noted that the Trust continued to report a Continuity of Service overall risk rating of level 3 at June 2015. In additionally, the Trust is also reporting a forecast year end overall rating of level 3. This level 3 rating is achieved primarily as a result of the Trusts healthy liquidity ratio.

Other Reports and Updates

The Committee received additional reports and verbal updates as follows:

- The verbal report from the Director of Finance verbal report included an update on the status of clinical contract sign off, confirming that only a small number of minor Commissioning contract SLA's remain unsigned, although it was noted that these contracts we all agreed under the Lead Purchaser arrangements. The Director of Finance also updated the Committee on the national financial position of the NHS and the likelihood that the TDA would request NHS Trusts to improve their 2015/16 financial positions.

- The Committee received the Quarterly Workforce report. This report provided details of the workforce profile, by discipline, as at 1 April 2015, together with the planned workforce changes over the next 5 years aimed at improving efficiency and productivity while also releasing cost savings. The 2015/16 planned workforce changes were also identified by those resulting from CIP/Re-design schemes and Growth resulting from developments.

- The Committee received a paper detail the current risks within the Trusts clinical contract portfolio. It was noted that, at month 3, the Trusts contract with NHS England Specialised Services Commissioners was operating below target. This underperformance has been detected early enough in the year and is expected to be pulled back as a consequence.

- A Performance Management report including TDA metrics, agreed targets, trends and a revised RAG rating. The reported noted that, at month 3, there were 2 metrics rated as Red and 5 as Amber. The Committee were briefed on the issues within these areas.

- A report was tabled and discussed updating the Committee on the Trust's current tender activity. Particular reference was made to the current Substance Misuse inpatient tender for Stoke and that the Trust had been awarded lot 3 of the tender. It was also noted that the Substance Misuse Staffordshire Inpatient tender had been released with a deadline response date of 12 August 2015. The Committee recognised the work currently being undertaken within the Trust to respond to the tender submission.

- The Committee received, for information, the minutes and report from the Trusts Capital Investment Group (CIG) that had taken place on 29 June 2015.

- The Business cases linked to the Trusts capital programme were discussed during the closed section of the meeting. The committee noted the significant investment proposed in schemes within the Children's and LD Divisions which indicates the Trusts confidence in the development of these Services.

- A brief verbal update on the completion and agreement of the Trusts Non Clinical Service Level Agreements (SLA's).

- Key Risks to finance and performance. A schedule was provided which described the key risks appertaining to the 2015/16 financial plan.

The Board is asked to note the contents of this report and take assurance from the review and challenge evidenced in the Committee.

On Behalf of Tony Gadsby – Chair of Finance and Performance Committee

Steve Blaise – Deputy Director of Finance

23 July 2015

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: **TRUST BOARD (OPEN)**

Date of Meeting:	30 July 2015
Title of Report:	Five Year Forward View – Time to Deliver
Presented by:	Andrew Hughes – Interim Director of Strategy & Development
Author of Report: Name: Date: Email:	Andrew Hughes – Interim Director of Strategy & Development 21 July 2015 Andrew.hughes@northstaffs.nhs.uk
Purpose / Intent of Report:	• For Decision • Performance monitoring • For Information - ✓
Executive Summary:	The NHS Five Year Forward View was published on 23 October 2014 and set out a vision for the future of the NHS. Subsequently the Time to Deliver report was published on 4 June 2015 and provides an update on progress to date from NHS organisations to deliver the vision for 2020.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Customer Focus Strategy - ✓ • Clinical Strategy - ✓ • IM and T Strategy • Governance Strategy • Innovation Strategy - ✓ • Workforce Strategy - ✓ • Financial Strategy - ✓ • Estates Strategy
Relationship with Annual Objectives:	Supports delivery of the above plans.
Risk / Legal Implications:	N/A
Resource Implications:	N/A
Equality and Diversity Implications:	N/A
Relationship with Assurance Framework [Risk, Control and Assurance]	Links to the annual objectives that helps inform the Trusts compliance with the Board Assurance Framework and Annual Governance Statement.
Recommendations:	The Board is asked to receive the Five Year Forward View – Time to Deliver

FIVE YEAR FORWARD VIEW

Time to Deliver

4 June 2015

1. Introduction

When the NHS came together to produce the *Five Year Forward View*[1], our ambition was to reframe the terms of debate: to set out a shared view of the challenges ahead and the choices we face about the kind of health and care service we want in 2020. Working with patient groups, clinicians, local government and think tanks, we tapped into an overwhelming consensus on the need for change, and a shared ambition for the future.

It's a future that empowers patients, their families and carers to take more control over their own care and treatment: a future that dissolves the artificial divide between family doctors and hospitals, between physical and mental health and between health and social care. One that no longer locks expertise into outdated buildings, with services fragmented, patients having to visit multiple professionals for multiple appointments; one organised to support people with multiple conditions not just a single disease.

The *Five Year Forward View* argued that this future was perfectly possible, provided that the NHS does its part, together with the support of the public and the Government. Last week the newly elected Government put our plan at the heart of the Queen's Speech:

"In England, my Government will secure the future of the NHS by implementing NHS's own Five Year Forward View, by increasing the health budget, integrating health care and social care and ensuring the NHS works on a seven day basis. Measures will be taken to increase access to General Practitioners and to Mental Health care."

This is a unique moment in time: we have a consensus about the challenges ahead, a shared vision for the future, a Government commitment to at least £8bn additional funds and support for the changes to drive it.

But the scale of the transformation required cannot be delivered by the NHS alone; nor can it be driven solely from Whitehall. Just as we developed the vision together, so we must deliver it together. That's why today we are launching a programme to bring together 'a coalition of the willing' to share knowledge, energy and ideas on how to

[1] http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

deliver the *Five Year Forward View* at scale and pace. We cannot afford to lose momentum, so today we set out:

- What we have achieved so far
- Initial actions to support the service during 2015/16
- The next steps we will take to transform the NHS and deliver the *Five Year Forward View.*

2. Progress to date

The NHS has responded with energy and enthusiasm since the publication of the *Five Year Forward View*, with local and national bodies coming together to lay the foundations for its vision for 2020 and start delivering it.

269 local areas came forward with their ideas on how to design new models of care. Following a process of peer assessment, 29 Vanguards were selected to form the initial cohort, and this leading edge of NHS organisations and Local Authorities will improve care for over 5 million patients, as well as help us identify and solve problems in a way that can be replicated more widely across the NHS.

Greater Manchester has developed radical proposals for bringing health and social care together into a £6bn pooled budget in 2016/17 that will accelerate improvement of the health and wellbeing of its 2.8 million people. And leaders in nine areas across the country are demonstrating how individuals with complex needs can be given more control over their combined health and social care budgets for the benefit of their citizens.

Reinforcing our commitment to help people stay well and independent, support carers and families, we have marshalled the resources of the voluntary and community sector through the Peoples and Communities Board, chaired by Jeremy Taylor of National Voices. The Board has developed a national alternative to the standard contract to enable the NHS to partner with or commission from the voluntary sector.

Nationally, we are taking action to create the conditions within which local leaders can deliver the Five Year Forward View, including:

- Reinforcing our commitment to become a service that prevents as well as treats illness by launching a nationwide Diabetes Prevention Programme together with Diabetes UK to engage 10,000 people at risk of diabetes in its first year.
- Initiated independent taskforces to help us improve cancer and mental health services led by Harpal Kumar of Cancer Research UK and Paul Farmer of Mind, respectively, with Baroness Cumberlege leading a task force on maternity services.
- Published a 10 point plan to underpin our new deal for primary care, focused on recruiting more GPs, retaining them better and encouraging those who have left to return to practice, and invested the first of a £250m per year fund into primary care premises, with further investment to follow.
- Created the Workforce Race Equality Standard that will – for the first time – require organisations employing the 1.3 million NHS workforce to demonstrate progress against indicators of workforce equality, including low levels of black, minority and ethnic Board representation.
- Established the NHS Five Year Forward View Board, comprising the CEOs of the NHS's principal leadership bodies, to provide strategic oversight of the delivery of the Forward View and support greater alignment between the different statutory bodies at a national and local level.

We have made a good start, but there is much more to do. The pressures described in the *Forward View* – demographics, expectations, technology – do not just apply in the future; they are faced by the service today. This means that we cannot treat 'transformation' as a separate project, distinct from the day job, nor can we afford to delay it whilst we stabilise the system. It is exactly because the service is under so much pressure today that we have to upgrade our prevention efforts and design new models of care.

But we need to do more to create the conditions within which local services can deliver during 2015/16. Over the next few months, we will be discussing with front line staff

what further actions we can all take to relieve some of the pressures in 2015/16. In advance of this, there are some clear areas where collective action can support local delivery.

3. Creating the conditions for success in 2015/16

Overall, the health sector managed within its budget in 2014/15, with the provider sector delivering more than £2bn of efficiencies, but this was only achieved thanks to the extraordinary efforts of frontline staff, and with provider deficits beginning to appear. This week we have announced a series of measures to support local leaders deliver on their responsibilities to deliver high quality care and financial control in 2015/16:

Collective action to support sustainable staffing

Whilst in the short term, agency staff can seem like a quick and flexible solution, over reliance on agency staff can compound and embed problems with quality and finance further down the line. So to support providers to take a more sustainable approach that provides a better deal for patients, tax payers and staff, we have announced a set of collective actions to help organisations reduce the costs currently charged by agencies. Subject to the detail set out in a letter to the service we will:

- Require all agency staff to be procured from existing, agreed frameworks
- Set maximum rates for grades and specialities of staff on a geographical basis
- Set a ceiling for agency spend for each provider.

More information can be found here.[2]

In addition to these controls, HEE will lead national action through the Workforce Advisory Board to tackle the underlying cause of the growth in use of agency staff, including:

[2] https://www.gov.uk/government/news/clampdown-on-staffing-agencies-charging-nhs-extortionate-rates

- Ensuring a greater supply of NHS nurses through extending the successful national Return to Practice Campaign which has already supported over 1,300 experienced nurses to come back to the NHS within months at a cost of £2,000 per person, rather than 3 years at a cost of £50,000
- Sharing of best practice on staff retention, and joint action on short-term international recruitment to alleviate immediate pressures whilst increased domestic supply from recent increases to training commissions comes on stream
- Supporting efforts to provide NHS staff with more flexible working including looking at shift patterns and pensions and supporting better career paths for our nurses
- Reduce staff sickness rates and the need for agency staff by improving the health of the NHS workforce, linking with the work led by the Prevention Board.

Leveraging our national buying power

NHS commissioners and providers spent £580m on consultancy services in 2014/15. Consultancy can be a good source of independent advice and delivery support, as well as external audit, but the NHS does not always use its purchasing power as well as it might. In order to help the service ensure better value for money, we will:

- Require all consultancy contracts over £50,000 to have advance approval from the relevant oversight body
- Discuss with the big consultancy firms how we can share the knowledge we commission from them where relevant across the NHS
- Explore other ways the NHS can combine its purchasing power to leverage better prices for the NHS locally.

Securing high quality care and financial balance today is a vital part of our shared ambition to deliver a new kind of health service tomorrow, but we cannot continue to manage these pressures through a series of quick fixes. The only sustainable solution is fundamental reform: getting serious about prevention, changing the way in which care is provided and delivering high quality care wherever it is provided, and getting the most value out of every pound that we spend.

4. Delivering the vision for 2020

The *Five Year Forward View* set out three underpinning principles for change:

- Our shared challenge is to close three gaps in health care: the health and wellbeing gap, the care and quality gap, and the funding and efficiency gap. For the NHS to meet the needs of future patients in a sustainable way, we need to close all three of these gaps. This means we can no longer simply respond to the forecasts of ill health and increased costs; the NHS must become a pro-active agent of change, taking bold action to 'bend the curve' on predicted trends.
- The NHS will not succeed in closing these three gaps by delivering the care in the same way that we have always delivered it. Success will require us all to think beyond our statutory and organisational borders to meet the needs of the people we serve. The role of national bodies is to create the conditions for local leaders to succeed.
- The NHS cannot close these three gaps alone. If we are to close all three gaps, then we will need our partners across health and social care in Local and National Government, individuals and their communities, the corporate and charitable sectors to use their levers, unleashing local energies to help create the future we want.

The following sections sets out the actions we will need to take as a system if we are to close all three gaps by 2020.

4a. Closing the care and quality gap

In the Five Year Forward View, we signed up to a double opportunity: to narrow the gap between the best and the worst whilst raising the quality bar higher for everyone.

Raising the quality bar higher for everyone

As a catalyst to create new ways of delivering care that are better suited to modern health needs and more productive, we are working with 29 Vanguard areas to develop and implement the new care models outlined in the Forward View. Our aim is not just to improve services in the Vanguard areas, but to develop models that can be replicated

elsewhere, drawing on recent lessons from other leading edge areas, such as the integrated care pioneers.

By July, we will publish a support programme to tackle common problems and accelerate implementation of new care models. Each Vanguard area will personally be sponsored by one of the ALB Chief Executives. This association will help national bodies deepen their understanding of barriers to implementation so that they can help to remove them. In tandem with the support programme, we will begin investing the £200m Transformation Fund available in 2015/16.

We have invited expressions of interest from hospitals across England interested in developing new ways of delivering and improving their local acute services. These new Vanguard sites will focus on promoting collaboration between acute providers. Drawing on the findings of Sir David Dalton's review, these new models may include greater use of clinical networks across nearby sites, joint ventures between NHS organisations, or the delivery of specialist single services across a number of different providers. Like the other Vanguards, they will benefit from a programme of support as well as investment from the Transformation Fund.

In addition, we are inviting areas covering five million people to become Urgent and Emergency Care Vanguards. Sir Bruce Keogh's *Urgent and Emergency Care Review* showed a strong consensus that this system should be redesigned. We must ensure people with more serious or life-threatening emergency needs are treated in hospitals with the very best expertise and facilities. Those with urgent but non-life threatening needs could be much more effectively treated outside of hospital but, in the past, out-of-hours services have been difficult to access or understand and the potential of the ambulance service has been under-utilised. The new Vanguards will help us design this differentiated approach in a way that can be replicated elsewhere, with a particular focus on developing convenient and technologically-enabled out of hospital services for people with urgent but non-life threatening needs. Similar to other Vanguards, we will partner with areas that are enthusiastic about implementing the Keogh review, moving further and faster with intensive national support, problem solving and transformation funding.

Workforce issues will be central to all Vanguards, as organisations do not deliver care to patients: people do. Through its local LETBs, HEE will work with the Vanguard areas to support the development of the new workforce required to deliver the New Care Models. The Workforce Advisory Board will shortly launch a drive for Exemplars – organisations who have already successfully implemented such changes and develop bespoke training and development packages to support staff in leading and delivering change.

Narrowing the gap between the best and the struggling

We know from the CQC's inspections and other national and international reports that there is still too much variation in the NHS. 65% of services across health and social care deliver good or outstanding care, but that means that about 1 in 3 services still require improvement, and they require this improvement now. Under the leadership of the National Quality Board, we will further align our understanding of quality in the NHS, how we measure it, and set common priorities for quality improvement. Ultimately, we want all parts of the NHS to provide high quality services through the New Care Models in the future. Focusing on individual providers alone will not achieve this, however. There are a number of local health and care systems where, unlike the Vanguard areas, the conditions for transformation do not yet exist. In these most challenged areas, we will introduce a new regime of support for whole health care economies to help create the conditions for success, the 'Success Regime'. This new approach will:

- Work across whole health and care economies as opposed to just individual organisations
- Be overseen jointly by NHS England, Monitor and the NHS Trust Development Authority at both a national and regional level, so that the efforts of the various statutory bodies and regulators are aligned
- Provide the necessary support and challenge to health and care economies by diagnosing the problems, identifying the changes required and implementing them
- Strengthen local leadership capacity and capability, with a particular focus on radical change and developing collaborative system leadership

- Actively consider how the New Care Models might form part of the solution for the selected health and care economies, rather than trying to patch up struggling services in old ways.

Following a period of national and regional assessment, work will now begin with the three health and care economies that will be the first to benefit from the Success Regime. These are:

- North Cumbria
- Essex
- Northern, Eastern and Western Devon.

More details on how the Success Regime will work, the first cohort of entrants and how the Success Regime Board will make decisions about future areas is available here. [3]

4b. Closing the health gap

We are living longer lives but we are not living healthier lives. The overwhelming majority of ill health and premature death in this country is due to diseases that could be prevented if people lived healthier lives. Many could also be detected earlier and better managed to prevent deterioration and hospitalisation.

The NHS cannot achieve this alone: bending the curve on ill health will require concerted action from individuals, local government and other public, private and third sector bodies alongside the health service. To drive this increased emphasis on prevention, and to coordinate between bodies, we have established a national prevention board, chaired by Public Health England and reporting directly to the NHS *Five Year Forward View* Board, composed of the CEOs of the seven national leadership bodies.

The early focus of this Board is diabetes prevention. Diabetes is a growing problem: since 1996, the number of people living with diabetes has more than doubled. If we do nothing, there could be more than four million people in England with diabetes in the

[3] https://www.gov.uk/government/publications/five-year-forward-view-the-success-regime-a-whole-systems-intervention

next 10 years. Treating the condition and its complications including blindness, amputations, stroke and heart attacks already accounts for around 10% of the NHS budget.

The Diabetes Prevention Programme aims to halt this rise, delivering at scale lifestyle interventions that have been shown to help individuals at high risk of developing Type 2 diabetes. Announced earlier this year, seven local demonstrator sites have been developing the early stages of the programme, in line with international evidence. Over the next few years, we will be rolling the programme out across England with the ambition of enrolling 100,000 people who are at risk.

The Diabetes Prevention Programme is the first step in upgrading our prevention efforts. Improving the health of the 1.3 million people who work for the NHS is another early priority. We will also continue to underline the importance of bringing obesity up the national agenda, with the development of a new cross-Government drive that will be developed over the coming months.

4c. Closing the funding and efficiency gap

The Forward View set the ambition for the NHS to achieve an extra 2 - 3% average annual net efficiency gain over the next period. This does not represent a cut in funds, but the headroom we need to find within our own growing budget to meet the forecast rise in demand. In order to achieve this there are three main areas where the NHS needs to take action:

- *Preventing and managing demand* – reducing, wherever possible, the need for health care in the first place by supporting people to keep healthy
- *Maximising the value of our £115bn spend* – driving up productivity and reducing inefficiencies so that more of our budget is spent on patients who need our care
- *Redesigning services* – investing in new ways of providing joined up care in a more clinical and cost-effective way for patients and their carers.

Some of the required actions are a matter for individual organisations to lead: Trusts are best placed to reduce staff sickness levels, for example. Other actions – such as levering our national clout to get the best pricing deals – are best taken at a national level whilst some issues – such as the redesign of services or preventing ill-health – are best achieved through collective action: not just by partnering with other sectors, but by harnessing the energy of local communities and voluntary groups.

So instead of simply drawing up a national blue print for how we plan to make £22bn efficiency gains in Whitehall, we will develop key elements of the programme just as we developed the vision: together with the service, our partners and the patients we serve. Below we set out some of the initial actions we will take at a national level to start making the efficiency gains, but we will embark upon a major programme of engagement to help identify the further opportunities that lie within organisations or as part of wider collective action.

Preventing and managing demand

Demand for health services is growing. Demand will continue to grow, driven by population growth, an increase in chronic conditions, technological change and an ageing society. In the *Five Year Forward View* we argued that we should not sit back and let forecasts become reality, but take active steps to moderate predicted hospital activity, whilst recognising that some demand will be dependent upon the ability of social care services to respond to needs in their sector. The most important way of doing this is to radically upgrade our prevention efforts, particularly in those areas that have an impact in the short – medium term. This is why we've already committed to a nationwide diabetes prevention programme: international evidence suggests that people completing these programmes achieve 5% weight-loss and within three years reduced downstream spending will outweigh initial costs.

Continued support to help people stop smoking brings immediate benefits in addition to long-term decreases in the risk of cardiovascular disease and cancer. Similarly, reduction in alcohol misuse immediately reduces the risk of ending up in A&E, and reductions in the prevalence of hypertension and high cholesterol can help avoid

hospitalisations. Even action on obesity can have short-term and well as long-term benefits: weight loss of 5-10% quickly lowers blood pressure and cholesterol, underlining the importance of bringing obesity up the national agenda, with the development of a new cross-government drive on obesity.

Supporting people to manage their own health and healthcare can both improve outcomes and reduce costs—something that 70-80% of the approximately 15 million people with long-term conditions could do with appropriate support. The Expert Patient Programme, for example, suggests that at a typical investment of £400 per patient could save about £4,000 per year.

We know that a small number of patients consume a very large proportion of total resources. Increasingly, we are able to identify these patients before their health deteriorates using a mix of predictive software and professional judgment. Through the Vanguard programme, we will develop effective tools for identifying and managing people at risk to all CCGs and providers—including care homes. The Vanguards will also implement new types of capitated contracts that will strengthen incentives to identify people at risk of falling seriously ill, to intervene early and to manage their care in the most cost-effective way. In mental health, we are investing substantially in improving early intervention for psychosis, as well as the introduction of the first ever mental health access standards.

Maximising the value of our £115bn spend

We will also take further steps to ensure that the money we spend returns the highest possible health dividend. Alongside investing more in prevention and early intervention, it also means examining our current patterns of expenditure for unwarranted variation.

For commissioners, tools such as RightCare's *NHS Atlas of Variation* and Commissioning for Value analyses illustrate how areas can achieve very different outcomes despite similar levels of expenditure, and vice versa. NICE's Quality Standards, dovetailing with CQC's inspection framework, pinpoint the practice that needs to be standardised to deal

with this variation. By benchmarking costs and outcomes across comparable areas, these tools help areas understand how they could change spending patterns to achieve better overall value and where to target their improvement programmes. For example, the RightCare approach helped Warrington CCG to identify higher non-elective admissions compared to its peers, which in turn led to implementing decision aids and other clinical improvements that have held down admissions and saved £15m per year. NHS England working in partnership with PHE will roll out the RightCare to all CCGs. In terms of provider efficiency, there is still a significant variation between the best and worst performers on a whole raft of areas including length of stay, day case rates and new-to-follow up ratios and so forth. Costs for the same goods can vary by as much as 35% between hospitals. In addition, estate efficiencies across the acute and mental health sectors could yield a gain of perhaps £1bn pa, with perhaps a further £1bn one-off gain from the sale of surplus estate; some estimates, even suggest figures up to £7.5bn. Although this would be a one-off, there may be opportunities to repurpose some of this estate in other ways.

To support the sector meeting this challenge, we will set clear expectations and incentives for the system to improve, ensuring consistency of approach and alignment between the different national bodies. This will be underpinned by making improvements to how we set incentives as part of the payment system, including setting a stretching and credible efficiency factor consistent with the size of the opportunity.

Following the introduction of CQC's new inspection and ratings approach, we now have greater transparency about the quality of care in our services than ever before, and the work of the National Information Board will support patients to make better choices by providing transparency on the quality of care. To understand if we are spending our money well we will need similar transparency about efficiency. We will work together to develop a common, comparable measure of the good use of resources in the NHS, and to ensure insights about service quality and use of resources sit alongside each other. Good performance and management information will be critical to driving improvements. We will support providers by making transparent and high quality productivity information available, building on the benchmarking work that is

developing through Lord Carter's review, so that they can lead the conversations about areas for improvement and greater efficiency.

We will develop a programme of support for the provider sector to help build management capability and align investments in leadership and management more closely with the productivity agenda, following the Smith Review. Further investment will be made in developing and disseminating good practice which can be shown to support productivity improvement, and we will harness the benefits of the information revolution to deliver further change.

Over the last four years, we have reduced central administration costs by a third in order to maximise funding for frontline services, including £700m of reductions to Department of Health and NHS England central programmes. Nationally, we will continue to hold central administrative costs and budgets down to ensure that frontline services take priority.

Redesigning more productive services

Monitor estimates that between 2-4 million A&E attendances could be dealt with outside hospital and up to 20% of admissions could be treated by ambulatory emergency services and sent home on the same day. Between 20-30 million elective attendances currently led by hospital consultants could also be shifted to out-of-hospital settings**.** Opportunities like these illustrate how we can rewire healthcare to increase its productivity.

This is already happening in some of our Vanguards. For example, Multispecialty Community Providers will incorporate some acute specialists such as consultant geriatricians, psychiatrists and paediatricians to provide integrated specialist services in out-of-hospital settings. We will be working with our first 29 sites to redesign these more efficient models and to do so in a way that can be replicated elsewhere.

Although delivering care that is more coordinated and delivers better outcomes or patients is the primary focus of our new models of care programme, it is also important that they are more productive – that they can do more with the same or less. The recently launched acute collaboration Vanguards will design ways of sharing clinical and/or back office services between hospitals in networks or chains, sweating assets more and making a fixed amount of resources go further—giving some district general hospitals a path to long term sustainability. Similarly, the new urgent and emergency care Vanguards announced yesterday will design ways of ensuring people's needs are met in the right place, making the most of the total resources available across a network of services primary, community and hospital services.

5. Delivering together

The publication of the *Five Year Forward View* was as an important moment for the NHS. If we are to achieve the profound changes in care that we know are needed, then we must work in partnership with patient groups, front line staff, social care and local government partners, as well as Government, business and representative bodies. In recognition of this, engagement is integral to our collective governance: the NHS *Five Year Forward View* Board meets quarterly with wider representatives of the system leadership, including NHS Confederation, NHS Providers, National Voices, Local Government Association, and Clinical Commissioners to discuss key issues, and each Programme Board has representation and advice from stakeholders relevant to the particular issue

We have now asked a range of stakeholders to come together and agree how best to implement the changes, drawing on their expertise and energy to help develop implementation plans over the next four months:

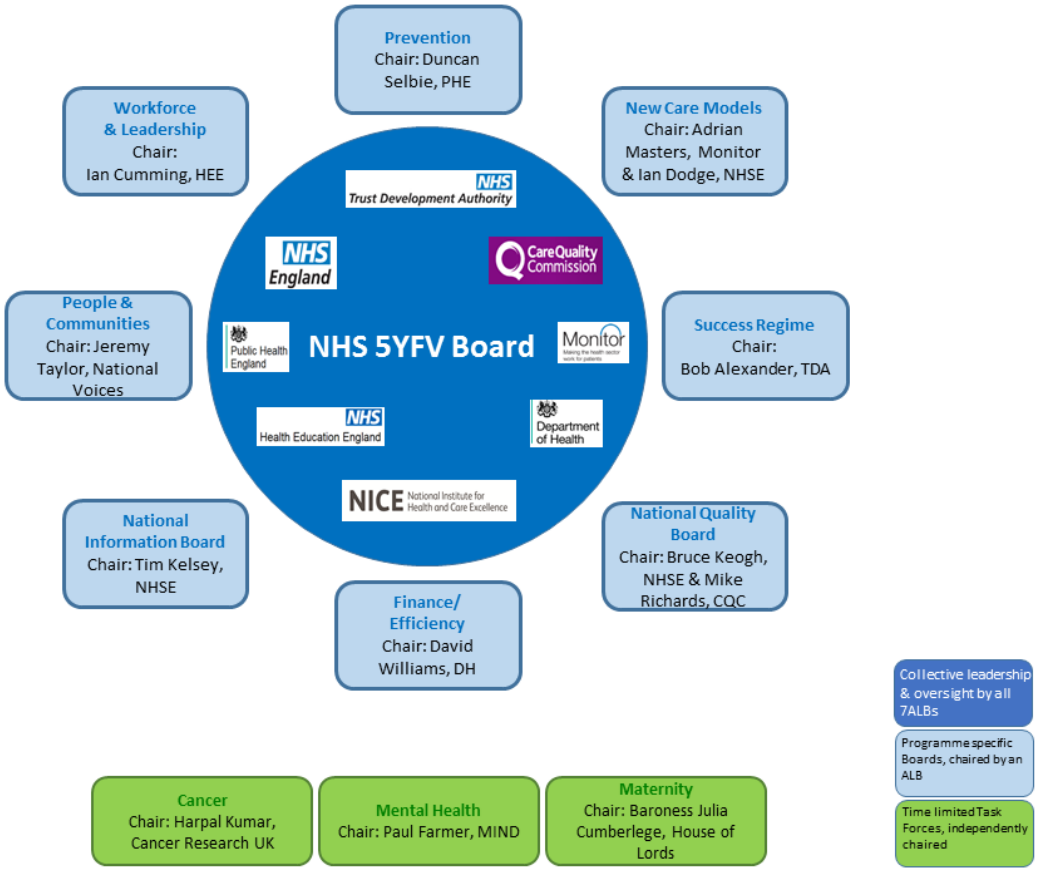
- *Closing the finance and efficiency gap*: The NHS Confederation and NHS Providers will work together with other partners to lead a series of round table discussions, bringing together local and national leaders from all professions and sectors, on behalf of the Finance Board.
- *Closing the care and quality gap*: The Stakeholder Forum of the National Quality Board will lead a series of engagement events through their existing networks on

how we can best close the quality gap, working with the stakeholder forum of the New Care Models Board.

- *Closing the health and wellbeing gap*: The Stakeholder Forum of the Prevention Board will work with the LGA and representatives of the People and Communities Board to lead a series of engagement exercises through their existing networks on how we can best close the health and wellbeing gap.

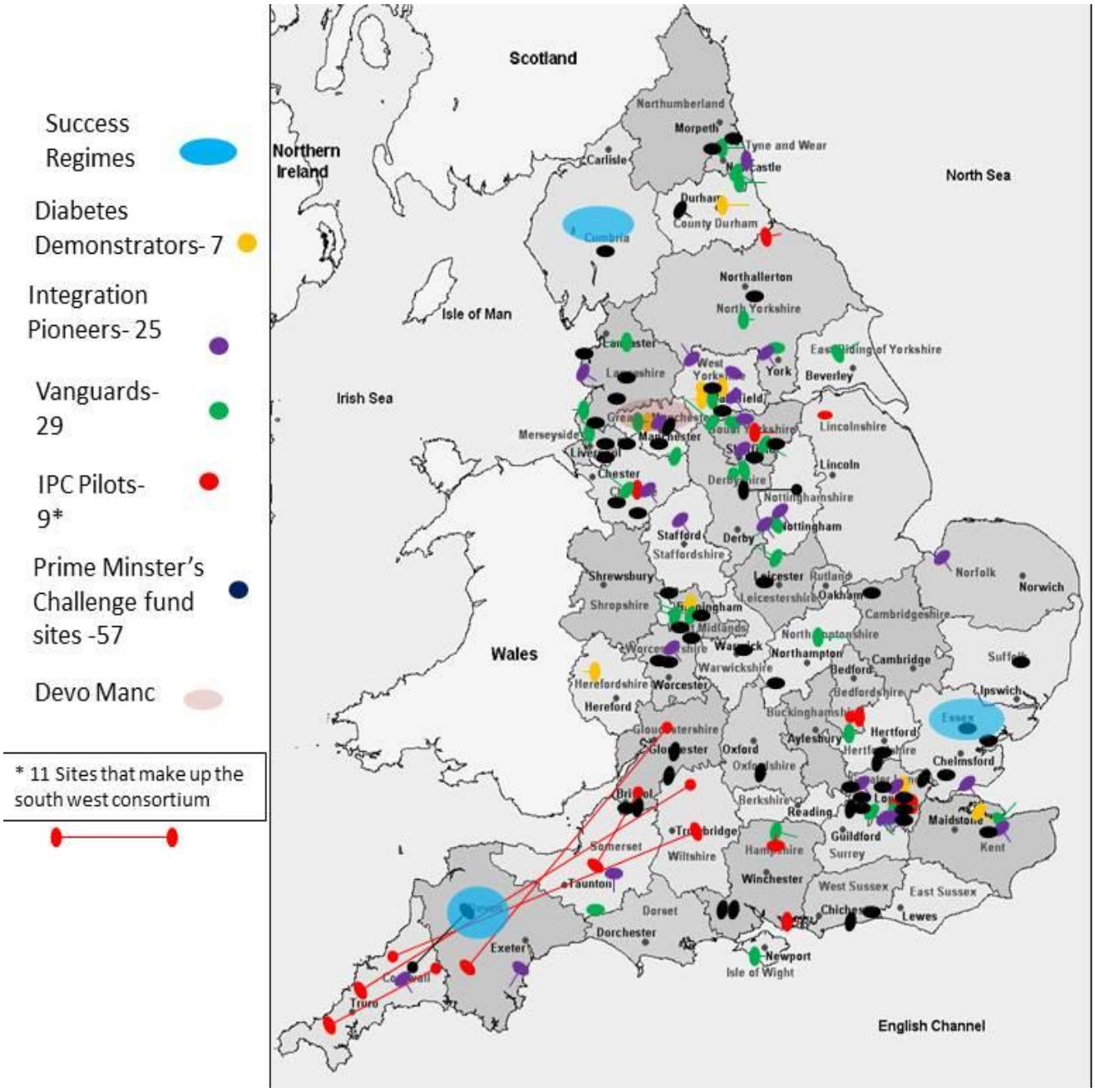
The results of this engagement process will inform our local and national planning processes in the autumn, but more importantly, it will provide the foundation for our success: we have a plan; we have the support, now we must deliver the *Five Year Forward View* together.

Annex A: Governance arrangements for driving forward the *Five Year Forward View*



The NHS *Five Year Forward View* Board consists of the CEOs of each of the seven Arm's Length Bodies. Non-statutory, it does not replace the individual accountabilities of each board, but provides the opportunity for collective oversight of the delivery of the 5YFV.

Annex B: Forward View progress to date: Pilot programme map




Care Quality Commission
NHS England
NHS Health Education England
NHS Trust Development Authority
Monitor
Making the health sector work for patients
Public Health England
NICE National Institute for Health and Care Excellence

North Staffordshire Combined Healthcare NHS
NHS Trust

Encl 15

REPORT TO: TRUST BOARD

Date of Meeting:	30 July 2015
Title of Report:	Performance Report – Month 3 2015/16
Presented by:	Ann Harrison, Interim Director of Finance
Author of Report: Name: Date: Email:	 Kevin Daley 23/07/15 Kevin.Daley@northstaffs.nhs.uk
Purpose / Intent of Report:	• Performance monitoring
Executive Summary:	This report provides the Board with a summary of performance to the end of Month 3 (June 2015). Performance against the TDA metrics and key National Targets is included within the report. A range of metrics is in place to monitor performance, quality and outcomes. The indicators are those set by our commissioners and local trust targets and aligned to the relevant Trust objectives. Performance against these KPIs has been reviewed by the Finance & Performance Committee prior to this report being presented to Trust Board In month 3 there is 1 metric rated as Red, 6 rated as Amber and 54 rated as Green; ratings for the 26 unrated metrics will be determined once technical guidance is received from the TDA. The report also provides details of year-to-date exceptions (i.e. not in month 3) and exceptions against internal targets. Executive leads will provide a verbal update at the meeting, where appropriate.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	Governance Strategy The Performance & Quality Management Framework measures performance across National and local indicators, presented against the Trust's enabling strategies, commissioning contract and the TDA's proposed assurance framework.

Relationship with Annual Objectives:	The Performance & Quality Management Framework measures performance across all annual objectives
Risk / Legal Implications:	All areas of underperformance are separately risk assessed and added to the risk register dependent on the outcome of the risk assessments.
Resource Implications:	Not directly as a result of this report
Equality and Diversity Implications:	Not directly as a result of this report
Relationship with Assurance Framework [Risk, Control and Assurance]	The Performance & Quality Management Framework is a key control within the Assurance Framework
Recommendations:	The Board is asked to • Consider and discuss reported performance with particular emphasis on areas of underperformance • Confirm sufficient detail and assurance is provided

PERFORMANCE MANAGEMENT REPORT TO TRUST BOARD

Date of meeting:	30 July 2015
Report title:	**Performance & Quality Management Framework** **Performance Report – Month 3 2015/16**
Executive Lead:	Interim Director of Finance
Prepared by:	Kevin Daley, Performance Development Manager
Presented by:	Glen Sargeant, Head of Performance & Information

1 Introduction to Performance Management Report

The report includes TDA metrics, targets where agreed, trends and revised RAG rating

- An Executive Summary (this report)
- Overall performance of metrics with targets (App A)

In addition to the attached appendices a full database (Divisional Drill-Down) has been made available to Directorate Heads of Service and Clinical Directors to enable them to scrutinise / check the supporting data and drive improvements based on that data.

2 Executive Summary – Exception Reporting

This section presents an overview and performance by exception across all Key Performance Indicators in place to measure performance, quality and outcomes.

In month 3 there is 1 metric rated as Red and 6 as Amber; targets for the unrated metrics will be updated once 2015/16 technical guidance is received from the TDA. Figures for year-to-date exceptions (i.e. not in month 3) and exceptions against metrics being monitored in-year are also provided in the table below.

	Month 3			
Metric Driver	**Red**	**Amber**	**Green**	**Unrated**
Exceptions – Month 3	**1**	**6**	**53**	**26**
Exceptions – Year to Date	3	2	n/a	n/a
Trust (Monitoring Metrics)	1	0	8	11

3 Exceptions - Month 3
4

Metric	Exec/Op Lead	Target	M3 Perf	YTD Perf	Forecast Outturn	Trend	Commentary
TRAINING: % staff compliant with mandatory training	Workforce Dir Op Lead B Dawson	**95%**	AMBER **89%**	AMBER **89%**	AMBER	↗	**89% @ month 3 from 88% at month 2** Month 3 breakdown Corporate Services = 89% AMH Community = 90% AMH In Patient = 85% Substance Misuse = 97% CYP = 88% Learning Disabilities = 94% NOAP = 90% Trust is proactively taking action with teams to ensure that all staff attend statutory & mandatory training and maintain their compliance.
APPRAISAL: Annual appraisal and personal development plan % - All staff	Workforce Dir Op Lead	**90%**	AMBER **89%**	AMBER **89%**	GREEN	↘	**89% @ month 3 from 92% @ month 2** Trust is proactively taking action with teams to ensure that all staff have an appraisal and PDR.
CPA: The proportion on Care Programme Approach (CPA) for at least 12 months Having formal review within 12 months	Dir of Ops Op Lead H of Dir	**95%**	AMBER **94%** AMBER **90.1%**	AMBER **94%** AMBER **90.1%**	GREEN GREEN	↔ ↘	**Contractual metric: 94% @ M3 from 94% @M2** **New method of calculation which now reflects the TDA monitoring process 90.1% @ M3 from 90.3% @ M2** Initiative being implemented to ensure that all reviews are undertaken within the appropriate timescale and input within 72 hours. Teams being targeted with weekly reports identifying patients whose review is due within the forthcoming 6 to 8 weeks.

							The majority of current underperformance is related to the Greenfield Centre, Head of Directorate copied in on weekly reports. To be addressed via PMS session
Metric	**Exec/Op Lead**	**Target**	**M3 Perf**	**YTD Perf**	**Forecast Outturn**	**Trend**	**Commentary**
Gatekeeping Admissions to inpatient services who had access to Crisis Resolution	Dir of Ops Op Lead N Griffiths	**95%**	**AMBER 93.2%**	**GREEN 96.5%**	**GREEN**	↘	**93.2% @ M3 from 100% @ M2** During June 4 patients admitted were not gate-kept in accordance with the Trust's procedure. Admissions took place without the Access (Crisis) team being contacted.
IAPT: - Min data set	Dir of Ops Op Lead S Woodall	**90%**	**AMBER 87%** (@M1)	**AMBER 87%** (@M1)	**GREEN**	↗	Last reported data was Provisional February 2015 provisional outturn position of **83%**. Using provisional data for April the Trust is above the national average **(74%)** compliance levels at **87%** and in the top cohort of Trusts in terms of data completeness. The IAPT data is 83% which is above the national average (74%) and is in the top cohort of Trusts in terms of data completeness, rated 'Green' using HSCIC data validity measures. The Trust is rated as Green using HSCIC data validity measures. The data for IAPT Services will not currently reach 90% target as a number of clients will step out of the service and initial assessment is not completed where the therapist complete min data set. Agreed Plan: · 3 demographics (Religion, Sexual Orientation, ethnicity) are reported on the HSCIC as 'not stated' for clients not being initially assessed in the service, HSCIC contacted for data quality guidance by Healthy Minds Data Lead on 26th May 2015, response from HSCIC indicates working through data quality query. HSCIC contacted again and still awaiting a response, the following actions implemented: Healthy Minds Team briefed about the data quality and to update demographic details. Honos clustering has been completed for all clients awaiting therapy. Provisional data for April on the HSCIC indicates the data quality is 87%.

Metric	Exec/Op Lead	Target	M3 Perf	YTD Perf	Forecast Outturn	Trend	Commentary
IAPT Cont: No. moving to recovery	Dir of Ops Op Lead S Woodall	**50%**	**RED 36.9%**	**RED 36.9%**	**GREEN**	↘	**39.6% @ month 3 from 45.8% @ month 2** Agreed Plan to improve recovery outlined below · Improved caseload management/supervision policy in line with NHS Review · DNA data reports developed to indicate DNA at Assessment or Treatment appointments. · Assistant Psychologist Audit to drill down drop out and recovery in the service · Development of new evidence based clinical pathway - now operational · CPD and training plan to be developed over year 3.

3.1 Exceptions - Year to Date

Metric	Exec/Op Lead	Target	M3 Perf	YTD Perf	Forecast Outturn	Trend	Commentary
IAPT - No. entering psychological therapies	Dir of Ops Op Lead S Woodall	**940 = Q1 Target**	**GREEN 373**	**AMBER 936**	**GREEN**	↗	**373 @ M3 from 266 @M2 - Agreed with commissioners to refresh local data whilst awaiting publication of the HSCIC data. April M1 refreshed data is 297** There is a 15% prevalence which has been graduated throughout year 3. The NHS Review Report indicated additional investment was required for the Healthy Minds Service to meet the agreed service targets. The Trust as lead contractor will invest the additional funds into the Healthy Minds Service. The recruitment is due to commence Quarter 2. The directive with the additional investment is outlined below: To reduce waiting times for therapy and increase clients entering treatment. Front end of the service will be redesigned to increase numbers of clients

							entering treatment. Streamline assessment process, increase staff resource: 1WTE therapist, 1.4 CPN To increase entering into treatment for low intensity step 2 service model , increase staff resource: 2 WTE therapists, 1WTE STR Worker Booking appointment system streamlined, to free up therapists to concentrate on clinical activity, increase staff resource: 1 WTE Admin recruited Service productivity is being monitored and managed monthly Increase number of self-referrals and engagement groups through marketing strategy Set trajectories based on capacity to meet performance targets.
Metric	**Exec/Op Lead**	**Target**	**M3 Perf**	**YTD Perf**	**Forecast Outturn**	**Trend**	**Commentary**
IAPT Cont: Proportion receiving psychological therapies	Dir of Ops Op Lead S Woodall	**3.33% @ M3**	**GREEN** **1.32%**	**AMBER** **3.32%**	**GREEN**	↗	**1.32% @ month 3 from 0.94% @ month 2, Quarter 1 cumulative (April/ May/June) target: 3.33%** **(Qtr 1 3.33% - Qtr 2 3.75% - Qtr 3 3.96% - Qtr 4 3.96%)** The NHS Review Report indicated additional investment was required for the Healthy Minds Service to meet the agreed service targets. The Trust as lead contractor will invest the additional funds into the Healthy Minds Service. The recruitment is due to commence Quarter 2. The directive with the additional investment is outlined below: To reduce waiting times for therapy and increase clients entering treatment. Front end of the service will be redesigned to increase numbers of clients entering treatment. Streamline assessment process, increase staff resource: 1WTE therapist, 1.4 CPN To increase entering into treatment for low intensity step 2 service model , increase staff resource: 2 WTE therapists, 1WTE STR Worker

							Booking appointment system streamlined, to free up therapists to concentrate on clinical activity, increase staff resource: 1 WTE Admin recruited Service productivity is being monitored and managed monthly Increase number of self-referrals and engagement groups through marketing strategy Set trajectories based on capacity to meet performance targets.
Admission: Number of patients 16/17 year old admitted to Adult Psychiatric Wards	Director of Ops Head of Dir	**0**	**GREEN** **0**	**RED** **1**	**RED**	↗	**1 @ month 2** Due to the unavailability locally or nationally of a CAMHS bed, 17 year old male has been admitted to Ward 2, Harplands Hospital. Given the age of the patient and lack of a suitable tier 4 placement this was reviewed clinically and thought to be the most suitable cause of action. Under current reporting requirements this does trigger a SI. Serious Incident 2015/15749 raised 01/05/15
Metric	**Exec/Op Lead**	**Target**	**M3 Perf**	**YTD Perf**	**Forecast Outturn**	**Trend**	**Commentary**
HCAI: Incidence of healthcare associated C-difficile	Director of Nursing Op Lead C Wagner	**0**	**GREEN** **0**	**RED** **1**	**RED**	↗	**1 @ month 2** The patient is a gentleman who is physically quite poorly, with co-morbidities of lung cancer and myocardial infarction. He has had numerous admission to the Royal Stoke prior to this most recent to the Harplands. He became symptomatic since his admission to the Harplands. Once the RCA is available we will be able to better understand any other predisposing factors (eg. Antibiotic therapy in the 3 month prior to the infection).
MH Tribunal process: % compliant returns within 3 weeks	Medical Director Op Lead S Dawson	**100%**	**GREEN** **100%**	**RED** **77%**	**GREEN**	↗	**75% @ April reporting** **NB/ This data is only available a month in arrears.** There has been an increase in performance from last month; a 'Practice Notice' has been developed which has been circulated to all relevant staff by the Medical Director. The deadline for 100% compliance with this requirement is **June 2015 data.**

4 Risk Ratings

The TDA measures Trust performance in five categories:
At month 3 we have maintained our rating of **Level 4** (out of 1 to 5), where 5 is best.

5 Recommendations

- Consider and discuss reported performance with particular emphasis on areas of underperformance
- Confirm sufficient detail and assurance is provided

The following metric is formally monitored during 2015/16; it will be live from 2016/17:

Metric	Exec/Op Lead	Target	M3 Perf	YTD Perf	Forecast Outturn	Trend	Commentary
Early Intervention: % of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks.	Dir of Ops Op Lead S Wilson	**50%**	**RED** **17%**	**RED** **17%**	**GREEN**	↘	**17% @ month 3 from 19.5% at month 2** These figures relate to current working practice, where allocations onto caseload are through the weekly team meeting – the Operational Lead is reviewing processes and an action plan is in place to close the gap.

Enclosure 16

REPORT TO TRUST BOARD

Date of Meeting:	30 July 2015
Title of Report:	NHS Trust Development Authority (NTDA) Monthly Self Certifications.
Presented by:	Ann Harrison, Interim Director of Finance
Author of Report: Name: Date: Email:	Glen Sargeant, Head of Performance and Information 20 July 2015 glen.sargeant@northstaffs.nhs.uk
Purpose / Intent of Report:	Information and approval
Executive Summary:	This paper confirms that the monthly NTDA self-certification documents have been reviewed by the executive team and are ready to be submitted, with no changes from last month's position of compliance to report. Declarations include: • Fit & proper directors • Registration with CQC • Provision of integrated care • Effective arrangements for monitoring and continually improving the quality of healthcare • Compliance with TDA Accountability Framework In all there are 26 self-certification declarations and these form part of the NTDA Oversight and Escalation Process. Following the Trust's submission of the report detailing the action it has taken after the inspection in December 2014 we have stated to the CQC that the Trust is of the opinion that the required actions are complete in relation to the services inspected and as such is now meeting the staffing regulation. The CQC is satisfied with the Trust's response as we provided a very detailed plan but from the CQC perspective it still remains as a compliance action against the Trust as they have not yet signed it off. Therefore the CQC suggested that in

	any correspondence with the TDA we should point out that in our opinion we are meeting the standard for staffing but the delay with sign off sits with the CQC. Based on June 2015 data, the Trust is therefore declaring compliance with all requirements.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	Clinical, Finance and Governance. There is no direct impact on patients or the public.
Relationship with Annual Objectives:	5: Robust plans delivering quality and sustainable services
Risk / Legal Implications:	None
Resource Implications:	None identified
Equality and Diversity Implications:	None identified
Relationship with Assurance Framework [Risk, Control and Assurance]	Supports the wider framework
Recommendations:	The Board is asked to : • Approve the submission for June 2015 data declaring compliance with all requirements. This is to be sent to the NTDA on or before the last working day of July 2015.

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: Open Trust Board

Enclosure 17

Date of Meeting:	Thursday 30 July 2015
Title of Report:	Board Assurance Framework
Presented by:	Dr Buki Adeyemo on behalf of Mrs Caroline Donovan
Author of Report: **Name:** **Date:** **Email:**	Caroline Donovan, Chief Executive Caroline Donovan 21 June 2015 Caroline.donovan@northstaffs.nhs.uk
Purpose / Intent of Report:	• For Assurance
Executive Summary:	The Board Assurance Framework (BAF) has been significantly developed over the last few months, aligning the Trust strategic objectives to our quality priorities and key risks including the Board's level of risk appetite. The BAF provides an update and RAG rating for those actions due during quarter 1 and provides an update against future actions including gaps and challenges to be addressed.
Which Strategy Priority does this relate to: **How does this impact on patients or the public?**	• Customer Focus Strategy • Clinical Strategy • IM and T Strategy • Governance Strategy • Innovation Strategy • Workforce Strategy • Financial Strategy • Estates Strategy
Relationship with Annual Objectives:	To ensure delivery of the trust's key objectives
Risk / Legal Implications:	N/A
Resource Implications:	N/A
Equality and Diversity Implications:	N/A
Relationship with Assurance Framework [Risk, Control and Assurance]	N/A
Recommendations:	To receive the Board Assurance Framework for assurance purposes

North Staffordshire Combined Healthcare NHS Trust

Board Assurance Framework (BAF)

Welcome to the Board Assurance Framework for North Staffordshire Combined Healthcare NHS Trust.

The Trust Board is responsible for ensuring that North Staffordshire Combined Healthcare NHS Trust consistently follows the principles of good governance applicable to NHS organisations. The Board does this through the development of systems and processes for financial and organisational control, clinical and information governance and risk management.

Our Board Assurance Framework identifies the procedures for risk management against our key strategic objectives, encompassing the management of all types of risk to which the Trust may be exposed, our controls and the assurances we have in place. This includes the effective integration and management of clinical and non-clinical risk.

Those key risks, mapped against our two strategic goals and 12 objectives are set out in the following pages. We have also categorised each objective against our quality priorities – SPAR. RAG ratings have been provided for those actions due during Quarter 1.

safe • personalised • accessible • recovery focused

spar

our vision
To be a **high quality** health and social care provider that continuously improves **patient experience** and deploys its **resources** intelligently and efficiently

our values
valuing people as **individuals**
providing high quality **innovative care**
working together for better lives
openness and **honesty**
exceeding expectations

Goal:	**To improve patient experience and pathways**
Objective 1:	**Focusing on quality and safety**
SPAR PRIORITY	
Exec owner:	Medical Director (MD) and Director of Nursing (DoN)
Assurance Committee:	Quality

Risk appetite									
Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2
Safety		4		1		0		1

RISK: The Trust fails to improve patient safety, eliminate avoidable harm and deliver high quality services, resulting in reputational harm, increased scrutiny and regulatory restrictions	**Gross Risk**			**Residual Risk**			**Target Risk**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	3	4	12	2	4	8	1	4	4

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**RAG status**
1.1	Reduce medication errors.	10% reductions based on 31 March 2015 position.	March 2016	Further embed pharmacist/pharmacy technician within teams to support awareness March 2016. Pharmacist allocated to each directorate and currently preparing summary for each directorate pharmacist to take to relevant directorate meeting to highlight changes to Medicines Management	MD	Select RAYG

				policy, medication safety thermometer, prescribing issues and incidents All open medicines incidents sent to heads of directorates to ensures these are reviewed and closed promptly.		
1.2	Deliver CQUIN targets: • Implementation of appropriate processes relating to cardiometabolic risk factors • Evidence communication to GPs of specified clinical information • Edinburgh Mental Wellbeing Scale. • Reducing medication errors through the implementation of the Medication Safety Thermometer in community services • Embedding a safety culture • Measuring service outcomes for people with learning disabilities.	Fully deliver targets.	March 2016	All Q1 requirements on track to be met, with the exception of the requirement for the Health Equality Framework Working Group to liaise with representatives from SSSFT, due to the identified contact at South Staffs being on annual leave for much of July. The Trust has not yet received detailed guidance in relation to the national CQUIN on cardiometabolic risk factors and has contacted NHS England seeking clarification. No response has been received to date. The Trust's proposed response to the GOAL 1 requirements around cardiometabolic risk factors and communication with GPs have been submitted to Commissioners.	MD	YELLOW
		Meet trajectory and in year targets as defined in the Operational Plan.	March 2016	Improvement and delivery plans in place for each CQUIN which enable the Trust to monitor progress and agreed milestones	MD	Select RAYG

		Establish the Patient Council Service User to sit on Board Committees and on the Board.	March 2016	Two Patient and Carer Council engagement events have been held with the formal committee meeting planned for August 2015	DoN	
1.3	Perform QIA of all CIPs ensuring no impact on delivery of quality service	All CIP schemes have QIA scrutiny resulting in Directorate, MD and ND approval and ongoing monitoring of quality metrics.	July 2015.	Action complete. Has been agreed at monthly Care Quality Review Meeting with Commissioners	MD/DoN	GREEN
1.4	Improve the multi-disciplinary team approach.	Psychology embedded in all directorates	March 2016	• Fully embedded within the Adult Inpatient and Community Directorates and within Learning Disabilities. • Within NOAP, work is ongoing to further • Children and Young People Directorate are awaiting completion of the Management of Change process • Substance Misuse model currently does not include psychology	MD	Select RAYG
1.5	Raise the service user voice in the Trust.	Family & Friends Test response rate increased by 30% (x 2015).	November 2015.	Action plan under development to increase Friends and Family Test response rate	DoN	Select RAYG
		PALs contacts increased by 10%.	November 2015.	Complaints lead working on updated plan	DoN	Select RAYG
		Complaints reduced by 10%.	November 2015.	Complaints lead working on updated plan	DoN	Select RAYG
1.6	Ensure Nurse Revalidation.	Embed process with HR to ensure 100% assurance.	February 2016	Corporate Quality Lead nurse working alongside HR to embed this process	DoN	Select RAYG

1.7	Reduce moderate harm incidents per 1,000 bed days.	Trust position, as measured by NRLS, reduced from average to better than average.	March 2016	Nursing Quality lead V. Stronach has taken leadership of this project from Nursing perspective	DoN	Select RAYG
1.8	Ensure infection free environments	Current position maintained. 10% increase in number of patients vaccinated against Flu. Nil MRSA cases.	March 2016	Vaccination programme launched and being led by IPC nurse	DoN	Select RAYG

Goal:	**To improve patient experience and pathways**
Objective 2:	**Consistently meeting standards**
SPAR PRIORITY	
Exec owner:	Director of Operations (DO)
Assurance Committee:	Finance and Performance

Risk appetite												
	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2
	Safety		4		1		0		1

RISK: The Trust fails to hit required performance targets and is placed under a greater scrutiny regime by the TDA.	**Gross Risk**			**Residual Risk**			**Target Risk**		
	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE
	3	4	12	2	4	8	1	4	4

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**RAG status**
2.1	Develop plan to hit mental health access targets.	Plan approved by Board.	June 2015	Action Complete	DO	GREEN
2.2	Deliver operational KPIs.	Deliver (measures monthly and report to F&P committee) with rectification plans as needed.	March 2016	Rectification plans developed for IAPT (Adults), waiting times and Care Programme Approach (CPA). Work to bring down waiting times within CAMHS services being operationalised	DO	Select RAYG

Goal:	**To improve patient experience and pathways**
Objective 3:	**Protecting our core services**
SPAR PRIORITY	
Exec owner:	Director of Strategy and Development (DSD)
Assurance Committee:	Business Development

Risk appetite										
	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2
	Safety		4		1		0		1

RISK: The Trust fails to consolidate its position as the local provider of local mental health and learning disability services, loses business to other providers and is not clinically, financially or operationally sustainable.	**Gross Risk**			**Residual Risk**			**Target Risk**		
	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE
	3	4	12	2	4	8	1	4	4

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**RAG status**
3.1	Respond to commissioners' service development opportunities.	Produce approved business cases for PICU, high dependency rehabilitation, ward reconfiguration, learning disabilities and dual care.	June 2015 to Commissioners July 2015 approved by Trust Board	Submitted to Commissioners 30 June. Received by QC and F&PC June and July.	DSD	GREEN

3.2	Respond to tender opportunities and lead the bidding process as prime contractor.	Deliver service and capital changes linked to approved business cases.	From August 2015 to agreed phasing	Shropshire Community Substance Misuse tender submitted 1 July 2015. Leicester Substance Misuse tender submitted 10 July 2015.	DSD	GREEN
		RAID	December 2015	Commissioners yet to publish commissioning intentions	DSD	Select RAYG
		IAPT	March 2016	Commissioners yet to publish commissioning intentions	DSD	Select RAYG

Goal:	**To improve patient experience and pathways**
Objective 4:	**Growing our specialised services**
SPAR PRIORITY	
Exec owner:	Director of Strategy and Development (DSD)
Assurance Committee:	Business Development

Risk appetite									
	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2
	Safety		4		1		0		1

RISK: The Trust fails to consolidate its position as the local provider of local mental health and learning disability services, loses business to other providers and is not clinically, financially or operationally sustainable.	**Gross Risk**			**Residual Risk**			**Target Risk**		
	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE
	3	4	12	2	4	8	1	4	4

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**RAG status**
4.1	Develop the Trust's capacity and capability for commercial change.	Appoint a substantive Director of Strategy & Development.	May 2015	Achieved. Starts 14 September 2015.	CEO	GREEN

		Establish a Business Development and Investment Committee.	July 2015	Paper received at June Board and decision yet to be taken	DSD	AMBER
		Produce a comprehensive business planning framework for annual business planning.	August 2015		DSD	Select RAYG
		Enhance horizon scanning and business opportunity identification.	August 2015	Consider Leicester Substance Misuse	DSD	Select RAYG
		Train SLT in core competencies: business case production and project management.	From April 2015 with NHS Elect	Tender report to Business & Development Committee	DSD	Select RAYG
		Establish rules and principles for bidding.	August 2015		DSD	Select RAYG
4.2	Respond to tender opportunities and lead the bidding process as prime contractor.	Stoke on Trent Substance Misuse services.	June 2015	Inpatients retained. Community and Recovery not successful.	DSD	GREEN
		Staffordshire in-patient Substance Misuse services.	September 2015	Work underway on tender documentation	DSD	Select RAYG
		Shropshire Community Substance Misuse services.	July 2015	Tender submitted	DSD	GREEN
4.3	Work with independent and third sector partners to implement new and innovative models of care.	Priory and Staffordshire Housing for CAMHS Tier IV	December 2015	Meeting held and work underway	DSD	Select RAYG

		RAPT for prison in-reach services	December 2015	Commissioners yet to publish commissioning intentions	DSD	Select RAYG
		Develop proposal for ICO with Stoke-on-Trent Council	May 2015	Proposal complete	CEO	GREEN
		Develop partnership with Northern Staffordshire GP Federation.	June 2015	Joint bid for dementia in primary care submitted to the Health Foundation	CEO	GREEN

Goal:	**To improve patient experience and pathways**
Objective 5:	**Innovating in the delivery of care**
SPAR PRIORITY	
Exec owner:	Medical Director (MD)
Assurance Committee:	Quality

Risk appetite												
	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2
	Safety		4		1		0		1

RISK: The Trust fails to exploit its potential in research activities and loses credibility and reputation in the healthcare community.	**Gross Risk**			**Residual Risk**			**Target Risk**		
	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE
	3	4	12	2	4	8	1	4	4

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**RAG status**
5.1	Raise the profile and influence of the Trust across region for innovation.	Chief Executive - Chair of Regional MHLETC.	June 2015	CEO chaired 1st Mental Health LETC and gave presentation to c200 stakeholders	CEO	**GREEN**
		Director of Leadership and Workforce – Regional W/F planning lead.	June 2015	Trust DL&W is regional lead	DL&W	GREEN

		Medical Director – Regional Dementia Lead	June 2015	A Skills and Competency Framework has been agreed, as has a catalogue of the resources and courses which are available to train and educate staff. A tool has been piloted which can be applied to any health or care organisation to identify training needs. Next steps include identifying what new courses and resources need commissioning, and setting up a web site and marketing campaign to inform every member of staff in organisations across the region how to access the resources.		GREEN
		Chief Executive – Leadership Lead for Shropshire & Staffordshire	June 2015	CEO leading on talent management and compassionate leadership across Shropshire and Staffordshire. CEO requested to lead workforce and leadership across Staffordshire. Director of Leadership and Workforce appointed		GREEN
5.2	Improve our approach to service improvement.	Establish service improvement capacity and capability within the Trust.	September 2015	Management of change process underway and posts will be recruited to once process completed	DL&W	Select RAYG
		Demonstrate improvements in at least 10 services.	March 2016	Management of change process underway and posts will be recruited to once process completed	DL&W	Select RAYG
		Train at least 30 staff in service	March 2016	Management of change process underway and posts will be recruited to once process completed	DL&W	Select RAYG
5.3	Participate in the Staffordshire wide research strategy and West Midlands academic health	Enhance relationships with local partners on the development and delivery of research.	March 2016	R&D Workshop held with Keele University to refresh vision. The Trust is part of the ongoing Staffordshire Wide Research group and is currently leading	MD	Select RAYG

	sciences network.			on a research engagement project on behalf of the WM CRN.		
5.4	Encourage increased participation in research across all professional groups across the Trust.	Develop Trust wide information of all published research.	September 2015	Ongoing work to gather recent publications for wider dissemination across the Trust	MD	Select RAYG
		Recognize research as part of REACH awards.	September 2015	Complete. Assessed under innovation category for 2015 and will be a standalone recognition award in 2016	MD	Select RAYG
		Establish Trust wide research group with multi-professional membership.	December 2015	Currently research discussed at the Clinical Effectiveness group with plans to re-establish the standalone Research Meeting	MD	Select RAYG

Goal:	**To improve patient experience and pathways**
Objective 6:	**Developing academic partnerships and education and training initiatives**
SPAR PRIORITY	
Exec owner:	Director of Leadership and Workforce (DLW)
Assurance Committee:	People and Culture Development

Risk appetite												
	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2
	Safety		4		1		0		1

RISK: The Trust fails to exploit its potential in research activities and loses credibility and reputation in the healthcare community.	**Gross Risk**			**Residual Risk**			**Target Risk**		
	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE
	3	4	12	2	4	8	1	4	4

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**RAG status**
	6.1 Improve our approach to education and development	Refresh the PDR process and ensure that 90% have a PDR and that we are above average in comparison with other MH Trust's for quality of experience as evidenced in the staff survey.	March 2016	Quality of PDR Audits will be undertaken which will inform a refresh of the process	DL&W	Select RAYG

		Business case for professorial unit	March 2016	First meeting with stakeholder held July. Initial paper to Board in July	DL&W / MD	Select RAYG
		Ensure that 95% of teams have undertaken the ARTP review process. Show improvement in 75% of the teams.	March 2016	Team Mapping gaps and actions complete. Remaining Team Leaders receiving training. Will be part of Dashboard at Team Level and report at Directorate and Trust level. Q4 CQQUIN showed 84% of the 25 CQUIN teams demonstrated improvement	DL&W	Select RAYG
		Launch You Tube learning channel.	November 2015	NSCHT You Tube channel in place. Additional learning channels with a specific focus on key trust services being developed by OD and Communications	DL&W	Select RAYG
		Improve education experience for learners within the Trust as demonstrated by improvement in all experience surveys. Improve JEST scores from good to excellent.	March 2016	JEST scores received in June achieved this. Two reported as 'needing attention' with all other scores at 'good' or 'excellent'	DL&W	Select RAYG
		All newly appointed Consultants allocated a mentor.	October 2015	System set up for a mentor to be allocated as part of the induction process. Objectives to be achieved set up for mentor and consultant with a quarterly review.	MD	Select RAYG
		Develop an OD plan including talent management	July 2015	In progress for next Execs in August	DL&W	Select RAYG

Goal:	**To improve patient experience and pathways**
Objective 7:	**Being an employer of choice**
SPAR PRIORITY	
Exec owner:	Director of Leadership and Workforce (DLW)
Assurance Committee:	People and Culture Development

Risk appetite									
	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2
	Safety		4		1		0		1

RISK: The Trust fails to manage relationships with it is staff, to improve engagement and enhance inclusion resulting in higher turnover and reduced effectiveness of service delivery, threatening clinical and operational sustainability	**Gross Risk**			**Residual Risk**			**Target Risk**		
	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE
	3	4	12	2	4	8	1	4	4

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**RAG status**
7.1	Become an employer of choice	Produce workforce plan that supports the Integrated Business Plan.	May 2015	Completed as part of the TDA and Health Education West Midlands submjissions	DL&W	**GREEN**

		Refresh the workforce planning process to strengthen competency based workforce planning produces Directorate detailed workforce plans.	June 2015	Template for Directorate one year workforce plans produced and populated by directorates	DL&W	GREEN
		Reduce stress at work and sickness to below 4%.	March 2016.	Stress Less Action Plan in place and being implemented. Monitored through PCD and linked to Staff Survey actions. As a % of the absence reasons there has been a decrease from April to May 2015 from 35.17% to 30.24%. The Adult Inpatient Directorate which had the highest % now shows a downward trend.	DL&W	Select RAYG
		Reduce the average time taken to recruit new employees by half.	March 2016	Part of LIA Team 'One stop shops' in place for large campaigns EDBS live in July OH process streamlined Discussed at WM Streamlining group to determine the details of the metric e.g. close of advert to final offer made or, date of interview to final offer made.	DL&W	Select RAYG
7.2	Improve Communication and Engagement.	Improve the staff survey results in 25% of areas.	March 2016.	Board Development Session planned for Autumn 2015 to outline our approach.	DL&W	Select RAYG
		Improve satisfaction of staff with experience of change measured by improving the staff survey scores to above average for MH Trusts.	March 2016.	LiA Pulse check second round shows improvement in staff experience	DL&W	Select RAYG

		Develop a communication strategy for Communication and Engagement that is co-produced across the Trust and approved by the Board	February 2016	Strategy to be developed	DL&W	Select RAYG
		Develop Corporate Accountability Framework (CAF).	October 2015	Accountability framework to be developed	DL&W	Select RAYG
		Implement CAF in line with agreed plan	March 2016		DL&W	Select RAYG
7.3	Support and enhance inclusion.	Develop a strategy and plan to improve inclusion, diversity and equality within the Trust.	November 2015.	Using Autonomy Framework as a start point this will be developed across the whole Trust with particular focus on delivery of accountability of corporate services to Clinical Directorates Appointment of dedicated lead in July. E&D Plan developed	DL&W	Select RAYG
		Implement approach to widening participation to ensure that we deliver: • 10 apprenticeships • Enable 10 people to use the process • Increase active volunteers by 25% • Introduce Peer Support Workers Every selection process across the Trust invites service user representation	March 2016.	Changes within the Workforce Directorate will ensure that there is dedicated capacity for this work to be delivered	DL&W	Select RAYG

Goal:		**To improve patient experience and pathways**									
Objective 8:		**Innovating in the delivery of care**									
SPAR PRIORITY											
Exec owner:		Chief Executive (CEO)									
Assurance Committee:		Quality									
Risk appetite	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2		
	Safety		4		1		0		1		

RISK: The Trust fails to secure an overall "good" rating in its CQC inspection, resulting in loss of reputation, reduced opportunity for development and greater scrutiny from regulators..	**Gross Risk**			**Residual Risk**			**Target Risk**		
	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE
	3	4	12	2	4	8	1	4	4

	CONTROLS	ASSURANCES	TIMESCALE	GAPS AND ACTIONS	Lead Director	RAG status
8.1	Update the current supervision policy and develop a management supervision policy, ensuring structures are in place at all levels of the Trust identifying supervisors for all staff. We will develop a data system whereby supervision can be	a. Update clinical supervision policy. b. Develop a management supervision policy. c. Ensure structures are in place at all levels of the trust including identifying supervisors for all staff including Band 3. d. Develop a data system whereby supervision can be recorded for example through ESR.	August 2015	Work is ongoing as part of the LiA process. Big Conversations have been held	DL&W	Select RAYG

	recorded and set supervision targets which are monitored through the directorate performance dashboards.	e. Set supervision targets that are monitored through the directorate performance dashboards.				
8.2	Review the Ligature Risk Review policy and environmental risk assessment tool, together with all risk assessment plans from wards and clinical areas to identify gaps/ problems.	a. Review the current policy and environmental RA tool. b. Review all RA plans from ward & clinical areas. c. Identify gaps and problems. d. Identify work that should be progressed to improve the clinical environments.	August 2015.	Trust has established LiA Environmental Risk Group comprising membership from operating corporate and estates teams. The group has - • Reviewed existing policy and compliance with policy. • Identified gaps in the policy and associated processes. • Reviewed Environmental Risk Registers and identified themes. • Enhanced the policy and recommended approval by the Quality Committee (21st July 2015)	DSD	Select RAYG
8.3	Develop a caseload management system use and embed this across all teams.	Develop a caseload management system for all community teams to use.	August 2015.	Caseload management tool devised and is being piloted with a view to future roll out. Links made with Supervision LiA workstream	DN	Select RAYG
8.4	Develop a transition policy for Children & Young People to Adult & Adult to Older People's services, and review transitions between learning disabilities and mental health services. Review systems and inter team working to identify issues	a. Develop a transition policy for children & YP to adult and adult to older people's services. b. Review transitions between LD and MH services. c. Identify any pathway issues/concerns and provide solutions in relation to above. d. Review systems and inter team working for example community	August 2015	Two big conversations held and ongoing work of the LiA group. Policy in development to be sent for consultation in August 2015	DSD	Select RAYG

	and improve the pathway for patients.	to inpatient and identify issues & solutions to improve the pathway.				
8.5	Improve MHA compliance in relation to record keeping.	a. Case file responsibility & general housekeeping. b. S17 leave. c. S132 Patient Rights. d. S58 Consent to treatment.	August 2015	1. All of these topics are being addressed by the LiA Record Keeping and Mental Health Act Paperwork group. 2. Action plan to address each issue is fully developed. 3. Meetings are planned through to October 2015 to review and update the action plan. 4. Section 17 leave – ongoing pilot continues on acute wards at Harplands to the 17th July 2015. 5. Section 132 Patient Rights – Guidance Tips for nursing staff issued by Sam Dawson and Mark Dinwiddy via the senior nurses forum. 6. Section 58 – Consent to Treatment - draft set of consent to treatment standards has been developed and is under review	MD	Select RAYG
8.6	Review the Bed Management processes to identify blockages in the system and also undertake a capacity and demand exercise. Establish and embed the bed management and establish metrics for success in relation to out for area bed usage, length of stay and	a. Review bed management processes. b. Identify blockages in the system. c. Capacity & demand exercise. Review bed usage by care cluster for example a high use by cluster 8s. d. Review gatekeeping. e. Review admission & discharge pathways. f. Review role of the community	August 2015.	A full review of the bed management process is underway with significant progress made to realise assurances.	DF	Select RAYG

	readmission rates.	teams & interface. g. Establish bed management				

Goal:	**To deploy our resources more efficiently and intelligently**
Objective 9:	**Becoming digital by choice**
SPAR PRIORITY	
Exec owner:	Director of Strategy and Development (DSD)
Assurance Committee:	Business Development

Risk appetite												
	Quality		Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2
	Safety			4		1		0		1

RISK: The Trust fails to invest appropriately in its infrastructure meaning that it is unfit for the future and the Trust is unable to deliver its business goals and objectives.	**Gross Risk**			**Residual Risk**			**Target Risk**		
	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE
	3	4	12	2	4	8	1	4	4

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**RAG status**
9.1	Establish a robust governance structure	Programme Governance Board in place. Information Sharing and Service Management Groups in place.	June 2015 June 2015	Achieved. Achieved.	DSD	GREEN
9.2	Enhance Trust internal capacity and capability.	Appointment of Chief Information Officer	June 2015	Achieved. Starts in post 27 July 2015.	DSD	GREEN

		Appointment of Head of Portfolio Management.	October 2015.			
9.3	Develop key partnerships to initiate and build on lessons learned elsewhere and to implement change within the Trust.	Formalised agreements with Airedale NHS Foundation Trust; SAS; Oracle; Service user app (Staffordshire University). Telemedicine Predictive text analysis HR and Suicide,	October 2015. September 2015 October 2015. Live November 2015.	Work continuing. Digital by Choice Programme Board.	DSD	Select RAYG
9.4	Progress on delivery of an electronic patient record for the Trust.	Business case development with CSC and approved by Trust Board.	October 2015	Joint submission made	DSD	Select RAYG

Goal:	**To deploy our resources more efficiently and intelligently**
Objective 10:	**Reviewing and rationalising our estate**
SPAR PRIORITY	
Exec owner:	Director of Operations (DO)
Assurance Committee:	Finance and Performance

Risk appetite												
	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2
	Safety		4		1		0		1

RISK: The Trust fails to manage its infrastructure, meaning that it's unfit for the future and the Trust is unable to deliver its business goals and objectives.	**Gross Risk**			**Residual Risk**			**Target Risk**		
	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE
	3	4	12	2	4	8	1	4	4

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**RAG status**
10.1	Sale of Bucknall Hospital.	Contract of sale exchanged. Contract of sale completed.	June 2015 December 2015	Exchange planned for July – issues re threshold from highway to site. Insurance quote for cover obtained at £10k.	DF	RED
10.2	Produce an estates rationalization plan.	Plan approved by Board, with clear trajectories and milestones to reduce accommodation footprint linked to a mixed economy of freehold and leasehold properties.	November 2015	Currently focussing on Business Cases to Commissioners for: • PICU • Ward reconfiguration • Locked rehab	DO	Select RAYG

				• A&T and Telford • Darwin		
10.3	Master plan for Harplands Hospital.	Approved development control plan demonstrating medium to long term potential.	September 2015	Currently focussing on Business Cases to Commissioners for: • PICU • Ward reconfiguration • Locked rehab • A&T and Telford • Edward Myers	DO	Select RAYG

Goal:	**To deploy our resources more efficiently and intelligently**
Objective 11:	**Reviewing and rationalising our estate**
SPAR PRIORITY	
Exec owner:	Director of Operations (DO)
Assurance Committee:	Finance and Performance

Risk appetite												
	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2
	Safety		4		1		0		1

RISK: The Trust fails to meet key regulatory and compliance requirements and is placed under a greater scrutiny regime by the TDA.	**Gross Risk**			**Residual Risk**			**Target Risk**		
	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE
	3	4	12	2	4	8	1	4	4

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**RAG status**
11.1	Develop a Board Assurance Framework.	BAF embedded and used to drive committee business.	June 2015 (achieved).	Achieved	CEO	GREEN
11.2	Maintain a strong Head of Internal Audit opinion.	No negative assurances in the annual governance statement Positive opinion, demonstrating robust system of internal control.	ongoing	Positive opinions received for 2014/15	CEO	GREEN
11.3	Maintain quality governance standards.	Maintain performance against Quality Surveillance Score green, CQC banding	ongoing	Achieved	CEO	GREEN

		1, TDA rating 4.				
11.4	Strengthen contract management.	Review approach to contract management, led by the Head of Legal Services.	March 2016	As part of contract pre meeting in July and September the Commissioning Team will identify the level of support required by the Trust to ensure any legal issues relating to contracts are considered. The role of the Legal Advisor will be drafted.	DF	Select RAYG
11.5	Improve effectiveness of the audit committee.	Timely delivery of the internal audit plan and completion of audit recommendations.	Sept 2016	Ongoing review to follow up action on outstanding recommendations	DF	Select RAYG

Goal:	**To deploy our resources more efficiently and intelligently**
Objective 12:	**Delivering our financial plan**
SPAR PRIORITY	
Exec owner:	Director of Finance (DF)
Assurance Committee:	Finance and Performance

Risk appetite												
	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2
	Safety		4		1		0		1

RISK: The Trust fails to meet its financial responsibilities and/or fails to deliver year one of its LTFM, resulting in greater scrutiny form regulators and commissioners and the threat of financial non- sustainability.	**Gross Risk**			**Residual Risk**			**Target Risk**		
	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE
	3	4	12	2	4	8	1	4	4

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**RAG status**
12.1	Spend within cash resource limit.	CIP plans are robust and delivered to time and financial targets. Budgets approved with a robust system of recording activity for payment by results (ongoing).	March 2016 May 2015	Small shortfall in CIP – New schemes under review with Associate Director Transformation	DF	AMBER
12.2	Embed service line	SLR information produced (quarterly)	August	2014/15 First draft will be finalised July	DF	AMBER

	reporting within Directorates.	with financial reporting based on commercial, profit and loss basis (ongoing).	2015	2015. Qtr 1 data will be finalised in late August 2015.		
12.3	Improve the Trust's performance management and reporting processes.	Board report developed to support better understanding of the Trust's financial position.	July 2015	First draft completed for in depth Financial review by Team before issuing to Exec	DF	GREEN
		Balanced scorecard developed with NHS Elect, showing workforce, quality, finance and performance quadrants.	July 2015	Quality completed 7 Performance commenced. Software providers preparing quote to automate process	DF	GREEN
		Responsibility for performance management transferred to the Director of Strategy and Development under the management of the Chief Information Officer and Digital by Choice.	November 2015	Discussion will take place in September with the Director of Strategy and Development and Director of Finance to make corporate arrangements for transfer	DF	Select RAYG
12.4	Focus on Efficiency and Productivity.	Review the pharmacy service delivery model by undertaking a cost benefit analysis.	March 2016	Review with Director of Strategy	MD	Select RAYG
		Implement revised PFI contract management arrangements, focusing on accountability through process.	June 2015	New structures operational. Work this year is focussed on improving value for money and improved transparency on contract particularly in relation to environment life cycle	DO	GREEN

		Seek best value for money in the PFI contract, identifying savings that could be realized.	September 2015.	Meeting to be held with Town Hospitals in August 2015	DO	Select RAYG
		Establish service improvement capacity and capability	September 2015.	Management of change process underway and posts will be recruited to once process completed	DL&W	Select RAYG
		Train at least 30 staff in service improvement techniques.	March 2016	Management of change process underway and posts will be recruited to once process completed	DL&W	Select RAYG
		Reducing Drugs overspend by 50%.	March 2016	DF has refreshed the Drugs budget and expenditure down to team level. Drug spend is being analysed by Chief Pharmacist in partnership with Clinical Directors	MD	Select RAYG
		Further embed improvement in GP relationships by increasing the use of GP support email by a further 20% from March 2015 baseline (March 2016).	March 2016	15 contacts made for the whole of last year. For the first 3 months of this year, 3 contacts via GP support email with 4 direct emails to the MD	MD	Select RAYG

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: **Trust Board**

Date of Meeting:	30 July 2015
Title of Report:	People and Culture Development Committee Report
Presented by:	Mr Peter O'Hagan Chair of the People and Culture Development Committee
Author of Report: Name: Date: Email:	Sandra Storey, Trust Secretary / Head of Corporate & Legal Affairs 23 July 2015 Sandraj.storey@northstaffs.nhs.uk
Purpose / Intent of Report:	• For approval (policies) / assurance
Executive Summary:	This report provides a summary of the meetings of the People and Culture Development Committee that took place on the 22 June and 20 July 2015. The report highlights key points discussed and agreed outcomes.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Workforce Strategy • Governance Strategy • Customer Focus • Clinical
Relationship with Annual Objectives:	Cuts across all objectives
Risk / Legal Implications:	N/A
Resource Implications:	N/A
Equality and Diversity Implications:	None in this report
Relationship with Assurance Framework [Risk, Control and Assurance]	Provides assurance to the Board that the committee is working in according with its Terms of Reference
Recommendations:	• To receive for information and assurance purposes. • Ratify policies noted in the report

Summary to Trust Board of the People and Culture Development Committee meeting held on the 22 June 2015

1. **Workforce Directorate Performance – April 2015**

   The committee received presentations by exception from each of the directorate leads on their performance against key workforce indicators.

   Members discussed areas such as sickness absence across each of the services and it was noted that this had decreased slightly in comparison to the previous month. The main reason for the absence across the Trust continues to relate to anxiety and stress and accounted for 36.5% of the absence (29.0% in March 2015). The use of overtime and in particular agency and bank spend was noted to have decreased during this reporting period.

   Full compliance was noted with the DBS requirements as well as a slight increase in statutory and mandatory training. It was noted that compliance with statutory and mandatory training still needed to improve and members discussed some of the reasons why at times there was difficulty in staff attending training. It was agreed that compliance was important and members agreed to reinforce with their teams the need to improve performance in this area. Evaluation forms have also been introduced for completion after each session to help inform ways in which on how training and the experience could be improved. E-learning is also being considered to improve compliance with statutory and mandatory training and more detail about this is included later in this report.

2. **Policy Review**

   The committee considered the revised Equality of Opportunity Policy, noting the review represents a significant change in the expressed ethos in the Equality Policy which makes a clear statement about the Trust's aspiration to have a culture of inclusion across the organisation and about the importance of valuing people as individuals. It was **recommended to the Trust Board that this policy should be ratified for a period of 3 years.**

3. **Workforce & Organisational Development Risks – June 2015**

   The committee received the workforce and OD risks at June 2015, which included those risks that had been carried forward from the previous year. The source of each risk, its risk rating and progress on action plans to mitigate those risks was discussed. No particular issues were highlighted. The risk to ensuring safe staffing levels is also being kept under close review by the Quality Committee given the potential risk to quality and safety of service provision.

   Members of the committee also considered any other risks that need to be added to the risk register. Going forward the committee noted that it will receive the workforce risks included as part of the refreshed Board Assurance Framework (BAF). This BAF will also inform the committee's work plan for the coming year and will be a means by which assurances are received to ensure progress against the Trust's workforce objectives.

4. Staff Profile update

The committee received a profile report of the workforce, the highlights of which gave a breakdown of the Trust's staff group, the composition of which remains in line with the previous quarter and this is also reflective of the full financial year. As a general overview the Trust's sickness rate (both rolling 12 month and in month) is consistently below the regional and Trust type benchmark groups. The only variation is around the additional clinical support group for Q4 where this staff group's sickness rate has been slightly higher than the benchmark groups. Should this continue a further in-depth analysis will be undertaken.

In respect to age profile, the report noted that the Trust Age Profile shows a potential risk as the Trust is approximately 3% higher in proportion for the age group of 45-55. Given that a large number of this staff group may qualify for Mental Health Officer status, more consideration is being given to succession planning and increasing the younger workforce as this is where the lower proportion is being presented. Turnover is considerably lower than the benchmarking groups which would also support the analysis.

5. Productive Workforce Metric

The committee received the productive workforce metrics dashboard for May 2015 which is provided by Health Education West Midlands. Following feedback there is now a new report page titled 'Data Quality Report', and this sheet gives a breakdown of the data quality figures with error and record counts for each individual data item. The Trust is currently ranked 8th out of 29 Trusts. While the committee accepted this as a reasonable position, it agreed that work should continue to improve the reporting in the areas such recruitment source and destination on leaving to understand more about what this is indicating and to identify any specific learning and action points.

6. Dragons Den

A further Dragon's Den is scheduled to take place in the Autumn 2015. Budding entrepreneurs from, the whole of the organisation will be encouraged to pitch their ideas. The process is envisaged to involve marketing the opportunity to gain real monetary commitment to support innovative ideas using some of the successful pitches from 2013 and 2014. There will be an application process where the top 10 shortlisted by members of the committee will be asked to pitch to a panel. The committee received the briefing paper in respect to the process and approved the proposed timetable for the implementation of Dragon's Den 2015.

7. Action Plan to Improve E-learning across the Trust

The committee received a report describing the national context and rational for change in progressing towards an application of e-learning. The aim is to ensure maximum use of this mode of learning delivery throughout the Trust with minimum duplication or waste of resources. The report highlighted some of the barriers such as investment and infrastructure and the actions required in order to start to increase the use of e-learning. The committee agreed that there was significant value in pursuing this particularly to increase compliance with statutory and mandatory

training, and supported the proposed action plan to develop this work further. The committee will receive further reports on how this work is progressing.

8. Display Screen Equipment – Assessments

The committee received a presentation from the Trust's Health and Safety Advisor on the management of Musculoskeletal Disorders (MSDs) providing information on how the signs and symptoms can be recognised early, with responsibilities for both employer and employees to take preventative action. It was noted that work had been undertaken to revise the Trust's policy, leading to improved risk assessment and controls being implemented, identified persons to undertake assessments and improved communication and awareness training for all staff**.**

9. Trust Equality Objectives

The Trust's Equality and Diversity Monitoring Report was agreed at the April meeting of the committee and formally approved at the Trust Board on the 30 April 2015. The committee received a subsequent paper which provided a summary of the progress made against the Trust's existing Equality objectives 2012-2015 and the proposed new Equality Objectives for the period 2015-18. The committee approved the updated Trust Equality objectives for publication on the Trust's website. The committee will receive reports as part of the monitoring against the action plan and compliance with the Equality Act 2010.

10. Pulsecheck – Listening into Action

The committee received a report on the second wave of the Listening into Action Pulse Check results which provided some very positive results. It was noted that there were improvements across all of the 15 questions ranging from a 10.06% to 17.91% increase**.** It was pleasing to note that the Trust has demonstrated higher improvement scores than all five other trusts in the same cohort at the one week stage. However at the time of the report, the Trust is still awaiting the final comparison figures. The results will be reviewed again in due course with an aim to continue to improve the scores year on year.

11. GMC National Trainee Survey 2015

The committee received a report which provided details of the national survey results for GMC trainees on their views regarding the training they receive. As part of the survey trainees are able to provide comments relating to patient safety and bullying and undermining, with the detail shared with the Clinical Tutor.

It was pleasing to note that the Trust did not receive any patient safety and bullying and undermining comments, or indeed any red flags, in the 2015 survey.

12. Next meeting: 13 July 2015

On behalf of the Committee Chair, Mr Peter O'Hagan and Mr Paul Draycott, Director of Leadership & Workforce

Sandra Storey
Trust Secretary / Head of Corporate and Legal Affairs
29 June 2015

Summary to Trust Board of the People and Culture Development Committee meeting held on the 20 July 2015

1. **Workforce Directorate Performance – May 2015**

   The committee received presentations by exception from each of the directorate leads on their performance against key workforce indicators.

   Members discussed areas such as sickness absence across each of the services and it was noted that this had increased slightly in comparison to the previous month. The main reason for the absence across the Trust continues to relate to anxiety and stress and accounted for 30.2% of the absence. It was noted that the use of overtime had increased and the spend on agency and bank had decreased.

   Full compliance was noted with the DBS requirements. A slight decrease in statutory and mandatory training was noted. It was noted that compliance with statutory and mandatory training still needed to improve and members discussed the need to improve performance in this area and how best staff can be supported to undertake this training. The E-learning proposals agreed at the last meeting of the committee should help to improve compliance in this area.

2. **Policy Review**

   The committee considered the Trust's **Performance Improvement Policy** which had recently been updated. The changes noted mainly relate to making reference to the preceptorship policy and also how pay will be progressed or deferred in line with the pay progression policy.

   The committee also considered the Trust's **Leave Policy**,
   Currently the Trust has a Compassionate & Special Leave Policy that covers paid/unpaid compassionate leave, time off for medical/dental appointments and similar related issues.

   Following some highlighted inconsistencies in how Annual Leave has been administrated between teams, some general principles of annual leave have been drafted in conjunction with Staff Side representatives. These will be incorporated into the Compassionate & Special Leave Policy which is to be retitled as the Leave Policy (incorporating Compassionate, Special and Annual Leave).

   Committee members also considered the Trust's **Medical Appraisal Policy** which sets out the Trust's local approach to medical appraisal, within the national appraisal and revalidation framework requirements as set out by the General Medical Council (GMC), Revalidation Support Team (RST) and the Academy of Royal Colleges. It also outlines the medical appraisal process; key roles and responsibilities; and links with other processes, such as Job Planning.

   It was recommended to the Trust Board that all three policies should be ratified for a period of 3 years.

3. **Workforce & Organisational Development Risks – July 2015**

   The committee received the workforce and OD risks at July 2015. The source of each risk, its risk rating and progress on action plans to mitigate those risks was

discussed. No particular issues were highlighted. The risks were accepted as ongoing with the same risk score. The risk to ensuring safe staffing levels is also being kept under close review by the Quality Committee given the potential risk to quality and safety of service provision.

Members of the committee also considered other risks that may require adding to the adding to the risk register. The workforce risks will be included as part of the refreshed Board Assurance Framework (BAF). As the BAF develops this will also inform the committee's work plan for the coming year and will be a means by which assurances are received to ensure progress against the Trust's workforce objectives.

4. Pulsecheck – Listening into Action

At the last meeting of the committee a report on the second wave of the Listening into Action Pulse Check results was received which provided some very positive results.

The committee received a further report which showed that the LiA Pulsecheck surveys and the NHS Staff Surveys covered similar ground over four differently timed and differently administered surveys.

The Trust has invested heavily in responding to staff feedback during 2014-15 and the 2015-16 to date and it would appear that this action is starting to have an impact, based on the very pleasing improvements in staff opinion identified in the latest LiA Pulsecheck survey. These results suggest that real and significant progress is being made in improving staff perceptions of the Trust as an employer and provider of services.

It is anticipated that much of the excellent progress observed in the second Pulse Check should be translated into improved NHS Staff Survey results come the NHS Staff Survey 2015 in the Autumn, if indeed the improvements measured relate to a step-change in organisation culture. The report noted that the Trust needs to continue to invest in its culture of listening to and responding to staff and to focus on combining the feedback and efforts in relation to the key feedback routes as identified in the paper. This will be discussed in more detail at the Trust Board meeting.

5. Staff Survey Directorate Plans

The committee heard about the directorate's plans that address the learning from the last staff survey and the work that is ongoing to improve engagement in the next survey. The plans are being further updated during the month of August and will be presented to the September meeting of the committee.

6. Investment in the Future of Healthcare – Letter from Sir Keith Pearson

The committee discussed the letter received that sets out the investment in the future of healthcare which concerns widening participation and development for the support workforce. As a measure of commitment the Trust has been asked to sign and return a Partnership Pledge to deliver against the strategic intentions. The Pledge offers a chance to recognise the work that the Trust is already doing and the value we place on our support staff and future workforce. The committee supported signing the pledge and it was agreed that this item would be discussed in more detail at the next meeting of the Trust Board.

7. Health Care Support Worker Learning Programme progress report

The support worker development approach was launched back in October 2013 and described a learning methodology that includes opportunities for support workers from recruitment to entry into registered professional training (where appropriate).

While the overall principles of the approach have remained a number of changes have occurred in legislation, national and local guidance in the intervening period. In September 2014 the approach was updated to take these into account.

The support worker action plan produced in October 2014 was to guide the delivery of these updated recommendations. This report summarises the progress made in relation to the main themes of the October 2014 action plan and makes further recommendations for continuing improvement and aligning widening participation and talent for care.

Talent for Care is a strategic framework nationally for the development of the healthcare support workforce. It focuses on three primary themes:

- Get In – opportunities for people to start their career in a support role

- Get On – supporting people to be the best they can be in the job they do

-Go Further – providing opportunities for career progression, including into registered professions.

The committee noted the strong progress and supported the further developments proposed.

8. Learning Disabilities Service proposed joint management structure

The committee received a report making reference to a number of national and local reports into the future of learning disability services which have recommended closer working and integration between health and social care. The paper proposed that an interim joint management structure is created across the City Council and North Staffordshire Combined Healthcare NHS Trust to manage current learning disability services and develop options for long term integration of the two organisations.

In addition to national policy drivers, it was noted in the paper that individuals who have a learning disability, their parents, carers and families have said they would like services to be integrated. This is a priority of the Learning Disability Partnership Board and was stated as one of the three most important priorities by people who have a learning disability and their advocates.

It is considered that an integrated structure will bring a number of benefits to people who use learning disability services and their carers. This proposal was accepted in principal by the committee with a review period in place and it was agreed that it would be appropriate for this to be discussed further at the Trust Board meeting.

9. Next meeting: 21 September 2015

On behalf of the Committee Chair, Mr Peter O'Hagan and Mr Paul Draycott, Director of Leadership & Workforce
Sandra Storey
Trust Secretary / Head of Corporate and Legal Affairs 23 July 2015

North Staffordshire Combined Healthcare NHS Trust

Enclosure 19

REPORT TO: Trust Board

Date of Meeting:	30th July 2015
Title of Report:	**Listening to Staff - NSCHT 2nd LiA Pulsecheck Survey (2014/2015) results benchmarked against Staff Survey (2013/2014)**
Presented by:	Paul Draycott Executive Director of Leadership & Development
Author of Report: **Name:** **Date:** **Email:**	Lesley Faux (Organisation Development), Sue Slater (LiA) and Dawn Burston (LiA), July 2015 Dawn.Burston@northstaffs.nhs.uk / Lesley.Faux@northstaffs.nhs.uk / SueD.Slater@northstaffs.nhs.uk
Purpose / Intent of Report:	• For information and assurance
Executive Summary:	Listening to and responding to staff in an important strand in the Trust's Staff Involvement and Engagement Strategy and the linchpin of any good staff engagement approach. The Trust has a wide range of means of gathering feedback from staff, both formal and informal. Two major ways in which the Trust has gathered information from staff during the past year or two are through our Listening into Action (LiA) approach and through the annual NHS Staff Survey. This report provides a comparative analysis between the LiA Pulsecheck results 2014-2015 and the NHS Staff Survey results 2013-2014, and offers assurance about action being taken and progress made in response to the feedback obtained.
Which Strategy Priority does this relate to: **How does this impact on patients or the public?**	• **Workforce Strategy** • **Governance Strategy** • **Clinical Strategy** LiA and the NHS Staff Survey are two major aspects of how as an organization we listen and respond to staff, which is a key component of staff engagement. Higher levels of effective staff involvement and staff engagement have been widely been found to correlate with improved service quality and safety, better patient satisfaction and clinical outcomes; improved staff satisfaction and individual and team performance; and stronger organisational and financial performance (in relation to NHS performance, see particularly University of Aston research and the work of Professor Michael West, University of Lancaster).
Relationship with Annual Objectives:	Links with Trust Objectives 2015-16 as follows:- 1. Focusing on quality and safety 4. Being an employer of choice

	9. Ensuring good governance
Risk / Legal Implications:	As outlined above.
Resource Implications:	Staff Involvement & Engagement Strategy – managed within existing resources. There are administration fees in relation to the NHS Staff Survey and the LiA approach. As noted above, investment in high levels of staff involvement and staff engagement, including listening to and responding to staff, have been found to link with stronger financial performance in NHS organisations.
Equality and Diversity Implications:	Supports the workforce strategy and delivery of the Equality Delivery System2 (EDS) in relation to listening to and responding to the views of all groups of staff/ staff from all backgrounds.
Relationship with Assurance Framework [Risk, Control and Assurance]	As outlined above. Significant areas of interest for the CQC linked with patient services, quality and effectiveness.
Recommendations:	It is recommended that the Board:- 1. **Notes the contents** of this report for assurance 2. Considers and **commits to personal actions** to further develop the culture of listening to and responding to staff and culture of staff engagement 3. **Acts as champions** of LiA, the NHS Staff Survey 2015, and future SFFT as they approach

North Staffordshire Combined Healthcare NHS Trust

WORKFORCE DIRECTORATE

Report to: **Trust Board**

Report by: **Lesley Faux, Sue Slater and Dawn Burston,**

Date: **July 2015**

Subject: ***Listening to Staff: NSCHT LiA Pulsecheck (2014/2015) results benchmarked against Staff Survey (2013/2014)***

1. Introduction

Listening to and responding to staff in an important strand in the Trust's Staff Involvement and Engagement Strategy and the linchpin of any good staff engagement approach.

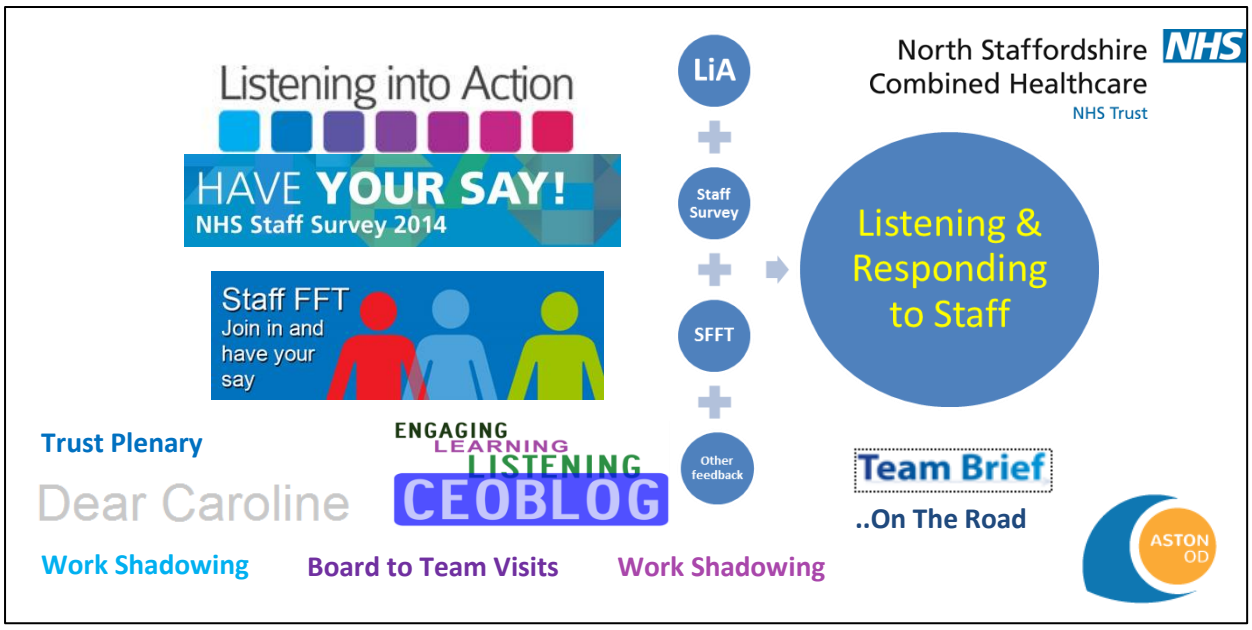
The Trust has a wide range of means of gathering feedback from staff, both formal and informal. This report does not go into detail with regard to our other staff feedback routes, suffice to say that each of these has its own approach to addressing the information. Some of the varied means of gathering information and opinions from staff across the Trust include:-

1. **Staff Survey and staff friends and family test**
2. **Listening into Action**
3. **Weekly CEO Blog** – staff are invited to contact the CEO with thoughts on topics covered
4. **Dear Caroline** – staff are invited to submit concerns on any Trust matter direct to the CEO via an anonymous email
5. **Team Working (Aston Effective Team Leadership)** – The Trust advocates a team working approach which involves an engaging leadership style and regular team meetings and one-to-one meetings in which staff have opportunities to engage in discussion, review and planning of their services and are empowered to influence change in their area. **Aston Effective Team Working Surveys** – All teams are asked to undertake the Aston ARTP+(Real Team) Survey with their staff.
6. **Monthly Trust Plenary** – The whole Trust leadership team is invited to engage in discussion, debate and planning in relation to a topical issue each month.
7. **Team Brief on the Road** – all staff are encouraged to attend Team Brief in their own area each month and to raise questions and engage in discussion these are led by the Executive team.
8. **Board to Team Visits** – All Board Members engage in a programme of visits to clinical and non-clinical teams and the focus is on 2-way exchange of ideas and information.
9. **Work Shadowing** – A programme of work shadowing designed to increase awareness of clinical roles for senior managers and vice versa.
10. **Formal Consultation** – The Trust engages in formal consultation in line with planned change programmes to seek staff views and to consider and respond to these.

11. **Informal Consultation** – The Trust also engages in informal consultation to engage and involve staff in change processes at an early stage to support 'bottom-up' shaping of change plans.
12. **Trust Committee Structures and Directorate Management Groups**
13. **Ad hoc surveys and focus groups** – there are numerous other information gathering exercises undertaken as and when required. Examples include: a Stress Survey undertaken at a Health and Wellbeing Event; Focus Groups on Improving Participation in the Staff Survey.

The Two major ways in which the Trust has gathered information from staff during the past year or two are through our Listening into Action (LiA) approach and through the annual NHS Staff Survey. Additionally, the Trust gathered feedback from staff via the NHS Staff Friends and Family Test (SFFT) Survey throughout 2014-15. The SFFT survey is reported on separately SFFT feedback report 2014-15 Q4 v3 FINAL.pdf

The Trust's key information sources supporting the 'Listening and Responding to Staff' strand are currently as summarised in the diagram below:-



This report provides a comparative benchmark particularly between the **LiA Pulsecheck results 2014-2015** and the **NHS Staff Survey results 2013-2014** and offers assurance about action being taken and progress made in response to the feedback obtained.

- The NHS Staff Survey is a national NHS process with set 'rules' about how the survey must be administered (with certain freedoms such as the ability to ask additional questions and (since 2014 for our Trust) the option to choose between paper on online survey distribution).

- LiA is a commercially available process/toolkit for addressing staff engagement. Application of this process is subject to rules under the LiA licence.

The report compares the two as far as is practicable given the different timing, content and approach of the two methods of data gathering incumbent in each approach. It is additionally important to note that the timeframes / reporting periods for the 2 surveys are therefore quite different, with the LiA Pulse Check Surveys covering a more recent period (July 2014 – June 2015) than the NHS Staff Survey (Sept 2013 – Dec 2014). The first Pulse Check was completed a couple of months ahead of the 2014 NHS Staff Survey. The second Pulse Check survey was

completed approximately 6 months after the most recent NHS Staff Survey and we are currently in preparation for the 2015 NHS Staff Survey to be released in September.

The following sections of this report analyse the key findings from these processes and outlines action taken and progress being made. For more detail on the results of the Pulsecheck and Staff Survey measures, see Appendices One-Three:-

- ***Appendix One*** provides a results summary for the two LiA Pulsecheck surveys
- ***Appendix Two*** provides a summary of the 2014 and 2013 NHS Staff Surveys results
- ***Appendix Three*** contains a detailed summary and comparison of the 2 surveys, as far as is practicable (see note above): LiA Pulsecheck surveys (Summer 2014 and Spring/Summer 2015) and NHS Staff Survey (Autumn 2013 and Autumn 2014).

2. Key Findings from the Feedback from Staff

Despite the differences between the approaches, the data in ***Appendix Three*** shows that common key themes have emerged through these separate engagement processes. Both processes have sound evidence bases and significant responses supporting the reliability of the data.

Key themes emerging through the first LiA Pulsecheck (and subsequent LiA Big Conversations) and the 2013 NHS Staff Survey – and also from the first 2 quarters of the Staff Friends and Family Test 2014-15 were identified in a PCD Report in September 2014. ***Appendix Four*** sets out these common or overlapping themes, which are summarised as follows:-

1. ***Maintaining and developing a workplace and services that staff are proud of***

2. ***Developing excellent team work and effective leadership communication throughout the Trust***

3. ***Addressing the causes of increasing work-pressure and work-related stress, and helping teams to cope***

These themes remain relevant further to the second Pulsecheck survey and the Staff Survey 2014.

The lowest ranked areas in the 2014 Staff Survey are detailed below:-

- *% feeling satisfied with the quality of work and patient care they are able to deliver (64%)*
- *% able to contribute towards improvements at work (65%)*
- *% agreeing that they would feel secure raising concerns about unsafe clinical practice (58%)*
- *Staff motivation at work (scale score 3.71)*
- *% agreeing that their role makes a difference to patients (86%)*

Whilst '*I feel we are providing high quality services for our patients'* was one of the higher scores and identified as one of the areas of greatest improvement (since Pulsecheck 1) in the second Pulsecheck survey, the percentage score (60%, from 50% at first survey) was similar to that for the 'satisfaction with quality of work and patient care' question in the Staff Survey (64%).

The following Pulsecheck results additionally support that, whilst improvement is being seen, patient service related elements of staff experience need to remain as a top priority if we are to deliver services that staff are proud of and in which patients and service users receive the best care and treatment:-

- *I am able to prioritise patient care over other work* (49% in the second Pulsecheck, up from 36% in 2014)
- *Our organisational structures and processes to support and enable me to do my job well* (37%)
- *Our work environment, facilities and systems enable me to do my job well* (41%, up from 23%)
- *Our organisational culture encourages me to contribute to changes* (44%, up from 26%)
- *Managers and leaders seek my views about how we can improve* (45%, up from 28%)
- *I feel that quality and safety of patient care is our organisation's top priority (53%, up from 42% in 2014)*

When the Trust Pulsecheck results were compared the other Trusts nationally North Staffordshire Combined Healthcare NHS Trust were above the national average in 14 of the 15 areas. (see Appendix 1)

3. Action Taken in Response to the Feedback from Staff

The Trust has invested significant effort in addressing the areas for action identified through feedback gathered in the LiA process, the annual NHS Staff Survey and the Staff Friends and Family Test. Action taken in response to staff feedback is outlined below.

1. Action on Listening into Action

   LiA action includes the following:-
   - Launch 'Big Conversations' – September 2014
   - Quick Wins
   - LiA Action Teams – 10 'Pioneering Teams' and 5 'Enabling Teams' – 20 week projects, many including project-related 'Big Conversations'
   - Pass it On Event - March 2015
   - 14 new LiA Action Teams set up

   Appendix Five sets out further details on the key milestones for the LiA Programme.

   Staff are regularly updated on progress and achievements via the weekly CEO Blog and regular LiA News, as well as posters and displays across the Trust.

2. **Action on Staff Survey 2014**

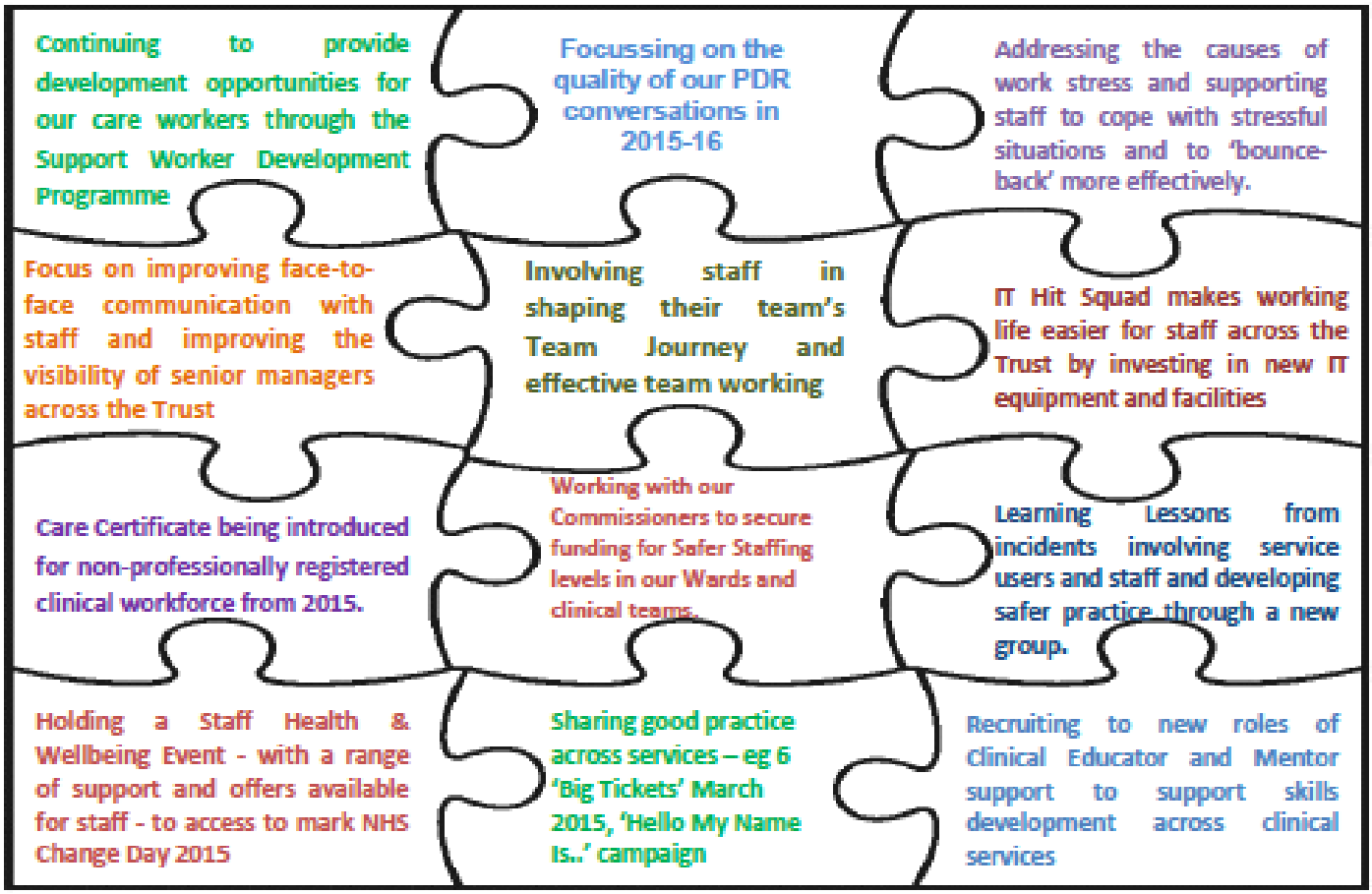
   In relation to the 2014 NHS Staff Survey, the Trust developed an initial response to the survey, including identifying priority areas for action in March 2015 (reviewed at PCD Trust Board). ***Appendix Six*** sets out the key priorities for action emerging from this report.

   A detailed Staff Survey Action Plan was approved by the Trust Board in April followed by individual Directorate Action Plans. These plans continue to be delivered across the organisation. As we reach the summer months, our thoughts turn to continuing to deliver and report progress on these plans to staff in readiness for the launch of the 2015 survey.

   Staff are have received updates on outcomes and action in response to the Staff Survey through Newsround, SID, Junction and via their own Directorate communication channels.

3. Action on Staff Friends and Family Test 2014-15

In relation to the Staff Friends and Family Test, a recent Staff Friends and Family Test feedback report for staff summarised action being taken in relation to all 3 of these staff feedback methods (LiA, Staff Survey and SFFT) as follows:-



In an attempt not to overload staff with potentially conflicting 'feedback about their feedback', from SFFT and that obtained from the annual Staff Survey, Listening into Action, and other feedback, a 'joined up' approach incorporating all feedback has taken place to link the findings and actions taken. There has been efforts made to link the different feedback sources in our communications to staff over the last 6-9 months and it is recommended that we extend this approach going forward.

4. Conclusions

The above analysis shows that the LiA Pulsecheck surveys and the NHS Staff Surveys covered similar ground over four differently timed and differently administered surveys. There is also considerable overlap with feedback from the 3 SFFT surveys of 2014-15.

The Trust has invested heavily in responding to staff feedback during 2014-15 and the 2015-16 to date and it would appear that this action is starting to have positive impact, based on improvements in staff opinion identified in the latest LiA Pulsecheck survey. These results suggest that real progress is being made in improving staff perceptions of the Trust as an employer and provider of services.

It is hoped and anticipated that much of the excellent progress observed in the second Pulse Check should be translated into improved NHS Staff Survey results come the NHS Staff Survey

2015 in the Autumn if indeed the improvements measured relate to a step-change in organisation culture. We need to continue to invest in our culture of listening to and responding to staff and to focus on combining our feedback and efforts in relation to the key feedback routes discussed in this paper.

It is recognised, however, that staff engagement and organisation culture can be difficult and slow to actively and purposefully improve and maintain for the long term. It is essential that the Trust maintains and continues to develop its approaches to staff engagement at every level and across all areas to ensure that the best conditions are created in which to realise significant improvement in the results of the 2015 Staff Survey.

For the Trust to see significant and sustained improvement in its culture of listening to and responding to staff (and its wider culture of staff engagement), it is essential that all Trust leaders - at every level and in every service - continuously display and actively encourage behaviours that promote trust, openness and service excellence, and strive to deliver services which staff are proud to work in and happy to recommend.

5. Recommendations

It is recommended that the Board:-

1. **Notes the contents** of this report for assurance
2. Considers and **commits to personal actions** to further develop the culture of listening to and responding to staff and culture of staff engagement
3. **Acts as champions** of LiA, the NHS Staff Survey 2015, and future SFFT as they approach

END

Appendices:-

Appendix One – Pulse Check Results Compared

Appendix Two – Staff Survey 2014 compared with Staff Survey 2013

Appendix Three – Detailed comparison of LiA Pulsecheck Surveys (2014-15) and NHS Staff Survey (2013-14)

Appendix Four - Common Themes Emerging From Pulsecheck 1, Staff Survey 2013 and SFFT Quarters 1&2 2014-15

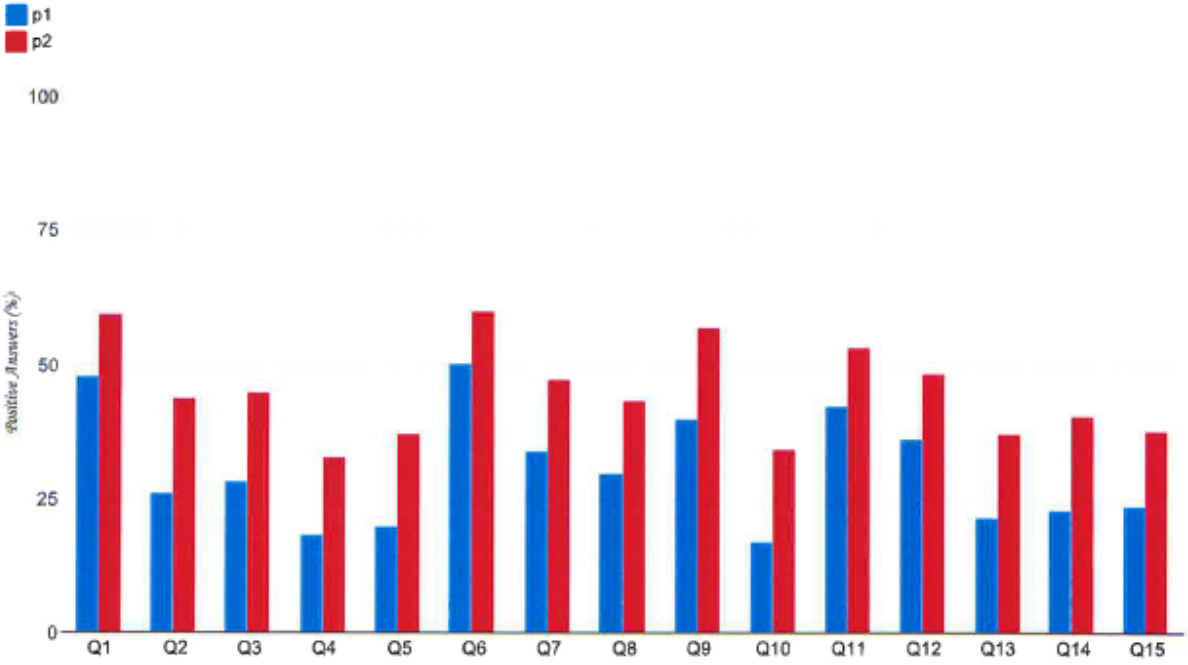
Appendix Five - Listening into Action Key Milestones

Appendix Six - Priorities Emerging from the 2014 NHS Staff Survey

APPENDIX ONE:

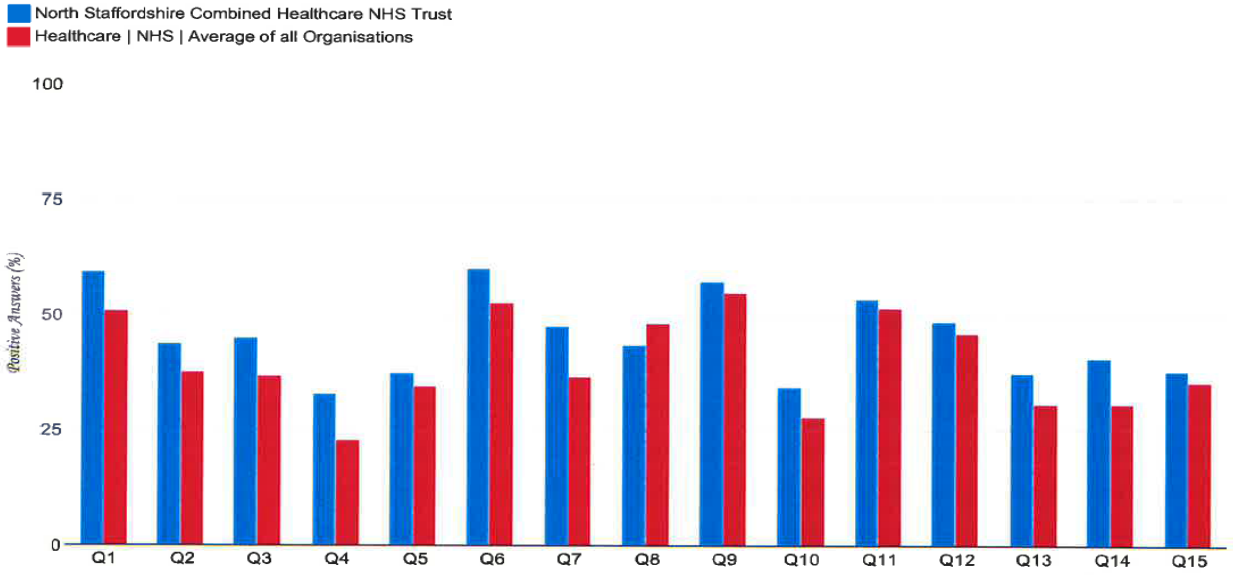
(A) LiA PULSE CHECK SURVEY RESULTS (Survey One and Survey Two Compared)

Pulse Check Range	1 - 2
Number of Responses	1,162



	p1	p2
Q1: I feel happy and supported working in my team/department/service	47.76%	59.48% (+11.72%)
Q2: Our organisational culture encourages me to contribute to changes that affect my team/department/service	25.96%	43.87% (+17.91%)
Q3: Managers and leaders seek my views about how we can improve our services	28.21%	45.17% (+16.96%)
Q4: Day-to-day issues and frustrations that get in our way are quickly identified and resolved	18.27%	32.9% (+14.63%)
Q5: I feel that our organisation communicates clearly with staff about its priorities and goals	19.87%	37.36% (+17.49%)
Q6: I believe we are providing high quality services to our patients/service users	50.16%	60.22% (+10.06%)
Q7: I feel valued for the contribution I make and the work I do	33.81%	47.58% (+13.77%)
Q8: I would recommend our Trust to my family and friends	29.65%	43.49% (+13.84%)
Q9: I understand how my role contributes to the wider organisational vision	39.9%	57.06% (+17.16%)
Q10: Communication between senior management and staff is effective	16.99%	34.39% (+17.4%)
Q11: I feel that the quality and safety of patient care is our organisation\'s top priority	42.31%	53.53% (+11.22%)
Q12: I feel able to prioritise patient care over other work	36.22%	48.51% (+12.29%)
Q13: Our organisational structures and processes support and enable me to do my job well	21.47%	37.36% (+15.89%)
Q14: Our work environment, facilities and systems enable me to do my job well	22.92%	40.52% (+17.6%)
Q15: This organisation supports me to develop and grow in my role	23.88%	37.92% (+14.04%)

(B) LiA PULSE CHECK SURVEY RESULTS (Survey Two NSCHT Compared with National Average for all LiA Trusts)



	p2
Q1 - North Staffordshire Combined Healthcare NHS Trust: I feel happy and supported working in my team/department/service	59.48%
Q1 - Healthcare | NHS | Average of all Organisations: I feel happy and supported working in my team/department/service	51.09%
Q2 - North Staffordshire Combined Healthcare NHS Trust: Our organisational culture encourages me to contribute to changes that affect my team/department/service	43.87%
Q2 - Healthcare | NHS | Average of all Organisations: Our organisational culture encourages me to contribute to changes that affect my team/department/service	37.59%
Q3 - North Staffordshire Combined Healthcare NHS Trust: Managers and leaders seek my views about how we can improve our services	45.17%
Q3 - Healthcare | NHS | Average of all Organisations: Managers and leaders seek my views about how we can improve our services	36.91%
Q4 - North Staffordshire Combined Healthcare NHS Trust: Day-to-day issues and frustrations that get in our way are quickly identified and resolved	32.9%
Q4 - Healthcare | NHS | Average of all Organisations: Day-to-day issues and frustrations that get in our way are quickly identified and resolved	23.12%
Q5 - North Staffordshire Combined Healthcare NHS Trust: I feel that our organisation communicates clearly with staff about its priorities and goals	37.36%
Q5 - Healthcare | NHS | Average of all Organisations: I feel that our organisation communicates clearly with staff about its priorities and goals	34.61%
Q6 - North Staffordshire Combined Healthcare NHS Trust: I believe we are providing high quality services to our patients/service users	60.22%
Q6 - Healthcare | NHS | Average of all Organisations: I believe we are providing high quality services to our patients/service users	52.64%
Q7 - North Staffordshire Combined Healthcare NHS Trust: I feel valued for the contribution I make and the work I do	47.58%
Q7 - Healthcare | NHS | Average of all Organisations: I feel valued for the contribution I make and the work I do	36.62%
Q8 - North Staffordshire Combined Healthcare NHS Trust: I would recommend our Trust to my family and friends	43.49%
Q8 - Healthcare | NHS | Average of all Organisations: I would recommend our Trust to my family and friends	48.28%
Q9 - North Staffordshire Combined Healthcare NHS Trust: I understand how my role contributes to the wider organisational vision	57.06%
Q9 - Healthcare | NHS | Average of all Organisations: I understand how my role contributes to the wider organisational vision	55.01%
Q10 - North Staffordshire Combined Healthcare NHS Trust: Communication between senior management and staff is effective	34.39%
Q10 - Healthcare | NHS | Average of all Organisations: Communication between senior management and staff is effective	28.02%
Q11 - North Staffordshire Combined Healthcare NHS Trust: I feel that the quality and safety of patient care is our organisation\'s top priority	53.53%
Q11 - Healthcare | NHS | Average of all Organisations: I feel that the quality and safety of patient care is our organisation\'s top priority	51.83%
Q12 - North Staffordshire Combined Healthcare NHS Trust: I feel able to prioritise patient care over other work	48.51%
Q12 - Healthcare | NHS | Average of all Organisations: I feel able to prioritise patient care over other work	46.15%
Q13 - North Staffordshire Combined Healthcare NHS Trust: Our organisational structures and processes support and enable me to do my job well	37.36%
Q13 - Healthcare | NHS | Average of all Organisations: Our organisational structures and processes support and enable me to do my job well	30.71%
Q14 - North Staffordshire Combined Healthcare NHS Trust: Our work environment, facilities and systems enable me to do my job well	40.52%
Q14 - Healthcare | NHS | Average of all Organisations: Our work environment, facilities and systems enable me to do my job well	30.77%
Q15 - North Staffordshire Combined Healthcare NHS Trust: This organisation supports me to develop and grow in my role	37.92%
Q15 - Healthcare | NHS | Average of all Organisations: This organisation supports me to develop and grow in my role	35.54%

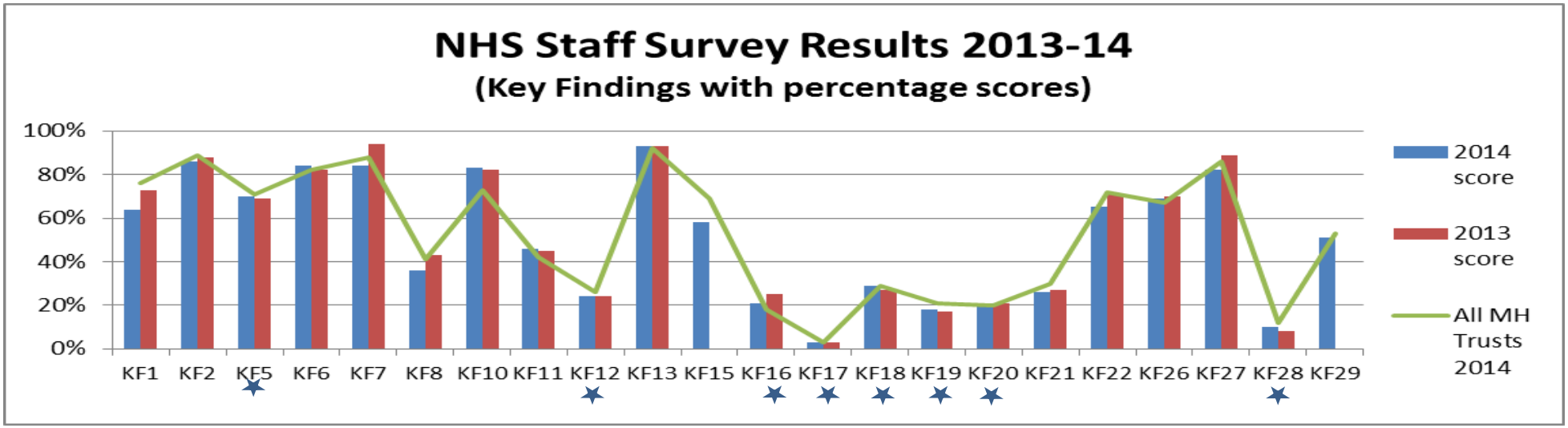
APPENDIX 2a:

SUMMARY OF NHS STAFF SURVEY 'KEY FINDINGS' RESULTS 2014

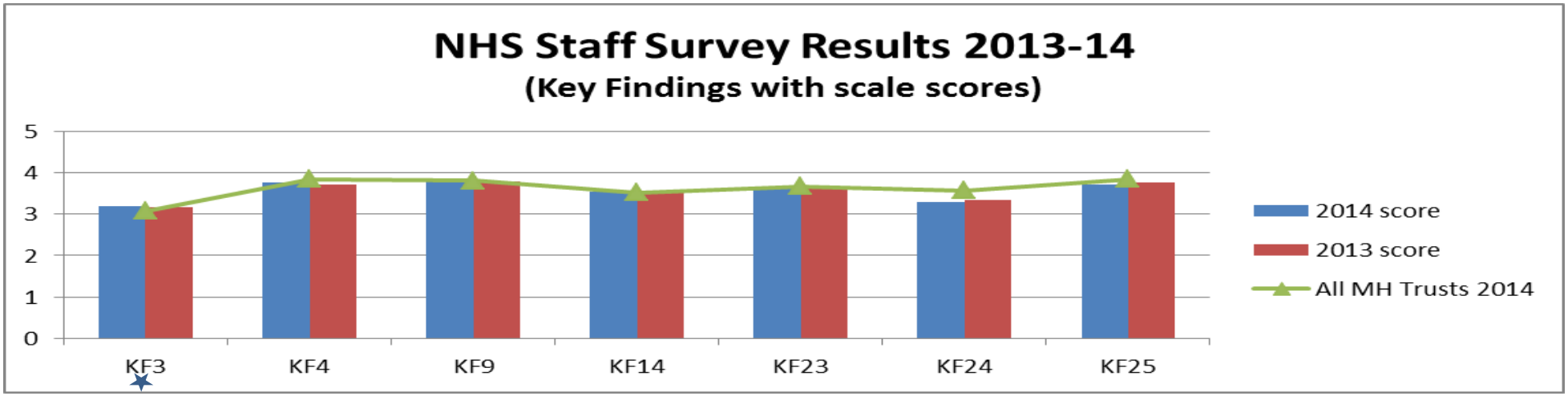
	Key Factor	Question Area	Benchmark* Position 2014 (*against other MH/LD Trusts)	Benchmark* Position 2013 (*against other MH/LD Trusts)	change in benchmark position 2013-14		2014 score	2013 score	Average MH Trust score 2014 (best in brackets)	Statistically significant change in Trust score since 2013?
	Staff Pledge 1: To provide all staff with clear roles, responsibilities and rewarding jobs									
	KF1	% feeling satisfied with the quality of work and patient care they are able to deliver	**Worst 20%**	Worse than Average	↓		64%	73%	76% (89%)	↓ stat sig
	KF2	% agreeing that their role makes a difference to patients	**Worst 20%**	**Worst 20%**	↔		86%	88%	89% (94%)	↔
★	KF3	Work pressure felt by staff	**Worst 20%**	**Worst 20%**	↔		3.19	3.17	3.07 (2.79)	↔
	KF4	Effective team working	Worse than Average	**Worst 20%**	↑		3.77	3.72	3.84 (4.06)	↔
★	KF5	% working extra hours	Better than Average	Better than Average	↔		70%	69%	71% (57%)	↔
	Staff Pledge 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential									
	KF6	% receiving job-relevant training, learning or development in last 12 months	**Best 20%**	Average	↑		84%	82%	82% (87%)	↔
	KF7	% appraised in last 12 months	Worse than Average	**Best 20%**	↓		84%	94%	88% (96%)	↓ stat sig
	KF8	% having well structured appraisals in last 12 months	**Worst 20%**	Average	↓		36%	43%	41% (58%)	↓ stat sig
	KF9	Support from immediate managers	Average	Worse than Average	↑		3.80	3.79	3.81 (4.07)	↔
	Staff Pledge 3: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential									
	KF10	% receiving health and safety training in last 12 months	**Best 20%**	**Best 20%**	↔		83%	82%	73% (90%)	↔
	KF11	% suffering work-related stress in last 12 months	Worse than Average	Worse than Average	↔		46%	45%	42% (33%)	↔
★	KF12	% witnessing potentially harmful errors, near misses or incidents in last month	Better than Average	Better than Average	↔		24%	24%	26% (13%)	↔
	KF13	% reporting errors, near misses or incidents witnessed in the last month	Better than Average	Better than Average	↔		93%	93%	92% (97%)	↔
	KF14	Fairness and effectiveness of incident reporting procedures	Better than Average	Average	↑		3.55	3.51	3.52 (3.75)	↔
	KF15	% agreeing that they would feel secure raising concerns about unsafe clinical practices	**Worst 20%**	n/a - NEW measure	n/a		58%	n/a - NEW measure	69% (78%)	n/a - NEW measure
★	KF16	% experiencing physical violence form patients/relatives/public in last 12 months	Worse than Average	**Worst 20%**	↑		21%	25%	18% (8%)	↔
★	KF17	% experiencing physical violence from staff in last 12 months	Better than Average	Better than Average	↔		3%	3%	3% (0%)	↔
★	KF18	% experiencing harassment, bullying or abuse from patients/relatives/public in last 12 months	Better than Average	Better than Average	↔		29%	27%	29% (16%)	↔
★	KF19	% experiencing harassment, bullying or abuse from staff in last 12 months	Better than Average	**Best 20%**	↓		18%	17%	21% (14%)	↔
★	KF20	% feeling pressure in last 3 months to attend work when feeling unwell	Average	Average	↔		21%	21%	20% (12%)	↔
	Key Factor	Question Area	Benchmark* Position 2014 (*against other MH/LD Trusts)	Benchmark* Position 2013 (*against other MH/LD Trusts)	change in benchmark position 2013-14		2014 score	2013 score	Average MH Trust score 2014 (best in brackets)	Statistically significant change in score since 2013?
	Staff Pledge 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services									
	KF21	% reporting good communication between senior management and staff	**Worst 20%**	Worse than Average	↓		26%	27%	30% (51%)	↔
	KF22	% able to contribute towards improvements at work	**Worst 20%**	Worse than Average	↓		65%	71%	72% (83%)	↓ stat sig
	KF23	Staff job satisfaction	Worse than Average	Worse than Average	↔		3.62	3.64	3.67 (3.93)	↔
	KF24	Staff recommendation of the trust as a place to work or receive treatment	**Worst 20%**	**Worst 20%**	↔		3.28	3.33	3.57 (4.15)	↔
	KF25	Staff motivation at work	**Worst 20%**	**Worst 20%**	↔		3.71	3.77	3.84 (4.09)	↔
★	KF26	% having equality and diversity training in last 12 months	Better than Average	Average	↑		69%	70%	67% (92%)	↔
	KF27	% believing trust provides equal opportunities for career progression or promotion	Worse than Average	Average	↓		82%	89%	86% (93%)	↓ stat sig
	KF28	% experiencing discrimination at work in last 12 months	Better than Average	**Best 20%**	↓		10%	8%	12% (7%)	↔
	KF29	% agreeing feedback from patients/service users is used to make informed decisions in their directorate/ dept	Worse than Average	n/a - NEW measure	n/a		51%	n/a - NEW measure	53% (77%)	n/a - NEW measure
		RESPONSE RATE					**40%**	**56%**	**48%**	
	Additional measure	Overall Staff Engagement (combination score derived from KFs 22, 24 & 25)	**Worst 20%**	**Worst 20%**			3.55	3.60	3.71	

★ Denotes a measure where a **low score is better**

APPENDIX 2b



★ denotes questions where a **low score** is better



APPENDIX 3:

DETAILED COMPARISON OF THE LiA PULSECHECK SURVEYS (2014-15) WITH THE NHS STAFF SURVEY (2013-14)

a.Survey approach and timing

The LiA Pulse Check:	**The Staff Survey:**
Is a simple tool with 15 questions (LiA standard tool) requiring a graded response from 1 = not at all to 5 = very much so, with no option to comment. This provides a snapshot view of how engaged and how valued staff feel at that moment in time. The first Pulse Check survey was issued both as an online survey and with paper copies attached to payslips to all staff in July 2014. The second Pulse Check survey was conducted during May 2015 again was an online survey, but this time, paper copies were made available to all teams, wards and departments throughout the Trust. The Pulse Check surveys were open for 3½ weeks in 2015 and for 6-8 weeks in 2014.	Is a mandatory multiple choice questionnaire (approximately 100 questions to national required template) which covers a range of employment related questions including: • *your job; your work with colleagues; leadership and supervision; health and safety,* and *your views on the Trust where you work.* • There is the opportunity staff to provide additional text comment at the end of the survey. These questions are then condensed into 29 'Key Findings' measures (plus one 'Overall Staff Engagement' measure). The NHS Staff Survey is usually live between late September and early December each year (ie approximately 10 weeks).
<u>Evidence Base</u> Listening into Action is a staff engagement methodology developed by Optimise, based upon change management techniques. Listening into Action has been trialled and proven over the last 7 years in the NHS. The Pulse Check identifies a baseline of staff responses in a given organisation, which is then repeated after engagement and action of teams throughout the organisation. This allows for a comparative analysis against the baseline, in order to measure the impact of engagement and change.	<u>Evidence Base</u> The NHS Staff Survey has been an annual feature of the NHS life for more than 10 years. Its findings have been the subject of considerable research by the Aston University Business School, such that correlation has been found between NHS organisational performance and a range of measures in the survey, including the degree to which NHS staff would recommend the organisation as a place to receive care or place to work.

Distribution LiA Pulse Check: All employed staff (1,365) were invited to take part. The Pulse Check was sent to all staff via Trust email, although opportunity to complete a paper copy was additionally made available in all wards and departments. Voluntary and bank staff **do** have the option to complete this survey.	Distribution For the first time in 2014, the Trust was able to introduce online completion for the majority of its employees. 60% of staff received the survey online, the other 40% received a paper survey (this group included all HCSW and equivalent staff, together with estates and ancillary workers). Altogether, 1398 staff received the survey in one form or the other in 2014. The survey rules and systems are in place to strictly ensure that each participant is only able to respond to each year's Staff Survey once. NEDS, voluntary workers, bank staff and contractors **do not** have the option to complete this this survey, as per the national survey rules.
Response Rate In the Baseline Pulse Check in 2014 we received 624 responses, a response rate of 45.7%. The second Listening into Action Pulse Check (2015) had 538 respondents giving a response rate of 39.4%.	**Response Rate** The Trust had a 40% response rate (512 responses) to the 2014 survey. This reflected the national decline in response rate for this survey. In contrast, in the 2013 survey the Trust had a 56% response rate.
Question answer format Staff were asked to rate the Trust's performance on the survey question areas from 1-5. The % score given for average responses is staff recording a score of 4 or 5 (range 1 – 5)	**Question answer format** Most questions gave a multiple choice format based on the format: *strongly agree/ agree/ neither agree nor disagree/ disagree/ strongly disagree* Percentage scores in this report (where given) relate to the percentage of staff who chose 'agree' or 'strongly agree' (note many of the survey key finding measures are actually an aggregate of a number of individual survey questions). Some of the survey 'key findings' are given a 'scale score' (0-5) rather than a percentage score.

b. Survey Results

The Trust's 2015 Pulse Check results have now been collated with some very positive results (compared with the 2014 survey). There are noticeable improvements across **ALL** 15 questions ranging from 10.06% to 17.91%.	**The Trust's 2014 NHS Staff Survey results** showed improvements (compared with the 2013 survey) in a range of the survey key findings rank positions, but with deterioration in a number of other areas. Overall, the Trust was average or better for fewer key findings measures than in the 2013 survey.
Best and worst areas at last survey The Trust's **top scoring survey key findings measures** in the 2015 Pulse Check survey were as follows: • *I believe we are providing high quality services for our patients….60.22%* *I feel happy and supported….59.48%* • *I understand how my role contributes to the organisational vision….57.06%* • *I feel that the quality and safety of patient care is our organisation's top priority….53.53%* • *I feel able to prioritise patient care over other work….48.51%* The Trust's **worst ranked key finding measures** 2015 were: • *Day to day issues are quickly identified and resolved….32.9%* • *Communication between senior management and staff is effective….34.39%* • *Our organisational structures and processes support and enable me to do my job well….37.36%* • *I feel our organisation communicates clearly about its priorities and goals….37.36%* • *This organisation supports me to develop and grow in my role….37.92%*	**Best and Worst Areas at last survey** The Staff Survey 'best' and 'worst' scoring areas are based on the rank position **compared with other mental health trusts**. The Trust's **top scoring survey key findings measures** in the 2014 survey were as follows (the first 2 of these were in the best 20%):- • *% receiving health and safety training in last 12 months (83%)* • *receiving job-relevant training, learning or development in last 12 months (84%)* • *% experiencing discrimination at work in last 12 months (10%)* • *% experiencing harassment, bullying or abuse from staff in last 12 months (18%)* • *witnessing potentially harmful errors, near misses or incidents in last month (24%)* The Trust's **worst ranked key findings measures** 2014 were (all bottom 20% of MH Trusts):- • *% feeling satisfied with the quality of work and patient care they are able to deliver (64%)* • *% able to contribute towards improvements at work (65%)* • *% agreeing that they would feel secure raising concerns about unsafe clinical practice (58%)* • *Staff motivation at work (scale score 3.71)* • *% agreeing that their role makes a difference to patients (86%)*

Where performance improved: As noted above, there was improvement on **all measures** in the second Pulsecheck survey. The measures showing the **highest level of improvement** in the 2015 survey were:- • *I feel that our organisation communicates clearly with staff about its priorities and goals (+17.49%)* • *Our organisational culture encourages me to contribute to changes that affect my team/department/services (+17.91%)* • ***Our current highest scores are shown in:*** • *I feel happy and supported working in my team/department/service (59.48%)* • *I believe we are providing high quality services to our patients/service users (60.22%)* In the Pulse Check NSCHT improved by an average of 13.6% across the questions from 2014 to 2015 and scored noticeably above average nationally.	**Where performance improved:** The Trust did not see statistically significant improvement in performance in any of the staff survey measures in 2014. However, the following measures saw an **improvement in their benchmark ranking** (ie comparative improvement against the group of all mental health and learning disability trusts). • *Effective teamwork (scale score 3.77 – 'worse than average')* • *% receiving job relevant training (84% - best 20%))* • *Support from line managers (scale score 3.80 - average)* • *Fairness and effectiveness of incident reporting procedures (3.55 – better than average)* • *% experiencing physical violence from patients/public in last 12 months (21% - worse than average)* • *% having E&D training in the last 12 months (69% - better than average)* It is not practicable to give a comparable percentage improvement score for the Staff Survey since some of the key findings measures are 'high score better' and some 'low score better', also some measures given as percentage scores and others as scale scores.
Worst performing areas / where performance deteriorated / lowest scoring areas There was no deterioration in any of the Listening into Action Pulse Check survey. The lowest scoring measures in the 2015 Pulse Check Survey were:- • Day to day issues and frustrations that get in our way are quickly identified and resolved (32.9%) • Communication between senior management and staff is effective ((34.39%)	**Worst performing areas / where performance deteriorated** The Trust's **worst ranked survey key findings** in the 2014 survey were:- • *% feeling satisfied with the quality of work and patient care they are able to deliver (64% - worst 20% of trusts)* • *% able to contribute towards improvements at work (65% - worst 20%)* • *% agreeing that they would feel secure raising concerns about* • *unsafe clinical practice (58% - worst 20%)* • *Staff motivation at work (3.71 – worst 20%)* • *% agreeing that their role makes a difference to patients (86% - worst*

	20%) The Trust's experienced deterioration (statistically significant) in their survey scores (since 2013) on the following measures:- • *% able to contribute towards improvements at work (65% - worst 20%)* • *% staff appraised in last 12 months (84% - worse than average)* • *% staff feeling satisfied with the quality of work and patient care they are able to deliver (64% - worst 20%)* • *% believing the trust provides equal opportunities for career progression or promotion (82% - worse than average)* • *% having well-structured appraisals in last 12 months (36% - worst 20%)*

c. Most comparable questions and results across the two surveys

Pulse Check: 2014 to 2015	**Staff Survey: 2013 to 2014**
• *I believe we are providing high quality services to our patients/service users* (2014: 50.16%; 2015: 60.22%) • *I feel that quality and safety of patient care is our organisations top priority* (2014: 42.31%; 2015: 53.53%)	• *Q12a: Care of patients / service users is my organisation's top priority (*2013: 53%; 2014 56%)
• *I feel able to prioritise patient care over other work (*2014: 36.22%; 2015: 48.51%)	• *Q9c: I am able to deliver the patient care I aspire to* (2013: 61%; 2014: 65%)
• *Our organisational culture encourages me to contribute to changes that affect my team/department/service (*2014: 25.96%; 2015: 43.87%) • *I feel happy and supported working in my team (2014: 47.76% 2015: 59.48%* • *I understand how my role contributes to the wider organisational vision (2014: 39.9% 2015: 57.06%)*	• KF22. *% able to contribute towards improvements at work* (2013: 71%; 2014 65%) • Q7c *I am involved in deciding on changes introduced that affect my work area / team / department* (2013: 54%; 2014: 52%)

• *Communication between senior management and staff is effective (*2014: 16.99%; 2015: 34.39%) • *I feel that our organisation communicates clearly with staff about it's priorities and goals (2014: 19.87% 2015: 37.37%)*	• *KF 21: % reporting good communication between senior management and staff (*2013: 27%; 2014: 27%)
• *Managers and Leaders seek my views about how we can improve our service (*2014: 28.21%; 2015: 45.17%) • *Day to day issues and frustrations are quickly identified and resolved (2014: 18.27% 2015: 32.9%)* • *Our organisational structures support and enable me to do my job well (2014: 21.47% 2015: 37.36%)*	• KF22 - *Staff able to contribute towards improvements at work* (65% 2014; 71% 2013) • Q11c - *Senior managers here try to involve staff in important decisions (*2013: 26%; 2014: 27%) • Q10d - *My immediate manager asks for my opinion before making decisions that affect my work (*2013: 60%; 2014: 56%) • Q8b - *I am satisfied with the support I get from my immediate manager* (2013: 73%; 2014: 69%)
• *I would recommend our Trust to family and friends* (2014: 29.65%; 2015: 43.49%) • *I feel valued for the contribution I make and the work I do (2014: 33.81% 2015: 47.58%)*	• Q12c - *I would recommend my organisation as a place to work* (2013: 42%; 2014: 43%) • Q12d - *If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation* (2013: 51%; 2014: 50%)
• *The organisation supports me to develop and grow my role (*2014: 23.88%; 2015: 37.92%)	• Q3e - *% my appraisal or development review identified training, learning or development needs (*2013: 72%; 2014: 68%)

Two questions that are non-comparable within the surveys are:

Our work environment, facilities and systems enable me to do my job well (2014: 22.92% 2015: 40.52%)	• *Q13c: Feedback from patients / service users is used to make informed decisions within my directorate / department" (2013: N/A; 2014: 50%)*

APPENDIX 4a – COMMON THEMES EMERGING FROM PULSECHECK 1, STAFF SURVEY 2013 AND SFFT QUARTERS 1&2 2014-15

<table>
<tr><th>Listening into Action</th><th>Staff Survey 2013</th><th>Staff Friends & Family Test Q1&Q2</th></tr>
<tr><td>1. Quality and safety</td><td>1. Effective team working and team leadership</td><td>1. Maintaining and developing a workplace and services that staff are proud of</td></tr>
<tr><td>2. Patient experience</td><td>2. Delivering a health service that our staff are proud of</td><td>2. Addressing the causes of work pressure and work-related stress</td></tr>
<tr><td rowspan="3">3. Enabling our frontline teams</td><td>3. Visible, supportive leadership, at every level</td><td>3. Helping teams and individuals to cope with change and service pressures</td></tr>
<tr><td>4. Helping staff to deliver high quality services and to contribute to making improvements in how services are delivered</td><td rowspan="2">4. Developing excellent team work and effective leadership communication throughout the Trust</td></tr>
<tr><td>5. Addressing the causes of increasing work pressure and work-related stress</td></tr>
</table>

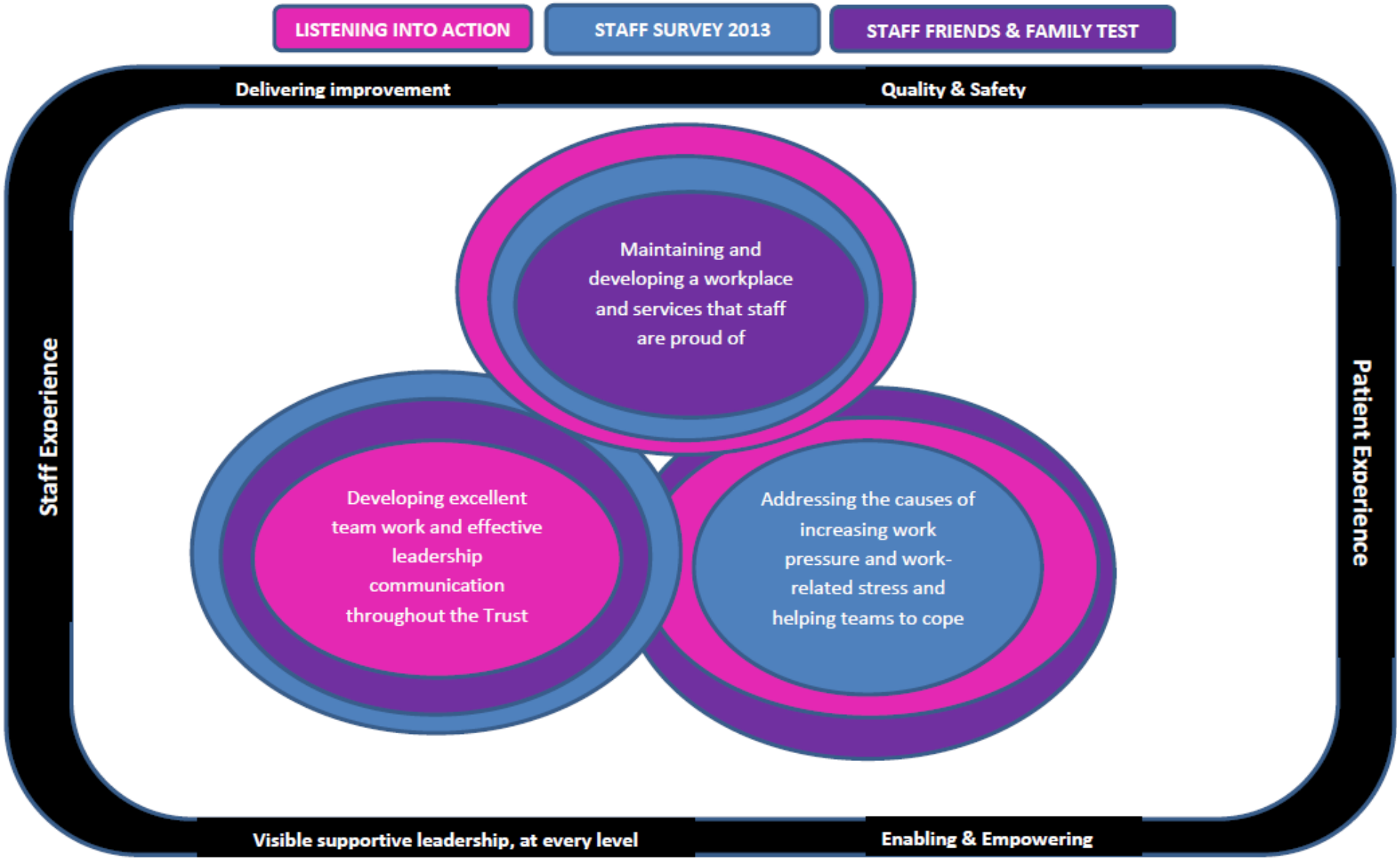
The above is summarised into the following 3 key themes (illustrated in diagram form at Appendix 6):-

Staff Engagement priorities from Staff Feedback as at September 2014:-

1. ***Maintaining and developing a workplace and services that staff are proud of***
2. ***Developing excellent team work and effective leadership communication throughout the Trust***
3. ***Addressing the causes of increasing work-pressure and work-related stress, and helping teams to cope***

These themes were illustrated in the diagram below in Appendix 4b.

APPENDIX 4b: COMMON THEMES FROM STAFF FEEDBACK AS AT SEPTEMBER 2014



APPENDIX 5 - LISTENING INTO ACTION KEY MILESTONES

- **Launch 'Big Conversations' – September 2014** - 5 Big Conversations were held at the outset, led by Caroline Donovan, Chief Executive, with attendance encouraged from across the staff groups and teams. Priorities for action were identified from these Big Conversations leading to the creation of the first 15 LiA teams as below**.**

- **Ongoing from LiA Launch - 'Quick Wins' –** improvements that can be made within 2-4 weeks and cut across all of the LiA project teams. Examples of this are; 'Nurse in Charge' badges in hospital settings for easy identification, Team Brief on Tour – Executives take out the Team Brief to different areas of the trust (Community and Hospital services), Welcome booklet in Acute Services.

- **LiA Action Teams** – 10 'Pioneering Teams' and 5 'Enabling Teams' – 20 week projects, many including project-related 'Big Conversations'. The First 15 staff-led LiA teams tasked with delivering meaningful change over a period of 20 weeks in relation to an area identified through staff consultation as priority for action. The 15 LiA teams included 10 'Pioneering Teams' addressing a specific issue within a particular service, and 5 'Enabling Teams', addressing challenges across the organisation.

  Successes to date from these Listening into Action groups included for example:-

  - The development of a more consistent approach for all those using Trust services at the point of access; for example through the introduction of a 24/7 Access service providing for all crisis and urgent response for those aged 16 and over
  - Introducing a more streamlined and speedier recruitment process for new employees at the Trust
  - Improving how staff learn lessons from incidents and complaints to ensure they can be better avoided in future
  - Renaming the Section 136 Suite at Harplands Hospital as the Place of Safety and making improvements to the service to enhance the service user experience
  - Involving North Staffordshire's Young Person's Council in the design of a poster raising awareness of did not attend (DNA) appointments within the Children and Adolescent Metal Health Service (CAHMS). The CAHMS team has also acquired funding to develop an interactive website
  - Ensuring that every locality GP in Stoke-on-Trent and North Staffordshire has a link to a named Consultant within the Trust's Community Mental Health Teams (CMHTs)
  - IT Hit Squad – a group led by the Chief Executive driving investment in technology across the Trust, including Wi-Fi access and easing frustration with IT user experience

- **Pass it On Event - 27 March 2015** • The first chapter in the Trust's Listening into Action journey was celebrated at successful 'Pass it On' Event. Which also introduced the next wave of Listening into Action Teams:

1. Supervision
2. Recruitment (continued journey)
3. Transitions between services
4. Caseload management
5. ‘Zokens’ staff wellbeing tool
6. Deaf awareness
7. Improving safety in inpatient environments
8. Improving bed management
9. Values and behaviours
10. Junior Doctor
11. Support staff
12. Ownership of quality environments
13. Improve record keeping around the Mental Health Act in line with current legislation
14. No Change About me Without Me (continued journey)

APPENDIX 6 – PRIORITIES EMERGING FROM THE 2014 NHS STAFF SURVEY*

Key priorities for action emerging (March 2015) from the 2014 Staff Survey are as follows:-

a. To improve the **response rate** the Trust and see significant improvement in the response rate in lower responding areas (Adult inpatient, Substance Misuse, NOAP).

b. Directorates and Corporate teams to develop plans with a view to improving our **comparative position** in terms of increasing the proportion of measures in the 'Best 20%' and 'Better than Average' categories and reducing the proportion of measures in the 'Worse than Average' or 'Worst 20%' categories.

c. Maintain and continue to develop and build upon our **positive culture of health and safety**, a learning culture and a culture where discrimination, harassment, bullying or abuse is rare.

d. Continue to invest in further development of **strong patient service culture** whereby staff have **confidence in the quality of care/service** they are able to deliver and in which they feel **able to contribute to improvements** at work. This needs to be at every level of the employment relationship, from Trust level programmes such as Listening into Action, and Aston, to individual staff having a voice in shaping practice (in big or small ways) in their own teams and Directorates. This links closely with the need to improve staff perceptions about the organisation in order to improve staff advocacy rates of the **Trust as a place to work and as a place to receive treatment**.

e. Understanding and addressing issues around **staff motivation and staff engagement** across the Trust. Tackling root causes and sharing information openly and honestly where the Trust has limited capacity to make changes (such as around service funding issues) will be important here.

f. Have a strong campaign highlighting the importance of staff feeling **secure to raise concerns** and clear communication about how to report unsafe or inappropriate care or behaviour should they observe or have reason to suspect it.

g. Turnaround the Trust's performance in relation to **appraisal (PDR) quality** of the appraisal discussion.

h. Seek to understand the reasons for a reduction in perceptions about equal opportunities in career progression and address these through the Trust recruitment approach in all Directorates. All Trust recruiting managers will need to share responsibility for addressing this matter.

i. Continue to implement and further develop the Trust's Stress Less approach to tackle the causes and symptoms of excessive **work pressure and work-related stress**.

j. Continue to seek to understand staff perceptions and preferences about what they consider to be effective **communications between senior managers and staff** and continually develop our processes in respect of this based on this feedback and understanding.

k. Explore the issues of **effective leadership** across the Trust to support all of the above.

[*priorities identified in Trust Board Report on 2014 Staff Survey, March 2015]

North Staffordshire Combined Healthcare NHS
NHS Trust

Enclosure 20

REPORT TO: **Trust Board**

Date of Meeting:	30th July 2015
Title of Report:	Update Report: Update Report Widening participation and development for the support workforce - including Health Care Support Worker learning programme progress report
Presented by:	Paul Draycott
Author of Report: Name: Date: Email:	Beverley Dawson Training Manager 10th July 2015 Beverley.dawson@northstaffs.nhs.uk
Purpose / Intent of Report:	To review our current position against Talent for Care, and Widening Participation frameworks and to take further opportunities, to expand, motivate and improve your workforce. It further summarises the progress made in relation to the main themes of the October 2014 action plan for the support worker development approach and makes further recommendations for continuing improvement and alignment to widening participation and talent for care.
Executive Summary:	This progress report has been grouped into themes that cross match with the Talent For Care themes of "Get In / Get on / Go Further. In addition a summary of the North Staffordshire Combined Healthcare NHS Trust Talent for Care pledge has been included in the report.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	Workforce Strategy The quality of care at the clinical interface is largely delivered by our clinical support workforce. This paper updates progress on our support worker learning approach which will impact on the way in which support staff are prepared for their caring role.
Relationship with Annual Objectives:	Supports governance through effective education, learning and training
Risk / Legal Implications:	none
Resource Implications:	Funding has been identified for this financial year and the project will need further support next year to continue which will be a priority from next year's learning and development budget
Equality and Diversity Implications:	none
Relationship with Assurance Framework [Risk, Control and Assurance]	
Recommendations:	The Board are asked to note the strong progress and support the further developments proposed.

NHS
Health Education England

Private Office
Blenheim House
Duncombe Street
Leeds
LS1 4PL

3 June 2015

Dear colleague

Investment in the future of healthcare – widening participation and development for the support workforce

This year, development for the support workforce for health and social care remains high on the list of priorities for national action, as is opening our doors and widening access to the breadth of NHS careers to enable future workforce supply.

Evidence shows a strong connection between high quality care delivered by successful organisations and their level of investment in development for support staff. Consistency in training standards offers fast routes to integrated care and other service change.

Last year, our review of training and development for the support workforce (those in Agenda for Change bands 1-4 roles and their equivalents) discovered many examples of good practice and innovation. However, the view overall remains a cause for concern. While support staff represent around 40% of the NHS workforce providing around 60% of patient care, this group receives less than 5% of the national training budget.

I am writing to ask that you work with us to change this picture during 2015/16.

Health Education England offers two new strategic frameworks; *Talent for Care*, and *Widening Participation: It Matters*. I ask you to review your current position against these frameworks and to take further opportunities, to expand, motivate and improve your workforce.

Talent for Care is the first ever national strategic framework for the development of the healthcare support workforce. It focuses on three primary themes:

- Get In – opportunities for people to start their career in a support role
- Get On – supporting people to be the best they can be in the job they do
- Go Further – providing opportunities for career progression, including into registered professions.

Widening Participation promotes action to build a diverse healthcare workforce that encourages people from all walks of life, and where success is based on merit, ability and motivation.

Both frameworks are strongly supported by the National Social Partnership Forum, NHS Employers, union leaders, royal colleges and other national bodies, and importantly by staff and organisational leaders, as demonstrated by the significant response to our consultations in 2013/14.

As a measure of your commitment, please sign and return our Partnership Pledge to deliver against the strategic intentions. The Pledge offers a chance to recognise the work that your organisation is already doing and the value you place on your support staff and future workforce.

I hope you will join the increasing number of employers who are aligning their business plans to widening participation, supporting people to deliver their best and nurturing those with the potential to progress.

Kind regards

Sir Keith Pearson JP DL
Chairman
Health Education England

Update Report
Widening participation and development for the support workforce - including Health Care Support Worker learning programme progress report

9/7/2015
Combined Healthcare
Dawson/Richardson/Ainsworth/Birch-Machin

Introduction

The development for the support workforce for health and social care remains high on the list of priorities nationally, as is widening access to the breadth of NHS careers to enable future workforce supply.

Widening Participation and support worker development endorses action to build a diverse healthcare workforce that inspires people from all walks of life.

Within North Staffordshire Combined Healthcare Trust, a widening participation lead has been identified as part of the re-structuring of the Workforce Directorate. The support worker development approach was launched back in October 2013 and described a learning methodology that includes opportunities for support workers from recruitment to entry into registered professional training (where appropriate). This approach is summarised in appendix 1.

With regard to the support worker programme, the overall principles of the approach have remained a number of changes have occurred in legislation, national and local guidance in the intervening period. In September 2014 the approach was updated to take these into account.

The changes are summarised below

Original Proposal	September 2014 Proposal
Widening access / Modern Apprenticeships are included as a way to recruit staff into band 1-4 roles.	A widening participation resource was s identified as a key role to recruit to. This aspect of the programme becomes a key part of this role
5 day Foundation programme delivered in classroom based setting and covering the content recommended for the care certificate	Five day programme replaced by access to care certificate learning, delivered in the same way that the proposed care certificate, with much stronger links to teaching in clinical areas.
Plans are made for the introduction of the Care Certificate from April 2015	Plan are consolidated for the introduction of the Care Certificate from April 2015
Clinical Skills training, tailored to the needs of local clinical areas are provided through the SERC project and clinical skills leaders	Clinical skills training, tailored to the needs of local clinical areas are provided through clinical skills leaders who are co-ordinated through a newly established clinical educator post.
Higher Certificate / Qualification level training for staff in bands 1-4. Certificate in Community Mental Health is offered annually for staff in specific roles and for staff identified through PDR's	Certificate in Community Mental Health is further developed and continues to roll out on an annual basis. The Higher certificate (once available) is offered alongside the CCMH. Scoping is carried out on other qualifications that may be relevant to specific clinical areas such as Children's services or Learning Disabilities.

Skills escalator – Structured approach to registered professional training for staff that are identified as eligible candidates for this programme.	Skills escalator – Structured approach to registered professional training for staff that are identified as eligible candidates for this programme.

The support worker action plan produced in October 2014 was to guide the delivery of these updated recommendations. This report summarises the progress made in relation to the main themes of the October 2014 action plan and makes further recommendations for continuing improvement and aligning widening participation and talent for care.

Talent for Care is a strategic framework nationally for the development of the healthcare support workforce. It focuses on three primary themes:

- Get In – opportunities for people to start their career in a support role
- Get On – supporting people to be the best they can be in the job they do
-Go Further – providing opportunities for career progression, including into registered professions.

This reflects the format of the Partnership Pledge that all Trusts have been asked to self assess against by Sir Keith Pearson, chairman of Health Education England and brings together the two strategic frameworks, Talent for Care and Widening Participation: It Matters. Our response to the partnership pledge forms the content of a separate report. (See Appendix 2).

In addition, our current position against Talent for Care, and Widening Participation frameworks and to take further opportunities, to expand, motivate and improve your workforce are described in the key areas of progress below:

Key Areas of Progress

Theme	Summary of Progress
Talent For Care theme "get in" Describing issues in relation to widening participation and recruitment	A review of recruitment of support workers has taken place to ensure that "new to care" workers are identified and enrolled on to the care certificate (see care certificate notes below). A widening participation lead post has been established as part of the re-structuring of the Workforce Directorate. This post will support the delivery of the "get in" objectives by promoting recruitment opportunities to a wider audience and supporting creative approaches to bring bank staff into established posts where appropriate and will also encourage recruitment to trial "assistant practitioner" posts.
Talent For Care theme "get on" Describing issues	Protected time for learning is identified as a principle in the re-ratified Learning and Development policy. A clinical educator post has been established to ensure that clinical skills training is

relating to continuing learning and development for employees in bands 1-4	co-ordinated across North Staffordshire Combined healthcare, and extended to support staff in addition to qualified staff. Clinical skills leads have been established in all clinical areas and are being prepared to deliver clinical skills updates. Clinical skills requirements for each clinical area have been established. Support workers will be included in the clinical skills training appropriate to their clinical area. The first training session for Clinical Skills Leads will take place week commencing 13/7/2015. Engagement with clinical areas has been achieved through the establishment of a clinical focus group. 2 cohorts of the 5 day Foundation programme have run successfully and this programme has now been fully modified to comply with the Care Certificate standards. (see care certificate below) 2 cohorts of the Certificate in Community Health have run successfully and recruitment to further cohorts is underway with an expected start date of October 8th 2015.
Introduction of the Care Certificate within Combined Healthcare NHS Trust	Engagement of managers in planning of the delivery of the Care certificate has been achieved through attendance at management groups and local discussions. Engagement of support workers in the planning for the delivery of the care certificate has been achieved through 2 LiA conversations with support workers. Promotion and advertisement of care certificate guidance has been included in team brief, news round and on SID A review of Assessor requirements to support the introduction of the care certificate has commenced and every clinical area required to identify a member of staff to undertake this role by July 17th North Staffordshire Combined Healthcare has produced guidance on the introduction of the Care Certificate and has communicated this to trust managers. All "new to care" support staff recruited after the 1st April 2015 are required to undertake the care certificate prior to working unsupervised. A review of the target group of support workers (those who do not hold NVQ2/3 or CCMH qualifications) is in progress and managers have been requested to provide an action plan to ensure that care certificate training for these staff is established in the next 24 months. This is over and above the recommendations of the Cavendish Review and is in line with the Trust ambition to be an employer of choice. Recording of care certificate achievements on OLM has been established, including assessment questions for each of the 15 modules. In addition the use of the Skills For Health learning materials has been established and cross checked against existing training courses to ensure cost effective training. The support worker training co-ordinator has been trained to Skills for Health assessor standards in preparation for her role supporting care certificate assessors

	across the Trust. Skills for Health accreditation has been explored but is not felt to be cost effective A pilot of local assessor training was completed in July and 2 further assessor training dates are scheduled for late July A pilot of the self-assessment tool and supported care certificate learning for existing support staff is planned to run in July Monthly care certificate theory sessions are planned from July onwards.
Talent For Care theme "go further" Describing issues related to the skills escalator and entry into registered education	Work has commenced on the development of information pages on the Staff Information Desk (SID) describing the entry criteria for professional registration training. Managers are encouraged to discuss future career progression with all staff using the talent conversation tool contained with the PDR documentation. The Trust is participating in a regional trial of Assistant Practitioner roles with one trainee Assist Practitioner post being trialed per ward. These band 4 posts will focus on ensuring timely and effective admission and discharge of patients.

Further planned developments

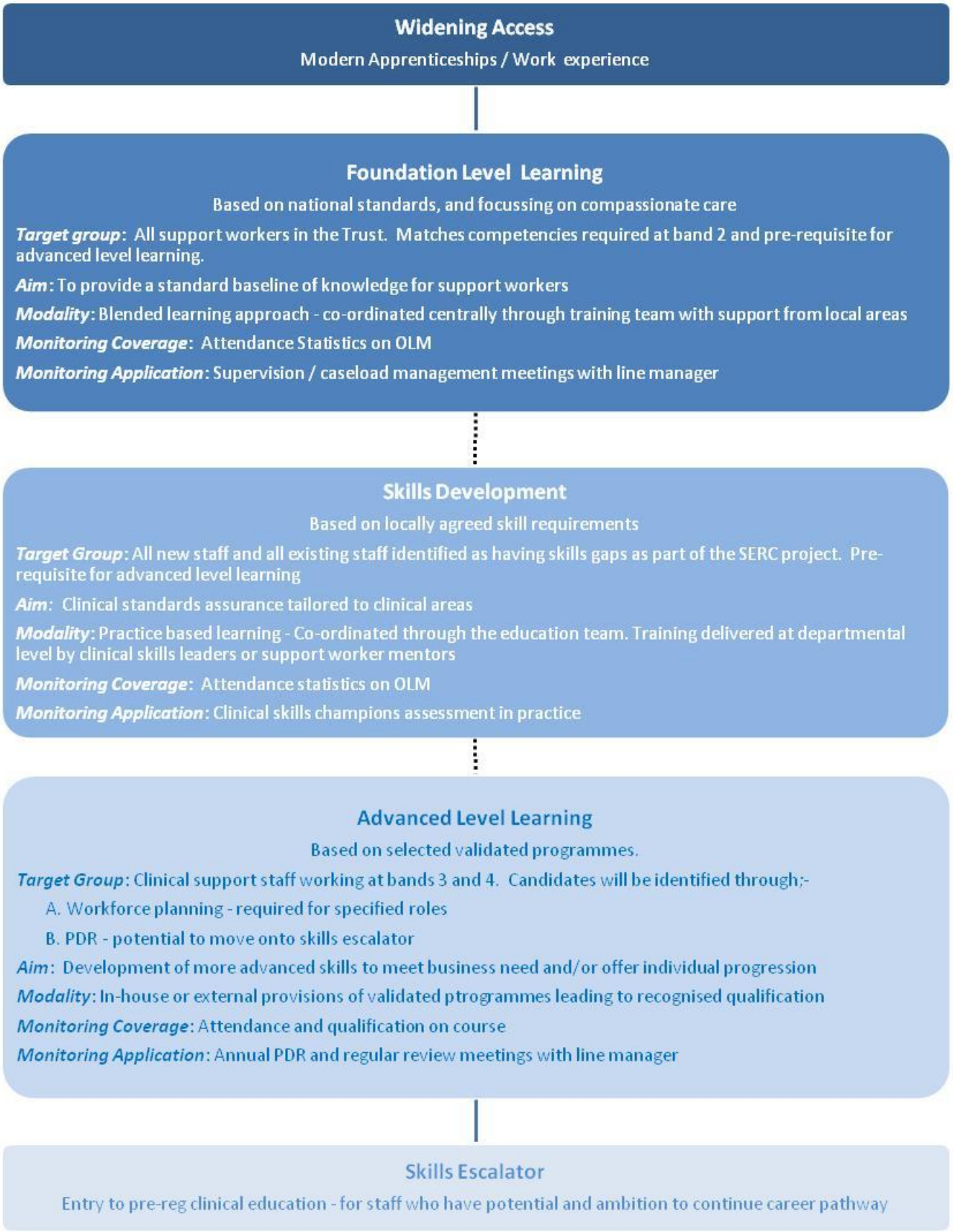
Theme	Summary of Progress
Talent For Care theme "get in" Describing issues in relation to widening participation and recruitment	Widening participation lead will be established in post from September 2015 providing leadership and direction for the "get in" objectives It is planned that the post holder will include the following actions within their portfolio • Scope the potential to raise profile of the Trust with schools, colleges and local job centres • Draw on and consider adoption of the HEE Work Experience commitment and the NHS Careers work experience toolkit • Consider working with job centres or charitable organisations such as the Prince's Trust to provide taster sessions to encourage job seekers to enter healthcare jobs • Offer project opportunities to schools, colleges, universities who have appropriate courses running to co-work with us on solving real problems. EG supporting the production of video materials, helping design IT solutions etc • Recruit and train health ambassadors within the Trust using the HEE Health Ambassador commitment as a guide Introduce PDR objective for each team manager to identify at least one way in which they could promote careers within their team to wider audience

	Workforce planning information will guide the recruitment to support worker posts, including the establishment of assistant practitioner posts once the trial period of these posts is completed. A developmental journey for bank staff to increase their readiness to apply for established posts as they become available to be further developed in collaboration with the bank staff manager. Clarity is established about payment of bank staff to undertake the care certificate
Talent For Care theme "get on" Describing issues relating to continuing learning and development for employees in bands 1-4	Clinical skills development is integrated into support worker learning pathways and all support workers have access to a clinical skills lead who can guide and provide local skills training. Advanced learning options to be introduced alongside the Certificate in Community Mental Health once the requirements of the higher care certificate are known. Continuing investment in support worker training is established.
Introduction of the Care Certificate within Combined HealthCare NHS Trust	Scoping of the target group of support workers eligible for the care certificate is completed. Evaluation of Skills For Health E-learning materials will take place in August 2015 and decisions about the inclusion of E-learning options are then finalised Development of theoretical input to support the care certificate is evaluated Care Certificate assessors to be established in remaining clinical areas Rollout of the care certificate with the intent that all support workers who require this have the opportunity to achieve the care certificate within the next 24 months.
Talent For Care theme "go further" Describing issues related to the skills escalator and entry into registered education	Further development of guidance in relation to career choices and opportunities to enter registered professions to take place in collaboration between HR business partners, widening participation lead and education and training lead. Accreditation of the care certificate is considered with local universities in order that this can form part of the access / APEL process for staff entering professional registration courses.

Recommendation

The Board are asked to note the strong progress and support the further developments proposed.

Appendix 1 Support Workers Learning Approach



Appendix 2 – North Staffordshire Combined Healthcare Response To The Talent for Care Strategic Intentions

		Trust Name:	Name of Responsible Officer	E-mail Address:					Tel No:
		North Staffs Combined Healthcare	Paul Draycott Director of Workforce and Leadership	ptt@northstaffs.nhs.uk					03001231535 (extn4605)
		National Strategic Intention	local Actions for this Trust	Timeline	Measurement of Scale (tick relevant box)				
					Not in Place	Working Towards	Delivering at Scale	Sustainable Approach	Model of Excellence
					E	D	C	B	A
Get In	1	Broaden the ways into training and employment, attract more young people, improve diversity	a) Structural changes are planned to introduce the role of Widening participation and apprenticeship lead for the Trust b) Recruit to the above post c) Scope the potential to raise profile of the trust with schools colleges and local job centres d) Draw on and consider adoption of the HEE Work Experience commitment and the NHS Careers work experience toolkit	2 year delivery plan		x			
	2	Increase chances for new experiences of working in the health sector	a) Structural changes are planned to introduce the role of Widening participation and apprenticeship lead for the Trust b) Recruit to the above post c) Consider working with job centres or charitable organisations such as the Prince's Trust to provide taster sessions to encourage job seekers to enter healthcare jobs d) Offer project opportunities to schools, colleges, universities who have appropriate courses running to co-work with us on solving real problems. EG supporting the production of video materials, helping design IT solutions etc.	3 yr delivery plan		x			
	3	Health Ambassadors who can promote health careers	a) Structural changes are planned to introduce the role of Widening participation and apprenticeship lead for the Trust b) Recruit to the above post c) Deploy widening participation and apprenticeship lead to recruit and train health ambassadors within the Trust using the HEE Health Ambassador commitment as a guide d) Introduce PDR objective for each team manager to identify at least one way in which they could promote careers within their team to wider audience	2 yr delivery plan		x			
Get on	4	Development programme for all support staff	a) Recruit Clinical Educator to co-ordinate local clinical skills leads, who will be at the heart of the development of support workers (strategic training bid submitted to support this) b) Recruit fixed term co-ordinator funded by regional budget of £30,000 to cross reference and update current foundation level programme against national guidance.(Recommendation of proposals to further develop Combined Healthcare's health care support worker learning programme, which was received by PCD October 2014) c) Continue to work towards comprehensive coverage of clinical skills leads in all of our clinical teams, who work closely with support workers to develop their clinical skill sets (continuation on an ongoing project led by the clinical education team and dependent on the recruitment to the clinical educator post mentioned above)	2 yr delivery plan		x			
	5	Care Certificate for all new HCSWs and ASCWs, and universally recognised Higher Care Certificate	a) Recruit clinical educator to co-ordinate local clinical training (strategic training bid already developed to support this) b) Recruit fixed term co-ordinator funded by regional budget of £30,000 to cross reference and update current foundation level programme against national guidance.(Recommendation of proposals to further develop Combined Healthcare's health care support worker learning programme, which was received by PCD October 2014 c) Scope higher care certificate and cross match against our existing Certificate in Community Mental health (strategic bid already in place for the continuation of the Certificate in Community Mental Health)	2 yr delivery plan		x			
	6	Double the number of apprenticeships and establish an NHS Apprenticeship Offer	a) Establish a widening participation and apprenticeship lead for the Trust and recruit to this post b) consider sign up for the NHS Apprenticeship Offer the (HENW) 'Apprenticeship Promise' c) Offer oppportunities for staff to gain work on the bank whilst studying for their apprenticeship	5 yr delivery plan	x				
Go Further	7	Simplify career progression, including part-time study for registered professions	a) Gain clarity about career pathway for support workers into registered professions, including national pathways. b) Support sponsored places to undertake professional qualifications - allowing the Trust to "Grow our Own" talent c) Ensure that we are able to offer higher apprenticeships which will allow staff to gain entry to professional programmes d) comment on the draft HCA Career Progression Framework due out in January 2015 and use the final document as a guide to planning career progression framework	5 yr delivery plan		x			
	8	Agree universal acceptance of prior learning, vocational training and qualifications	a) Gain Clarity about the access criteria for professional qualifications and standardise recommendations about what is required. b) Work in partnership with HEI's to design a bespoke pathway to move from support worker experience to professional registration qualifications.	3 yr delivery plan		x			
	9	Support talent development for those with the potential to go further	a) Continue to develop the talent management component of our PDR process for all staff in the Trust. b) Build talent management conversations into all support worker PDR's with the expectation that a significant proportion will have the capacity and ambition to move to through the skills escalator	12 month delivery plan			x		
Making it Happen	10	Programme partnership with a national campaign, information, pilot projects and good practice	a) Recruit to the support work co-ordinator post and commence scoping against the 10 essential criteria b) The national Talent for Care programme partnership will support this framework with a national campaign. We will publish information, support pilot projects and spread good practice to continue c) Local Management and Staff Side sign a Partnership Pledge to implement these plans d) Plans launched with appropriate communications and publicity			x			