North Staffordshire Combined Healthcare NHS Trust

# MEETING OF THE TRUST BOARD

## TO BE HELD IN PUBLIC
## ON Thursday 22nd November 2018, 10:00AM,
**BOARDROOM, LAWTON HOUSE, TRUST HEADQUARTERS,**
**BELLRINGER ROAD, TRENTHAM LAKES SOUTH,**
**STOKE ON TRENT, ST4 8HH**

| | AGENDA | |
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| 1. | **APOLOGIES FOR ABSENCE**<br>*To NOTE any apologies for absence* | Note |
| 2. | **DECLARATIONS OF INTERESTS RELATING TO AGENDA ITEMS** | Note |
| 3. | **MINUTES OF THE OPEN AGENDA – 25th October 2018**<br>*To APPROVE the minutes of the meeting held on 25th October 2018* | Approve<br>Enclosure 2 |
| 4. | **ACTION MONITORING SCHEDULE & MATTERS ARISING FROM THE MINUTES**<br>*To CONSIDER any matters arising from the minutes* | Note<br>Enclosure 3 |
| 5. | **CHIEF EXECUTIVE'S REPORT**<br>*To RECEIVE a report from the Chief Executive* | Note<br>Enclosure 4 |
| 6. | **CHAIR'S REPORT**<br>*To RECEIVE a verbal report from the Chair* | Note |
| 7. | **STAFF RETIREMENTS**<br>*To EXPRESS our gratitude and recognize staff who are retiring*<br>*To be introduced by the Chief Executive and presented by the Chair* | Verbal |
| 8. | **REACH RECOGNITION INDIVIDUAL AWARD ON EXCELLENCE**<br>*To PRESENT the REACH Recognition Individual Award to Adam Chambers, Substance Misuse Nurse, Stoke Heath Prison*<br>To be introduced by the Chief Executive and presented by the Chair | Verbal |

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| 9 | **PATIENT STORY – FAMILY DEMENTIA GROUP WARD 4**<br>*To RECEIVE a Patient Story from THE Family Dementia Group – Ward 4 to be introduced by Maria Nelligan, Executive Director of Nursing & Quality* | Verbal / Video |
| | **QUESTIONS FROM MEMBERS OF THE PUBLIC** | |
| 10 | *To RECEIVE questions from members of the public* | Verbal |
| | **TO ENHANCE SERVICE USER AND CARER INVOLVEMENT** | |
| 11 | **SERVICE USER AND CARER COUNCIL**<br>*To RECEIVE an update from Maria Nelligan, Executive Director of Nursing and Quality* | Assurance<br>Verbal |
| 12 | **PERSON CENTREDNESS FRAMEWORK**<br>*To RECEIVE the Person Centeredness Framework from Maria Nelligan, Executive Director of Nursing and Quality* | Assurance<br>Enclosure 5 |
| | **ENCOURAGE, INSPIRE AND IMPLEMENT RESEARCH AND INNOVATION AT ALL LEVELS** | |
| 13 | **TOWARDS OUTSTANDING INNOVATIVE PRACTICE – INNOVATION NATION**<br>*To RECEIVE a briefing re: Towards Outstanding Innovative Practice from Dr Dennis Okolo, Associate Medical Director* | Assurance<br>Enclosure 6 |
| 14 | **UPDATE ON DIGITAL EXEMPLAR**<br>*To RECEIVE an update re: Digital Exemplar from Suzanne Robinson, Director of Finance, Performance and Digital* | Assurance<br>Enclosure 7 |
| | **TO PROVIDE THE HIGHEST QUALITY SERVICES** | |
| 15 | **NURSE STAFFING MONTHLY REPORT (SEPTEMBER 2018)**<br>*To RECEIVE the Nurse Staffing Monthly Report from Maria Nelligan, Executive Director of Nursing & Quality* | Assurance<br>Enclosure 8 |
| 16 | **SIX MONTHLY SAFER STAFFING REPORT**<br>*To RECEIVE the Six Monthly Safer Staffing Report from Maria Nelligan, Executive Director of Nursing & Quality* | Approve<br>Enclosure 9 |
| 17 | **QUARTER 2 SERIOUS INCIDENT REPORT**<br>*To RECEIVE the Quarter 2 Serious Incident Report from Dr Dennis Okolo, Associate Medical Director* | Assurance<br>Enclosure 10 |

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| 18 | **QUARTER 2 MORTALITY SURVEILLANCE REPORT**<br>*To RECEIVE the Quarter 2 Mortality Surveillance Report from Dr Dennis Okolo, Associate Medical Director* | Assurance<br>Enclosure 11 |
| 19 | **MHA COMPLIANCE ACTION PLAN QUARTER 1 & 2 REPORT**<br>*To RECEIVE the MHA Compliance Action Plan Quarter 1 & 2 Report from Dr Dennis Okolo, Associate Medical Director* | Assurance<br>Enclosure 12 |
| 20 | **TOWARDS SMOKE FREE PROGRESS REPORT**<br>*To RECEIVE the Towards Smoke Free Progress Report from Dr Dennis Okolo, Associate Medical Director* | Assurance<br>Enclosure 13 |
| 21 | **DIRECTOR OF INFECTION PREVENTION AND CONTROL (DIPC) QUARTER 2 REPORT**<br>*To RECEIVE the Director of Infection Prevention and Control (DIPC) Quarter 2 report from Maria Nelligan, Executive Director of Nursing and Quality* | Assurance<br>Enclosure 14 |
| 22 | **PATIENT LED ASSESSMENT OF THE CARE ENVINROMENT (PLACE) 2018**<br>*To RECEIVE the Patient Led Assessment of the Care Environment eport from Maria Nelligan, Executive Director of Nursing and Quality* | Assurance<br>Enclosure 15 |
| 23 | **ENHANCED PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 6**<br>*To RECEIVE the Month 6 Performance Report from Suzanne Robinson, Director of Finance, Performance and Digital* | Approval<br>Enclosure 16 |
| | **CREATE A LEARNING CULTURE TO CONTINUALLY IMPROVE** | |
| 24 | **BEING OPEN QUARTERLY REPORT**<br>*To RECEIVE the Being Open Quarterly Report from Jonathan O'Brien, Director of Operations* | Assurance<br>Enclosure 17 |
| 25 | **FREEEDOM TO SPEAK UP (FTSU) BOARD SELF ASSESSMENT**<br>*To RECEIVE the Freedom to Speak Up Board Self-Assessment from Caroline Donovan, Chief Executive Officer* | Assurance<br>Enclosure 18 |
| | **MAXIMISE AND USE OUR RESOURCES INTELLIGENTLY AND EFFICIENTLY** | |
| 26 | **FINANCE REPORT – MONTH 6 (2018/19)**<br>*To RECEIVE for discussion the Month 6 Financial position from Suzanne Robinson, Director of Finance, Performance and Digital* | Approval<br>Enclosure 19 |

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| 27 | **ASSURANCE REPORT FROM THE FINANCE, PERFORMANCE & DIGITAL COMMITTEE**<br>*To RECEIVE the Finance, Performance & Digital Committee Assurance report from the meeting held on the 8th November 2018 from Tony Gadsby, Chair/Non-Executive Director* | Assurance Enclosure 20 |
| 28 | **ANNUAL DECLARATION OF EMERGENCY PREPAREDNESS**<br>*To RECEIVE the Annual Declaration of Emergency Preparedness from Jonathan O'Brien, Director of Operations* | Assurance Enclosure 21 |
| 29 | **FIRE ANNUAL SAFETY REPORT**<br>*To RECEIVE the Fire Annual Safety Report from Jonathan O'Brien, Director of Operations* | Assurance Enclosure 22 |
| | **ATTRACT AND INSPIRE THE BEST PEOPLE TO WORK HERE** | |
| 29 | **ASSURANCE REPORT FROM THE PEOPLE AND CULTURE COMMITTEE**<br>*To RECEIVE the People and Culture Committee report from the meeting held 12th November 2018 from Lorien Barber, Non-Executive Director* | Assurance Enclosure 23 |
| 30 | **ASSURANCE REPORT FROM QUALITY COMMITTEE**<br>*To RECEIVE the Assurance report from the Virtual Quality Committee meeting from Patrick Sullivan, Non-Executive Director* | Assurance Enclosure 24 |
| | **CONTINUALLY IMPROVE OUR PARTNERSHIP WORKING** | |
| 31 | **Received as Item 18 within Closed Trust Board** | |
| | **CONSENT AGENDA ITEMS** | |
| 32 | **NHS PROVIDERS: THE STATE OF HEALTH AND ADULT SOCIAL CARE IN ENGLAND 2017/18**<br>*To RECEIVE a report on the State of Health and Adult Social Care in England 2017/18 from Laurie Wrench, Associate director of Governance* | Information Enclosure 25 |
| | **ANY OTHER BUSINESS** | |
| | *The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday 24th January 2019 at 10:00am.* | |
| | **MOTION TO EXCLUDE THE PUBLIC**<br>*To APPROVE the resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admissions to* | |

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| | *Meetings) Act 1960)* | |
| | **THE REMAINDER OF THE MEETING WILL BE IN PRIVATE** | |
| | **DECLARATIONS OF INTEREST RELATING TO AGENDA ITEMS** | Note |
| | **SERIOUS INCIDENTS** | Assurance |
| | **PERFORMANCE** | Approve |
| | **ESTATES** | Assurance |
| | **WORKFORCE AND AGENCY** | Assurance |
| | **ANY OTHER BUSINESS** | |

# TRUST BOARD

**Minutes of the open section of the North Staffordshire Combined Healthcare NHS Trust Board meeting held on Thursday 25th October 2018 At 10:00am in the Boardroom, Trust Headquarters, Lawton House Bellringer Road, Trentham, Stoke on Trent, ST4 8HH**

## Present:

**Chairman:**

David Rogers
Chairman

**Directors:**

Lorien Barber
Non-Executive Director

Maria Nelligan
Executive Director of Nursing and Quality

Jonathan O'Brien
Director of Operations

Joan Walley
Non-Executive Director

Caroline Donovan
Chief Executive

Suzanne Robinson
Director of Finance, Performance and Digital

Gan Mahadea
Non-Executive Director

Andrew Hughes
Joint Director of Strategy and Development

Dr Darren Carr
Associate Medical Director / Clinical Director North Staffordshire

Patrick Sullivan
Non-Executive Director

Tony Gadsby
Non-Executive Director

**In attendance:**

Laurie Wrench
Associate Director of Governance

Lisa Wilkinson
Corporate Governance Manager (minutes)

Joe McCrea
Associate Director of Communications

Jenny Harvey
Unison Representative

Members of the public:
Mary Barlow - CCG

Retirees
Lynn Glasby
John Morgan
Andy Oakes
Diane Ashley
Julie Elden

REACH Team Recognition Award
Ward 4 Harplands Hospital
Janine Burgess
Josey Povey
Mike Groden
Karen Timmis

The meeting commenced at 10:03am.

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| **208/2018** | **Apologies for Absence**<br><br>Dr Buki Adeyemo, Medical Director, Wendy Dutton, Chair of Service User Carer Council, Dr Keith Tattum, GP Associate | **Action** |
| **209/2018** | **Declaration of Interest relating to agenda items**<br><br>David Rogers declared he is now a Trustee of Staffordshire Wildlife Trust | |
| **210/2018** | **Minutes of the Open Agenda – 26th September 2018**<br><br>The minutes of the open session of the meeting held on 26th September 2018 were approved.<br><br>Page 24 194/2018 Smoke Free Progress Report – Patrick Sullivan, Non-Executive asked for the minutes to read:<br><br>*Patrick Sullivan highlighted that Ward 3 is an outlier in terms of incidents. Out of 63 incidents there have been 47 on Ward 3. Patrick noted that staff are challenged as there are individuals admitted to Ward 3 who smoke which creates a concern for the safety of staff and patients.* | |
| **211/2018** | **Matters arising**<br><br>The Board reviewed the action monitoring schedule and agreed the following:-<br><br>***116/2018 – Learning from Deaths Quarterly Report –*** *Agenda Item*<br><br>***140/2018 – Safer Staffing Monthly Report April 2018*** *– Agenda Item*<br><br>***141/2018 (1) – Serious Incident Report (1)*** *– Falls Report agenda item for 2nd November 2018 Quality Committee*<br><br>***184/2018 – Questions from Members of the Public*** *– Every service user has received a personal letter to advise point of contact during their care.*<br><br>***189/2018*** *–* ***Infection Prevention and Control*** *– Actioned. Flu vaccination will be available during the lunchtime break for members of the Board in the Breakout Room at Lawton House.*<br><br>***192/2018*** *–* ***AHP Strategy*** *– Discussions underway and plans in place to implement section on the internet. David Rogers asked for an update from Communications Department regarding the new intranet therefore action to remain on schedule.*<br><br>***199/2018*** *–* ***Declaration of interests*** *– Actioned.* | **JMc** |

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| **212/2018** | **Chief Executive's Report**<br><br>This report updates the Board on activities undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest.<br><br>**LOCALITY STRUCTURE GOES LIVE**<br><br>The Trust mobilised its new structure, with Associate Directors and Clinical Directors formally responsible for their new Directorates. Service Managers and Quality Leads (Matrons) will be working with their new Associate Directors and Clinical Directors to coordinate handover to new roles as swiftly and efficiently as possible.<br><br>Alastair Forrester has been appointed as Head of Nursing & Professional Practice. The Trust has also completed appointments to Service Manager and Quality Improvement roles.<br><br>The Trust has started transitioning to its new structures and appreciate that this will mean change for lots of people.<br><br>Phase 4 of the restructure will be about how we can think of new ways of working and transformation. Our improvement partner, AQUA, will be working alongside us supporting this next phase.<br><br>A very big thank-you to Jonathan O'Brien, our Executive Director of Operations, who has done a fantastic job in supporting the redesign to date. Maria Nelligan and Dr Buki Adeyemo have led the professional structure and Nicky Griffiths has given Jonathan great support, as have the Clinical and Associate Directors, Nursing and HR teams – so a massive thank-you to everyone.<br><br>**NHS STAFF SURVEY**<br><br>The annual NHS Staff Survey feedback is crucial for us to understand what we are doing well and where we can further improve.<br><br>Following feedback from last year, staff identified areas for improvement, resulting in:<br><br>• Focused work on Diversity and Inclusion and specifically on how to improve the experiences of staff from a BAME background<br>• 16 teams supported to complete our Towards Outstanding Engagement programme<br>• A quality improvement approach to encourage greater empowerment of teams to make improvements<br>• Refreshed being open and raising concerns at work through the Freedom to Speak up Guardian<br>• Medical staff development programme<br>• The launch of our first care conference for frontline staff, which included an LiA big conversation | |

Last year, we achieved a response rate of 52% and, whilst this is higher than the national average, we want to increase this even further.

We have put in place incentives to encourage as many people as possible to take part:

- Teams reaching their target response rate will automatically be entered into a prize draw to receive £250 to spend on a team-focused priority
- Staff will have dedicated time off for completing the survey – managers have been encouraging them to take this 10 minutes to do so
- We are providing roaming polling stations, providing space and a laptop to complete surveys, with staff on hand to provide IT support

**COMBINED FLUFIGHTERS 2018**

Our #CombinedFluFighter 2018 campaign launched formally on Friday 5 October. We have been holding clinics at various locations throughout the Trust.

This year, we have 27 peer vaccinators and a record number of people received their jabs in the first couple of weeks.

This year, we have 20 golden tickets randomly placed across the vaccines. Once a vaccine box is open, if it contains a golden ticket, staff can exchange this for a £10 Love To Shop voucher.

Our aim is to be the best-performing mental health Trust in the country for vaccination of our frontline staff and are urging all staff to be a #CombinedFluFighter to help us achieve this goal.

**ANOTHER GREAT CONTRACT WIN FOR SUBSTANCE MISUSE**

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

It sees North Staffordshire Combined Healthcare NHS Trust teaming up with Shropcom and The Forward Trust to form what is being called the Stoke Heath Integrated Care partnership (SHIC), with Shropcom taking the lead. The partnership brings together three exceptionally experienced, passionate and proven healthcare providers with extensive experience, safely and seamlessly transitioning services. Combined will deliver secondary mental health and clinical substance misuse services. All three organisations already deliver health services at the prison, near Market Drayton, but the new contract involves the introduction of a new model of care that will be shaped over the next six months in the run-up to the launch on 1 April 2019.

**LEARNING FROM CQC REVIEWS**

Caroline Donovan advised she was privileged to have been asked by the CQC to present at a national conference on our experiences and learning from the Stoke-on-Trent CQC system review. York and Birmingham were also asked to share their experiences.

Paul Edmondson-Jones, Director Social Care, Health Integration & Well-being Stoke-on-Trent Council, and Mark Seaton supported the event. Caroline advised it was really good to hear of others' experiences and quite cathartic to be able to talk about the progress that has been made. The CQC is returning to Stoke in November and has already started a system review of Staffordshire. Both reviews will report on their findings before the end of the year.

**SECOND AHP CONFERENCE**

The Trust held its second AHP Conference, chaired by the Director of Nursing and Quality, Maria Nelligan. The event was a chance for team leaders, senior leadership team members, executives, AHP colleagues, partners and service users to find out about our innovative practices, as well as formally launching the AHP strategy.

**DIGITAL BOARD**

Caroline advised she was pleased with the progress that has been made at our STP Digital Board. All organisations across Staffordshire have worked really well together identifying collective digital priorities for us to submit to NHS England for significant funding to come into Staffordshire.

A big thank-you to Gwyn Thomas, Digital STP Lead Director, Paddy Hannigan, the STP Chief Clinical Information Officer, and Chris Bird, Integrated Care Record Senior Responsible Owner, for leading this within a very short timescale. Thanks also to all the Chief Information Officers for their work.

**GREAT MENTAL HEALTH ACT REPORT FOR FLORENCE HOUSE**

Caroline advised it was a real pleasure to read a great Mental Health Act Report following an unannounced MHA inspection. The report was in keeping with the teams CQC rating of outstanding and acknowledges some of their good practice.

It went onto to highlight the following areas of good practice;

- Florence House producing its own newsletter for patients; the letter is succinct with information about local and Trust events and is used to tell staff stories, healthy food recipes and other interesting topics
- A copy of the MH code of conduct available in the lounge area for all patients (their patients had designed some of the booklet)
- Employed an STR worker who is happy to share his own experience

of receiving mental health care, creating a sense of hope amongst the patients
- Patients describing a very positive response form Advocacy and IMCA service
- Staff explaining that patients were provided with a swipe card to exit the unit when they wished to smoke; this included informal and detained patients (who had the required leave). There had been no concerns.
- Work towards a least restrictive environment with a view to converting the unit into an open rehabilitation unit
- Florence House staff actively promoted independence and autonomy – patients' care & risk plans were clearly developed with them and person centred
- Regular patient community meetings and a 'you said, we did' board that was up to date and evidenced a response to patient requests for a BBQ, Karaoke machine etc.

Invariably, as a result of an inspection, there are areas for improvement which the team have promptly responded to, including a telephone ringing during the night and a few of the community meetings not always having a response / update from the ward manager. The report also highlighted the need for the medical team to ensure that they are recording, in Lorenzo, any discussions that they have with patients relating to consent.

**LAUNCH OF FREEDOM TO SPEAK UP CHAMPIONS**

October was Freedom to Speak Up month and we marked the event by launching our Freedom to Speak Up Champions initiative. Working with the Trust's Freedom to Speak Up Guardian, Zoe Grant, the Champions will help to promote a positive culture in which staff feel comfortable and supported to speak up about things that may concern them.

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

The Champions will be supported by Zoe, and their role will be supporting staff to speak up and helping her identify themes and trends emerging from the front line.

**ACTION ON DIVERSITY**

The Trust's latest Leadership Academy took the opportunity to watch and reflect on the insights and lessons we can learn from our recent Staff Nurse Story film, featuring the words of a BAME member of staff, and discussed the action plan we are putting in place. Five key areas for action have been identified for us as a Trust which Caroline is personally leading:

- Developing HR Processes for inclusion
- Supporting the development of our BAME staff
- Reporting, learning and improving following incidents and incidences

of racist abuse and aggression
- Culture of Inclusion
- Communication for inclusion

The Trust has BAME Leaders sponsoring each of the programmes who will work alongside each of the project managers to ensure co-production.

Everyone has a responsibility to speak out if we observe any behaviours which are not congruent with our values.

**CHANGES TO THE EXECUTIVE TEAM**

Caroline Donovan advised she was delighted to announce that the Trust have appointed Ursula Martin to be Assistant Chief Executive Officer. This is a new role for which the Board had recognised the need - particularly with Caroline's role being increasingly demanding as she focusses on the leadership of pan-Staffordshire STP priorities. The post will lead on corporate governance and quality improvement, working very closely with other Executive Directors. It will also lead on Freedom to Speak Up and Communications.

Suzanne Robinson, Director of Finance, Digital and Performance, will be leaving the Trust. She has been appointed as Director of Finance at Pennine Care NHS Foundation Trust, which provides Mental Health & Community services across Greater Manchester. Whilst the Trust is very sad to see Suzanne leave, we are extremely proud that she has been appointed to the role, which is a promotion for Suzanne and incredibly well deserved.

The Trust has also advertised for a substantive Director of Strategy and Development post. Andrew Hughes has worked with Combined since the summer last year on a fixed-term contract. Andrew has always been clear that he did not want to take up a substantive role, as he has worked as a consultant across the health sector as well as various other roles, including being a Trustee on the Teenage Cancer Trust.

**NATIONAL UPDATE**

**NAO REPORT ON IMPROVING CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH SERVICES**

The National Audit Office published a report during October on improving children and young people's mental health services. It says that steps taken by the government to improve parity of esteem between physical and mental health are welcome but there is a long way to go to ensure equal access to care.

It also warns that even if current initiatives are delivered as intended, there would remain significant unmet need for mental health services amongst young people.

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| | It adds that slow progress on increasing the mental health workforce in England by 40% is emerging as a major risk to delivering the government's ambitions to implement its 2015 strategy, Future in Mind, in full.<br><br>**NEW MINISTER FOR SUICIDE PREVENTION**<br><br>The Government has announced the appointment of a minister for suicide prevention.<br><br>Jackie Doyle-Price will be given the new brief and tasked with ensuring that every local area has effective plans in place to stop unnecessary deaths, and investigating how technology can help identify those most at risk.<br><br>Tony Gadsby highlighted it would be good to invite the new minister to the Trust's Suicide Conference in November. This was agreed and Dr Buki Adeyemo will extend an invite.<br><br>***Received*** | **BA** |
| **213/2018** | **Chair's Report**<br><br>David Rogers, Chairman provided an update.<br><br>**National Update**<br><br>David talked about Matt Hancock, the new Secretary of State, his focus is on digital, the benefits and the crucial role this has clinically and organisationally.<br><br>**Local Update**<br><br>David highlighted there is a strong intention that the integration agenda be pushed forward quickly locally so there is real integrated working in place in the next few years. The Trust has been working hard to follow that agenda.<br><br>David advised the Closed Session of future Trust Board meetings will be restricted to items that have commercial confidentiality or settlements within them that should be discussed in confidence. If there are difficult things that require discussion or not we will commit to do this in the open session of future Trust Board meetings. Board meetings are more strategic and much less about managing the organisation. Gradually we should try and make this more apparent in the board meetings and have less about day to day management and focus more on health priorities and our role within this.<br><br>***Noted*** | |
| **214/2018** | **Staff Retirements**<br><br>**John Morgan – Recovery Co-ordinator**<br>John came to Combined on the 28th February 1987 he has worked over in a variety of areas within mental health as well as substance misuse in a | |

variety of roles and has been there to support many people along the way.

John has showed great professionalism through his time with the Trust and has been a huge asset to the service. He has led with dignity and supported all his colleagues over his career. His knowledge and understanding of effective patient care has helped him to support many hundreds, possibly thousands achieve their goal of recovery and improvement of their own personal health and well-being.

During the last year John has been working with the One Recovery Team within the HALT (Hospital Alcohol Liaison Team), John's colleagues told us that it has been a pleasure to have worked with John and getting to know him as a person and a professional has been a privilege. However, it has become apparent that John has made multiple attempts to leave but this time could be his last. John did leave for a brief time in 2008 but soon returned to support service delivery within substance misuse.

He will be sorely missed by all colleagues and patients alike, we would like to wish him all the best with his future endeavours and hope he enjoys his retirement with his family and friends. Thank you John.

Maria Nelligan, Director of Nursing and Quality presented John with a nursing badge.

**Lynn Glasby – Academic Personal Assistant**

Lynn has been working for The Trust since February 2002. Her first post was as Personal Secretary to Head of Occupational Therapy based at The Harplands. This role involved secretarial support and working alongside Universities to secure placements for trainees OT's. This experience helped her to secure a 14 month secondment in October 2008 to Stoke PCT as a Work Experience Co-ordinator, this was a new role which Lynn developed and included spending time visiting schools and colleges to speak to students interested in Health & Social Care and to promote work experience within the PCT.

On return to The Trust Lynn was offered an Academic post. This involved organising the CPD Programme for the Trust doctors and leading on administration for the MRcPsych Course for the trainee psychiatric doctors.

In 2011 a new role was offered to Lynn to lead on administration for the undergraduate programme. This involved forging good relations with the undergraduate medical school at Keele University to ensure the placements for medical students were organised and available, this required liaison with undergraduate tutors in relation to the teaching elements. Lynn worked closely with Dr. Okolo who is our Hospital Dean.

In June 2017 Lynn chose to reduce her hours to be able to care for her mum who has dementia and took the decision to continue with the postgraduate element of her role. Lynn worked alongside Dr. Jo Barton the MRcPsych programme lead prior to her official retirement and has now

returned to continue supporting the programme.

Whichever post Lynn has been in she has met the demands with her high energy and determined style. She has excellent organisational skills not only ensuring weekly CPD runs efficiently and smoothly but also more demanding events such as conferences. She is always willing to help colleagues and with her quick wit and good sense of humour we are glad she has returned after retirement to continue to work alongside us. We wish Lynn all the best.

**Diane Ashley – Recovery Co-ordinator**

Diane commenced her nursing career as a Nursing Cadet on the 30th June 1980, Diane went on to complete her RMN training and registered on the 9th December 1984.

Diane commenced her nursing career working within the inpatient services for older adults as a staff nurse at St Edwards hospital, with a highly dependent group of patients where 90% of them required full nursing care. Ex colleagues have said, the shifts when she was in charge were certainly much easier to complete because of Diane's cheery disposition and dedication to her role. Colleagues, patients and their families loved having her around and she certainly brought some sunshine into their lives. Nothing was too much trouble, there was a job to be done and Diane would make sure it got done. No matter what happened on any shift, you can safely say that Diane had either seen it, smelled it, touched it and heard it.

Diane moved on to work to work in a completely different setting as a staff nurse with Ward 2 which was equivalent to a PICU in in its function and purpose, Diane then moved on to a role as an Acting Ward Manager in Menzies House, where she was highly respected and valued in her role. Diane then went on secure a substantive position as a Deputy Ward Manager working in Menzies House. As part of this role Diane also extended her experience to working a month in the nursing office and three months in the neuro behavioural unit. She then progressed on to commence her post registration Diploma in Nursing.

In 1999 Diane moved on again to join the Sutherland Centre Community Mental Health Team to enhance her knowledge and skills working in the community setting.

In 2000 Diane returned back to the hospital setting where she commenced a new role as a Deputy Ward Manager working in the substance misuse field with Ward 93, the Substance Misuse Team this was initially a secondment, however Diane went on to secure the post substantively. Diane was a highly valued key contributor to the development of the excellent of the Edward Myers unit as the Deputy Ward Manager working with Tina Mottram and Darren Bowyer, who said himself; he learnt such from Diane when he joined the team. Diane also worked hard in an additional role supporting the homelessness project at the Snow Hill Medical Centre.

Diane moved on from the inpatient service to work within the Newcastle Community Substance Misuse services and then joined the One Recovery Service when the Trust won the County wide Substance Misuse services contract. Diane worked extremely hard to support the service and service users as a Recovery Coordinator within the new structure, developing positive relationships with the new key partners whilst modelling excellent practice, working alongside Recovery Coordinators from Addiction Dependency Solutions.

News soon came regarding the funding cuts for Substance Misuse services; therefore in April 2017, Diane positively engaged with the next chapter of her career and due to the Management of Change process returned to the Sutherland Centre. Diane continued to deliver high level and excellent recovery focused services to the people of South Stoke.

Diane has been a huge asset to the services she has worked with during her career and has contributed to a wide range of services across the Trust. She has been a font of knowledge and has practiced in a way that has ensured service users feel highly cared for, safe and have had hope for their futures. Diane has retired and since returned to her post on a part time basis, the team have welcomed her back and are already grateful for all that she brings, her warmth, organisational skills, her infectious laugh and her positive can do approach.

Diane has dedicated 38 years of her life to the Trust and continues to do so; we are truly blessed to have her commitment and on-going dedication to ensuring we deliver the best to the people of Stoke on Trent.

Maria Nelligan, Director of Nursing and Quality presented Diane with a nursing badge.

**Andy Oakes – Head of Partnerships**

Andy started work in Stoke-on-Trent in 1977, the same year that Saturday Night Fever was released. He has been cutting shapes ever since.

His first day was as a care assistant at Hillcrest Hostel Activity Unit. With a pleasing sense of symmetry, Andy's last meeting next Wednesday, some 41 years later, will be to catch up with friends at Hillcrest.

Relationships have always been at the core of Andy's working life. As a Social Worker he has been cherished by his clients, and as a manager he has been valued by his team. Indeed, he got on so well with his one of his colleagues that, 6 years after appointing her, they got married. Cheryl and Andy have two fabulous children and it has always been a pleasure to hear the latest news on what they're up and, importantly, how they are.

Andy has worked in Newcastle, Kidsgrove, Biddulph and Hanley. He loves this city. Much more, he is a highly respected professional in this city. It is no exaggeration to say that without him and his networks our partnerships

with the voluntary sector would be much less strong, and our recent success with the Partnership Hub in Meir might not even have been realised.

Just one example is the Potteries Housing Association, now Brighter Futures. It started with one house for four people in the poorest part of the city to join up housing, mental health and social care support. Today, that partnership has delivered over 200 homes for people with mental health issues, the Clubhouse Network and numerous other spin offs. That's quite some legacy.

Since joining the Trust as part of Section 75 integration in 2007, Andy has been Head of Service, Head of the Stoke Community Directorate and, for the past three years, Head of Partnerships. Back to relationships again, his friends in the Strategy Directorate have immensely enjoyed working with him and wish him all the very best in his new life as a semi-professional golfer. As we all do.

**Julie Elden – Service Manager**

Julie commenced employment as a Nursing Assistant in 1982 on a ward at St Edwards Hospital for people with Learning and Physical Disabilities. In 1983 Julie undertook Student Nurse Training and qualified in 1986 and became a Staff Nurse in Elderly Care until 1988.
Julie worked as a Ward Manager until 1992 at a Therapeutic Community Hospital for clients with a diagnosis of Personality Disorder. This was unique in as much as there was no night staffing facility and the community 'managed' themselves after 9pm until staff arrived at 8am the following morning.

From 1992 -1996 Julie worked as a Senior Manager for night duty at the Psychiatric Unit, City General covering Wards 90, 91, 92 and 93. In 1996 Julie was successfully appointed as the Centre Manager of a Community Resource Centre, providing a day service for the Adult Community which moved to 24hr provision at the then Clydesdale Centre.

From 2005- 2015 Julie worked as a Senior Manager of various Adult Community Services including SPA, Criminal Justice Team and CHMT's, finally spending the last 3 years working as the Service Manager in the Adult Community Directorate.

Patrick Sullivan added Julie has always been an extremely valuable member of staff since she began working for the Trust; she is highly respected by patients, staff and managers. All staff that Julie has managed have found her to be extremely approachable, friendly and consistently dedicated to excellent patient care. Julie is a valued member of the management team, she has fantastic leadership skills and is able to motivate others, inspire, listen and support other people. Julie will be sadly missed by the Directorate and is wished all the best in her retirement. Patrick wished to add his personal best wishes having worked with Julie a long time ago.

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| | Maria Nelligan, Director of Nursing and Quality presented Julie with a nursing badge.<br><br>Patrick commented we have people who have given their working lives in mental health services and he wished to extend his personal best wishes to everyone. | |
| **215/2018** | **REACH Team Recognition Award October 2018**<br><br>**Ward 4 Harplands Hospital**<br><br>Ward 4 is commissioned for 15 beds accepting patients with complex physical health needs & organic illnesses and supporting them reach their maximum potential. The service supports timely discharge from Royal Stoke University Hospital (UHNM) and admission/transfer avoidance via the wards and emergency portals.<br><br>Ward 4 is a place where the emphasis is on a person centred approach. It should be a comfortable, safe and helpful place for patients, carers, visitors and other team members. Ward 4 focuses on all of the complex factors that influence a patient's presentation, working to the biopsychosocial model of care, to understand the patients' needs best and help them reach their maximum potential.<br><br>There have been many highlights for the services over the last 12-18 months, including AIMS accreditation for our older people's inpatient wards and MSNAP accreditation for Memory clinic.<br><br>Our services have stretched to develop and be even more responsive to our service users including the expansion of the Outreach Team, supporting flow at UHNM to offering an all age service through Mental health Liaison which offers a 24/7 all age response from December 2018.<br><br>Over the past 12 months ward 4 has gone through some significant changes and faced a number of challenges.<br><br>The ward needed to come together as a NEW team to overcome a very busy year yet the whole team have worked together and embraced this. A new ward manager and deputy team was put in place over 12 months ago and an incredible journey they have had. The team has shown commitment, hard work and dedication to make the ward an even better service offered to very complex and frail patients. Some of the challenges they have embraced have included;<br><br>- Managing and showing resilience in not only the most recent CQC visit but also visits and scrutiny by a re-visit from CQC, internal assurance visits and Healthwatch all resulting in some very positive feedback along with actions which they have owned and made changes.<br>- A Falls reduction programme showing a significant decline in the number of falls incidents | |

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| | - How to best care for patients at the end of their life forming strong working relationships with the Douglas MacMillan Hospice<br>- A very well attended and well received carers group - now held weekly due to the popularity and positive feedback from those carers who attend<br>- Significant sustained improvement around individualised person centred care planning<br>- A strengthened team approach in managing complex physical health needs to avoid the need to be transferred to A&E & UHNM<br>- A smooth and streamlined admission pathway forming strong working relationships with the Older Persons Outreach Team<br><br>These are just a few examples but all of the above have been achieved whilst still managing vacancy challenges and the team have come together and gone above and beyond to support each other.<br><br>Janine Burgess, Ward Manager and Josey Povey, Modern Matron provided a presentation for the Board.<br><br>The presentation focussed on highlights of the last 12 months, quality improvement, 'What I Like' posters, 'On Yer Feet Duck' Campaign and Caring Together for the Unexpected.<br><br>Mike Groden talked about Annie, a patient admitted to Ward 4. Annie had a number of health problems including history of chronic anaemia, rectal prolapse, diabetes, thickening of the bladder wall & mixed dementia. During her admission the lady did not respond to rehabilitation and a decision was taken to put a 'ceiling of care' in place. Annie's health changed quickly and she became too ill for transfer to a fast track palliative care bed in the Community. A decision was made to provide end of life palliative care on the ward four and keep her as comfortable as possible. Surrounding by her family, pain free and comfortable Annie sadly died in our care. We are proud to say that Annie had a 'good death'. Annie's family still attend our family & Friends group for support.<br><br>Having access to a Senior Advanced Nurse Practitioner gave continuity in assessment and decision making regarding physical health changes and management. It has been acknowledged by our team and the wider arena that this has allowed us to manage far more complex patients thus the need to transfer to UHNM has been significantly reduced.<br><br>Josey talked about the future of Ward 4. To have an outstanding CQC report, further reduction in Falls, carer led discharge support groups, further enhance physical health skills and competencies of all staff, clear end of life policy and local operating procedures.<br><br>Tony Gadsby told the team that they had underplayed some of what they do advising that he and Patrick Sullivan attended the Innovation Nation event yesterday where Ward 4 talked about the development of the family group, Tony highlighted this is fundamental to the ethos of the ward and the way family are integrated into everything. Tony congratulated the team on a | |

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| | fantastic job.<br><br>Maria Nelligan highlighted the work undertaken around falls on the ward and advised she was looking forward to seeing more improvement, Maria also congratulated the team.<br><br>Patrick Sullivan asked if there was anything the Board are able to do to make life better or easier for the team.<br><br>Josey highlighted that sometimes blockages are system wide and the movement through the wards is difficult some are external to our Trust some are hurdles we have to jump through to move patients through the system, we work closely with social care partners to get through these barriers. Environmental changes may be something we can look at.<br><br>Joan Walley highlighted that doing the right thing is what we are about as an organisation but we are not commissioned to do this and asked in terms of strategic discussions if there are any lessons to be learnt from how we can press for recognition and understanding that commissioning does not quite match what is being procured.<br><br>Janine advised the team are linking in with Douglas Macmillan and sometimes its about recognising that placements are there but questioning if it is right to move to a patient to a strange environment or to keep them with us on Ward 4.<br><br>Caroline Donovan highlighted that Ward 4 has a history of being innovative and congratulated the team. Caroline highlighted this is a very person centred service and asked if these ideas have been spread across other wards i.e. involving families, carers group. Josey advised is it is high on everyone's agenda, the carers groups have come together as an inpatient forum now to share the learning.<br><br>Janine added that it is the passion of the staff, their drive and the fact they go above and beyond that makes this successful.<br><br>Mary Barlow, Lead Quality Nurse CCG, commented that she had visited Ward 4 and was very impressed, so impressed in fact that some of this work was presented to the CCG Quality Committee.<br><br>***Noted*** | |
| **217/2018** | **QUESTIONS FROM MEMBERS OF THE PUBLIC**<br><br>There were no questions from members of the public. | |
| **218/2018** | **SERVICE USER AND CARER COUNCIL**<br><br>Maria Nelligan, Director of Nursing and Quality provided an update in Wendy Dutton's (Chair) absence.<br><br>**Service User & Carer Council Business Meeting** took place 26th | |

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| | September 2018.<br><br>An update was received from Ben Boyd on Care and Risk Assessments linked to the first pilot of the Patient Aide app.<br><br>BAME was discussed as an on-going issue as to how the Council can actively engage and encourage participation of a more diverse membership of the Service User & Carer Council and volunteering.<br><br>Peer Support Mentors potential was discussed with a definite date for a meeting to focus on this agreed. This meeting has since taken place and was well attended with a lively, productive discussion and concrete actions suggested.<br><br>Discussion took place with Clinical Audit, highlighting their role and the possibility of working with the Service User & Carer Council to identify 'gaps' which could lead to a meaningful piece of work.<br><br>Discussion has taken place with Ben Boyd on the use of patient transport, looking at the eligibility criteria with suggestions for greater clarity were taken on board.<br><br>Phil Leese, Healthwatch Stoke, highlighted work on raising the issue of Loneliness which is going from strength to strength<br><br>**Workshop /Educational meetings**<br><br>Having now undertaken 3 workshops it was agreed to focus on the following:<br>• Election of a new Vice Chair<br>• Refreshing practicalities of the Service User & Carer Council for example; Terms of Reference, Confidentiality Agreement, DBS, Roles and Responsibilities to be reviewed. This would enable is greater clarity and consistency for all.<br>• A review of who is attending what for the Service User & Carer Council to enable members to discuss/change/highlight areas of interest with a clear focus of representing the wider service user and carer population.<br>• A robust review of all open actions with a view to refreshing targets and agenda in line with the new Directorate structure.<br><br>This work will be supported by the Executive Director of Nursing & Quality.<br><br>Peer development programme for peer mentors – a piece of work will be undertaken with a view to having a campaign looking at volunteers to come and work with us with clearer support for mentors moving on in employment. Terms of reference agreed. Now working on job descriptions<br>and a training programme.<br><br>Tony Gadsby made reference to Healthwatch and the issue of Loneliness and advised it would be helpful if we could have some indication of work that is being undertaken. Maria Nelligan to obtain further detail. | **MN** |

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| | ***Received*** | |
| **219/2018** | **TOWARDS OUTSTANDING INNOVATIVE PRACTICE**<br><br>Dr Darren Carr, Associate Medical Director / Clinical Director presented the report in the absence of Dr Buki Adeyemo.<br><br>Following the success of using Florence simple telehealth text messaging with people who had mild cognitive impairment (MCI) and other vascular risk factors, the idea for a related project in which two everyday technologies would be 'bolted' together was developed.<br><br>Outcomes of the project included; three out of the four participants showing a reduced number, and reduced total duration, of community team appointments (pre and post project entry compared). The Autographer + Flo project was presented at the West Midlands Health Informatics network, Technology enabled care regional conference and local GP conference as part of the wider WMAHSN exemplar project.<br><br>Caroline Donovan asked Dr Carr what is preventing the Trust rolling out the programme ourselves, Dr Carr advised there is nothing preventing us doing so but if we roll out across the entire MCI cohort the Trust would be looking at purchasing hundreds of ipads which could be a huge cost implication.<br><br>Suzanne Robinson advised the STP Digital Programme had been successful in identifying separate funding, Suzanne felt this would be good opportunity to link the two. Suzanne to look at funding to scale up the project. | **SR** |
| **220/2018** | **NURSE STAFFING MONTHLY REPORT (AUGUST 2018) AND RECRUITMENT AND RETENTION INITIATIVES**<br><br>Maria Nelligan, Executive Director of Quality and Nursing presented the report.<br><br>The paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during August 2018 in line with the National Quality Board requirements. The performance relating to fill rate (actual numbers of staff deployed vs numbers planned) during August 2018 was 73% for registered staff and 104% or care staff on day shifts and 81% and 111% respectively on night shifts. Overall a 94% fill rate was achieved. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover and Ward manager supporting clinical duties. The data reflects that Ward Managers are staffing their wards to meet increasing patient needs as necessary.<br><br>There has been no reported harm to service users as a result of staffing.<br><br>In addition to the report the Board received the action plan for recruitment and retention which has been submitted to NHSI. This action plan came to | |

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| | Board in April; a number of actions have been completed and are ongoing.<br><br>Positively we have 29 newly qualified nurses that have commenced employment in October who are being supported with a 12 month preceptorship which includes mentorship and action learning sets.<br><br>Ward 6 levels of acuity remain challenging and an update will be made available to the Board. Recruitment is still ongoing on Ward 2.<br><br>Joan Walley enquired as to whether there was any knock on effect of nurse bursaries and people coming forward to start nursing training. Maria confirmed nationally this has been an issue as there has been a reduction in uptake of 25%. Universities have widened the places they have available. Nursing Associates, additional funding has been made available and for Learning Disability Nursing Associates which recognises the fact there is a significant shortfall of Registered Nurses for Learning Disability Services nationally. Maria advised that last year Keele University were unable to fill 50% of their Learning Disability programme.<br><br>Caroline Donovan added that Matt Hancock, Secretary of State has indicated there is no appetite regarding the request for student nursing funding to be looked at and has been clear it will not be in terms of the 10 year plan at this stage.<br><br>Tony Gadsby asked if the Trust has a number of people it will be offering placements to at the end of this year. Maria advised there are similar numbers to last year that we have given a conditional offer to.<br><br>Maria talked about the 'career pathway on a page' this is so people can see there is an escalation as to future career opportunities. Work life balance and well-being work is important.<br><br>Patrick Sullivan asked if we have we considered over recruitment on HCSW's. Maria advised that we have an active recruitment for our bank and the plan is we recruit through bank with a move to substantive posts as posts are available.<br><br>Caroline advised achieving a position of full recruitment would be good to ensure we do not spend agency on healthcare support workers.<br><br>Patrick asked if the Trust was confident in opening the PICU and ensuring we are not overstretching the system as there are vacancies on adult wards and PICU needs stability. Maria confirmed she was reassured that the position is healthy all newly qualified staff have been buddied up and mentored by experienced staff, most newly qualified staff will not go to PICU. A previous safer staffing report provided a proposal that once PICU opened we would reduce staffing on Ward 1 as that function will change and we would look at making adjustments across other wards. We are admitting patients gradually to ensure provision is safe.<br><br>Jonathan O'Brien confirmed we have significant ongoing recruitment in | |

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| | terms of HCSW's and 35 are shortlisted for bank interviews over the next two weeks. From a resourcing perspective, there is more work to be done converting to permanent employment and further work to do around a coordinated approach in advertising these posts. These are attractive posts as we are offering AfC Band 3 whereas other trusts are offering AfC Band 2.<br><br>Jonathan advised that he was assured with regards to PICU as Natalie Larvin, Associate Director of Acute and Urgent Care ensured that admissions will be phased and therefore risks have been mitigated as far as possible.<br><br>Tony Gadsby highlighted that February and March months are notorious for holidays and asked if we are doing anything proactively to ensure spread of annual leave. Maria advised the e-roster system sets out when people take holidays; ward managers plan the e roster months ahead. 17% of annual leave is catered for in the system. There are peaks and troughs throughout the year. A Safe Care module has been introduced in October looking at performance management in terms of how well ward managers are e-rostering. Jonathan confirmed he reports monthly on this issue and tracks and challenges where required.<br><br>Jenny Harvey highlighted that this is an issue for every Trust. One of the solutions looked at previously is to change to annual leave spread over a year for some e.g. birthdate and financial year for others. This was previously stopped due to accounting but still seems an odd reason not to do something if it helps staffing issues. Maria will follow this up. Suzanne Robinson advised the financial accounting issue would not be a problem for this Trust.<br><br>***Received*** | **MN** |
| **221/2018** | **ANNUAL RESTRAINT AND SECLUSION REPORT**<br><br>Maria Nelligan, Director of Nursing & Quality presented the report.<br><br>The purpose of this report is to provide information regarding the use of physical restraint and seclusion within the inpatient services of North Staffordshire Combined Healthcare NHS Trust. The report focussed on the use of physical restraint and seclusion, comparing activity for the 2017-18 financial years.<br><br>The report showed a considerable reduction on Ward 1 of around 64% but also showed significant increases for A&T (57%), Ward 3 (39%) and Darwin (58%). Ward 3 and A&T had the highest use of physical restraint during 2017-18 with 180 and 162 incidents respectively.<br><br>There were 20 instances of prone (face down) restraint during year. This represented a reduction of 40% on the previous year (33 instances).<br><br>The number of seclusion episodes during 2017-18 was 10. | |

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| | The incidence of rapid tranquillisation by month and similarly to physical restraint showed a downward trend over the reporting period. In total there were 223 incidences of rapid tranquillisation during the reporting period across the Trust.<br><br>To note, positive behaviour support (PBS) is a person-centred approach to people with a learning disability and/ or autism, who display or are at risk of displaying behaviours which challenge. This is the model of support which is implemented within the Trust Learning Disability services. The training is based on the BILD model of PBS and arose out of the PBS competence framework.<br><br>The Board is asked to approve this Annual Report.<br><br>***Approved / Received*** | |
| **222/2018** | **QUARTER 1 SERIOUS INCIDENT REPORT**<br><br>Dr Darren Carr, Associate Medical Director / Clinical Director presented the report.<br><br>This report provides analysis of Serious Incidents which occurred during April to June 2018. It is noted that the number of serious incidents, especially the number of suspected suicides, has increased. The report also includes a statement regarding the Trust Duty of Candour reporting position.<br><br>There were 13 serious incidents reported for the Adult Community Directorate. There were 10 unexpected, potentially avoidable deaths, 1 incident of serious self-harm and 1 incident of potentially avoidable harm. Of the deaths reported 2 people were known to mental health and substance misuse services, therefore joint investigations will be completed.<br><br>There were 6 unexpected, potentially avoidable deaths in the Substance Misuse Directorate. This includes the death of 1 person who was open to substance misuse services and adult mental health services.<br><br>In the NOAP Directorate, there were 2 incidents of a physical health nature.<br><br>There were 3 incidents in the Adult Inpatient Directorate. 1 incident involved the assault on a member of the general public by a person who had absconded from the ward. 1 person suffered a fracture to the foot as a result of kicking a piece of furniture and 1 person suffered fractures whilst receiving ECT.<br><br>There were 2 incidents of admissions to adult mental health services as a result of CYP and LD services being unable to locate beds in the appropriate services.<br><br>Reporting has increased which is positive. | |

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| | The number of falls related SIs has reduced in this quarter. The NOAP teams have implemented a number of falls reduction initiatives as part of a quality improvement programme. The review of these initiatives will continue to be monitored through the weekly incident review group and the physical health group.<br><br>During Q1 no incidents met the criteria for reporting under the Duty of Candour requirements. The ongoing SI investigations may determine that incidents meet the Duty of Candour criteria as part of the investigative process.<br><br>***Received*** | |
| **223/2018** | **DIRECTOR OF INFECTION PREVENTION AND CONTROL (DIPC) QUARTER 1 REPORT**<br><br>Maria Nelligan, Director of Nursing & Quality presented the report.<br><br>The report provides the Board with assurance in relation to the IPC arrangements within the Trust. The report also provides an overview of the Water Safety arrangements within the organisation.<br><br>During the Q1 period there were no HCAIs to report, in relation to Blood Stream Infections, MRSA Bacteraemia or C-difficile.<br><br>MRSA screening continues to result in a zero return in terms of positive results and no exceptions have been reported externally.<br><br>At Combined we have a robust water quality assessment process with external organisations. One via Combined and another via Serco. Regular testing and flushing takes place which is reported into IPCG.<br><br>***Received*** | |
| **224/2018** | **MORTALITY SURVIELLANCE QUARTER 1 REPORT**<br><br>Dr Darren Carr, Associate Medical Director / Clinical Director presented the report.<br><br>This report provides analysis of the mortality surveillance activity during Q1 2018/19. The report identifies any learning from the MS review process and provides assurance regarding the trust compliance with the national learning from deaths agenda.<br><br>The vast majority of deaths reported to the Trust are for the Neuro and Old Age Psychiatry Directorate and relate to elderly people who have had some contact with the memory service. In the main these deaths relate to people who are over 75 years of age and/or have been out of service for over 12 months and therefore they would not meet the criteria for mortality surveillance. The process for reviewing the deaths of people with Learning Disabilities (LeDeR) is a separate process which is hosted externally to the | |

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| | Trust.<br><br>During Q1 the mortality surveillance group reviewed the care of 15 people. There were 12 people who were reviewed under the mortality surveillance criteria and 3 people whose deaths were investigated under the SI Framework. These deaths did not occur in Q1.<br><br>With regards to the mortality surveillance of people with Learning Disabilities, there have been a total of eight deaths reported to LeDeR since 1st October 2017.<br><br>The Trust continues to monitor the deaths of people whose deaths are outside of the Serious Incident process. The monthly Mortality Surveillance Group receives and reviews investigations in order to provide assurance as to the quality of the care provided. The group identifies any learning from the reviews and offers recommendations for practice when required. In the deaths reviewed during Q1, there were no examples of problems in the healthcare provided by the trust which may be considered to have contributed to the death of any individuals.<br><br>Patrick Sullivan shared his concerns about cuts to drug services and an increase in number of people dying whether related or not and asked if a piece of work is required around this or is already being undertaken? Caroline Donovan advised that Dr Adeyemo has commissioned this work independently. Dr Adeyemo to bring a briefing back to Trust Board. We are looking to get CCGs and Local Authority to joint own this.<br><br>***Received*** | **BA** |
| **225/2018** | **PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 5**<br><br>Suzanne Robinson, Executive Director of Finance, Performance and Digital, presented the report highlighting key points.<br><br>Access and Waiting Times:<br><br>- 90% of clients referred for treatment through the Early Intervention team have been treated within 2 weeks (Target 50%)<br>- 93.9% of patients have received treatment or intervention within 18 weeks of referral (Target 92%)<br>- 66% of IAPT patients are moving to recovery (Target 50%)<br><br>CPA compliance:<br><br>- 96.4% of those on a Care Programme Approach (CPA) have received a follow up contact within 7 days of discharge (Target 95%)<br><br>Exceptions<br>- Delayed transfers of care 7.8% against target of 7.5%. Ward 4 has improved. From a Stoke CCG perspective the health delays in | |

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| | AMHIP are a consequence of delays in securing CCG funding through panel and a lack of availability of residential and nursing home places. This has been escalated to commissioners. Staffordshire - There is a particular issue at the moment with the approval process in Staffordshire County Council, which is adding to delays. The Trust continues to liaise Staffordshire County Council to expedite the assessment and placement of individuals in need of social care packages or care home placements.<br>- CPA - This measure has been consistently achieved year to date and has dipped to 93.8% in M5. All Directorates have action plans in place to ensure that the standard is achieved in M6 and sustained going forward.<br>- 7 day follow up - 87.3% at M5 from 80.2% at M4. This is a new contractual requirement introduced in M4 to ensure that all patients discharged from an inpatient admission receive a 7 day follow up, both CPA and non CPA.<br><br>David Rogers highlighted there is a delay of 128 days for Stoke and 104 for Staffordshire and asked how this relates to mix of patients? Suzanne Robinson will look into the prevalence of the number of days of DTOC and include in the next report to Board.<br><br>The Trust Board is asked to receive the Trust reported performance, management action and committee oversight on the Month 5 position.<br><br>***Received / Approved*** | **SR** |
| **226/2018** | **DIVERSITY AND INCLUSION ACTION PLAN**<br><br>Caroline Donovan, Chief Executive presented the report highlighting key points.<br><br>Caroline highlighted this was a long term diversity and inclusion action plan up to 2019.<br><br>An Inclusion Council led by Caroline has been arranged. There will be five work streams and a member of BAME staff has been identified to support each with a Project Lead and Exec Lead sponsoring.<br><br>David Rogers highlighted this as an area of focus and we are resourcing and including a wide range of people to work on this. East London has the best WRES in the country and has a waiting list for nurses for which David felt certain this was linked.<br><br>Jenny Harvey confirmed she attended an NHS Employer event and highlighted that one of the problems nationally is that Trusts are pulling from the same pool of people.<br><br>Joan Walley felt this provided the Trust an opportunity to be outward facing. For example, the Red Card Racism Day is a wonderful opportunity to be inclusive. Joan advised there is scope to look at this with other partners in | |

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| | the wider Staffordshire economy. If we have an example of good practice it is an opportunity to show what we are doing.<br><br>***Received*** | |
| **227/2018** | **MONTH 5 FINANCE REPORT**<br><br>Suzanne Robinson, Executive Director of Finance, Performance and Digital, presented the report highlighting key points.<br><br>The report summarises the finance position at Month 5 (September 2018).<br><br>The Trust Board are asked to:<br>Note:<br>- The reported YTD surplus of £290k against a planned surplus of £210k. This is a favourable variance to plan of £80k.<br>- The M5 CIP achievement:<br>o YTD achievement of £445k (52%); an adverse variance of £416k<br>o 2018/19 forecast CIP delivery of £1,533k (55%) based on schemes identified; an adverse variance of £1,262k to plan<br>o The recurrent value of schemes transacted at £1,050k, 38% of target.<br>- The cash position of the Trust as at 31st August 2018 with a balance of £10,310k; £1,485k better than plan<br>- Month 5 capital expenditure at £179k compared to planned capital expenditure of £342k<br>- Use of resource rating of 2 against a plan of 2.<br><br>Approve:<br>- The Month 5 position reported to NHSI.<br><br>***Noted / Approved*** | |
| **228/2018** | **ASSURANCE REPORT FROM THE FINANCE, PERFORMANCE & DIGITAL COMMITTEE**<br><br>Tony Gadsby Non-Executive Director and Chair of the Finance, Performance and Digital Committee presented the report for assurance from the meeting that took place on 11th October 2018.<br><br>- **Use of Resources Self-Assessment –** Ahead of the launch of NHSI's Use of Resources assessment for Mental Health, the trust have designed a local framework based on the Acute Use of Resources Assessment. The Trust has self-assessed against the 5 Key Lines of Enquiry and suggested data collection and estimates that it is currently operating at an overall use of resources score of Good. A draft action plan has been proposed, based on areas where the trust could improve.<br><br>- **Restated 2018/19 Capital Plan –** An update of the 5 year Capital plan | |

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| | which restates 2018/19 for the up to date capital commitments agreed through CIG. The Capital plan will be refreshed in detail for the 5 years as part of the 2019/20 planning process.<br><br>Additionally the assurance report addressed:<br>- **October Digital Update -** The committee received an update around Key Digital Developments, which included final approval from NHS Digital for the Digital Exemplar funding.<br><br>- **Finance, Performance and Digital Risk Register -** The committee received an update on current risks which have an impact on Finance, Performance or Digital.<br><br>- **Lord Carter Action Plan -** An update around the Lord Carter review of Operational Productivity; Unwarranted Variation in Mental Health and Community Services, outlining the 16 recommendations to deliver £1bn efficiencies.<br><br>***Received*** | **SR** |
| **229/2018** | **CYBERSECURITY REPORT**<br><br>Suzanne Robinson, Executive Director of Finance, Performance and Digital presented the report.<br><br>To improve data security and protection for health and care organisations, the Department of Health and Social Care, NHS England and NHS Improvement published a set of cyber security standards called the 2017/18 data security protection requirements (DSPR) that all providers of health and care must comply with. This report provides an update to the Trust Cyber action plan submitted to the May Trust Board<br><br>Suzanne confirmed that Cyber Security Risk currently sits on our Trust risk register as a 12. The NHS is deemed vulnerable to a certain extent from cyber-attacks due to some of the systems in place and whereas we may not be necessarily targeted we may be caught by future attacks. The action plan in place mitigates against these risks but cannot mitigate entirely; the Board will receive training in the near future as part of this plan to ensure we are all vigilant and understand how Board members may be individually targeted.<br><br>The Trust operates a comprehensive system of CARECERT deployment and the development of Control Framework will give GOLD Standard assurance to the Board in relation to Cyber Risk.<br><br>Gan Mahadea highlighted the risk of clicking on the unsubscribe notice within an email can this can lead to infiltration. This was duly noted.<br><br>***Received*** | |
| **230/2018** | **LORD CARTER NHS OPERATIONAL PRODUCTIVITY IN MENTAL HEALTH** | |

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| | Suzanne Robinson, Executive Director of Finance, Performance and Digital presented the report.<br><br>In May 2018, Lord Carter issued a review around the Operational Productivity; Unwarranted Variation in Mental Health and Community Services. This paper outlines the findings of the review and actions, where appropriate, for the Trust in order to deliver the recommendations.<br><br>The review identified four important areas where operational improvement must be made;<br><br>- **Staffing**<br>- **Contract specification**<br>- **Technology**<br>- **Delivery**<br><br>The action plan was included in the report and will be overseen via the Trust Committee structure.<br><br>The Trust Board therefore:<br>- Supported the development of action plans to deliver suggested actions by the deadline dates overseen by the relevant Board Committees.<br>- Agreed to receive a progress report on relevant actions in 6 months' time (March 2019)<br><br>***Received*** | |
| **231/2018** | **ASSURANCE REPORT FROM THE QUALITY COMMITTEE**<br><br>Patrick Sullivan, Non-Executive Director presented the report for assurance from the meeting that took place on 27th September 2018.<br><br>- **Patient Story -** The committee watched a video story presented as a poem from a former staff member's BAME perspective of working within the Trust. Committee members welcomed the presentation with its powerful message around culture. It was noted that this poem had been heard at other meetings and events such as the Trust Board and AGM.<br><br>- **Policy report** – The Committee approved the following policies and requested ratification of policies by the Trust Board for 3 years, or otherwise stated as follows:<br>o 4.27 Protected Mealtime Policy - Remove as now incorporated into the Nutrition & Hydration Policy<br>o 1.25 Food Waste - Remove – Remove as now incorporated into the Nutrition & Hydration Policy<br>o IC9 Food Safety - Remove – Remove as now incorporated into the Nutrition & Hydration Policy<br>o 7.1 Confidentiality of Patient & Employee Information - Approve 3 years<br>o 7.2 Subject Access Request - Renamed to Access to Health & Employee Records – approve 3 years | |

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| | o 7.3 Information Security & Data Protection Policy - Approve 3 years<br>o 5.20 Health & Safety Audit Procedures Remove – incorporated into new Health & Safety policy<br>o 1.68b Guidelines for physical healthcare Remove – the guidelines have been incorporated into the new physical health policy 1.62 approved by Trust Board, which also approved 1.62a SOP to support the physical health policy and 1.62b SOP to support neurological observations.<br>o 1.34 Pulse Oximetry Guidelines Remove – as above<br>o 1.70 Managing Allegations of Abuse - Approve 3 years<br>o 4.22 Children Visiting Mental Health and Learning Disability premises - Approve 3 years<br>o 4.44 Policy on managing visits to Trust premises by Celebrities VIPs and other Famous People - Approve 3 years<br>o 5.22 Management of Mercury Guidance Remove – Policy no longer required<br>o 5.26 Sharps Find Procedure - Remove – incorporated into the IC1 policy<br>o R10 Policy for the Provision of Physical Interventions and Advice to Parents and Carers - Approve 3 years<br>o R07 Guidelines for when the Police use Incapacitant Spray or Taser on Trust Premises - Approve 3 years<br>o 1.19 Chaperone Policy - Approve 3 years<br>o 4.32 Privacy Dignity and Respect Policy - Approve 3 years<br>o 5.38 Lockdown Policy - Approve 3 years<br>o 5.42 Display Screen Equipment - Approve 3 years<br>o 1.75 Domestic Abuse - Approve 3 years<br>o 4.33 Clinical Photography - Approve 3 years<br>o 4.33a - Digital Photography Standing Operating Procedure - Approve 3 years<br>o 1.78 Palliative Care - Extension to 30.11.18<br>o 1.55 Advanced Statements - Extension to 30.11.18<br>o 1.04 Complimentary Therapies - Extension to 30.11.18<br>o 4.20 Volunteer Policy - Extension to 30.11.18<br>o 4.40 Being Open incorporating Duty of Candour - Extension to 30.11.18<br>o 5.01 Incident Reporting - Extension to 30.11.18<br>o 5.32 Serious Incident Policy - Extension to 30.11.18<br>o MHA16 Mental Capacity Act Policy - Approve 3 years<br><br>***Ratified / Received*** | |
| **232/2018** | **LOCALITY WORKING /RESTRUCTURE**<br><br>Jonathan O'Brien Director of Operations presented the report.<br><br>The paper provides an overview of progress to date and a briefing on the Trust's localities working restructure. The paper sought to brief the Trust Board on progress to date and the current position. | |

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| | Phase 3 of the locality restructure focused on the management structures within each of the newly established Directorates. These included the roles of Service Managers, Quality Improvement Lead Nurses, Clinical, Psychology and AHP Leads. The newly appointed CD's and AD's have led this phase, including ownership of the launch and the resulting consultation under a management of change process.<br><br>Phase 3 launched into formal consultation with staff on Monday 16th July 2018 and was implemented from 1st October 2018.<br><br>The appointment processes for Clinical Leads, Psychology Leads and AHP Leads are currently taking place.<br><br>Jonathan provided an update on the Corporate Services Task & Finish Group (CSG). All corporate services have reported that work is complete in relation to supporting the new structure and that data from 1st October 2018 will be reported on the basis of the new four Directorates.<br><br>Terms of Reference and membership of the Senior Operational Team meetings, chaired by the Director of Operations, have been fully updated and signed off through the Senior Leadership Team meeting.<br><br>All committees of the board have the restructure programme identified on their risk registers to provide assurance and ensure risks are appropriately managed and mitigated. These continue to be reviewed at each committee and will be modified as the described risks associated with the restructure subside.<br><br>The Trust Board is asked to:<br>• Receive the report.<br>• Note completion of Phases 1-3 of the Trust restructure.<br>• Receive a further update on progress and activities within the new structure in November 2018.<br><br>***Noted*** / ***Received*** | |
| **233/2018** | **TRUST BOARD / COMMITTEE DATES AND TRUST BOARD CYCLE OF BUSINESS 2018/19 AND 2019/20**<br><br>Laurie Wrench, Associate Director of Governance presented the report for information.<br><br>We have mapped every committee cycle of business against this. All in agreement.<br><br>***Received*** | |
| **234/2018** | **Any Other Business**<br><br>There were no items for discussion | |

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| **235/2018** | **Date and time of next meeting**<br><br>The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday 22nd November 2018 at 10:00am, in the Boardroom, Lawton House, Trust HQ. | |
| **236/2018** | *** Motion to Exclude the Public**<br><br>The Board approved a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted. | |

The meeting closed at 1.25pm

Signed: _____ Date_____
Chairman

# Board Action Monitoring Schedule (Open Section)

Trust Board - Action monitoring schedule (Open)

| Action | Meeting Date | Minute No | Action Description | Responsible Officer | Target Date | Progress / Comment |
|---|---|---|---|---|---|---|
| 1 | 26-Sep-18 | 192/2018 | AHP Strategy<br>Joe McCrea highlighted the new intranet was launched at the AGM and there is currently no dedicated section on the current internet for AHPs. Joe agreed to work with AHPs to get an AHP section on the intranet and raise the profile.<br>25.10.18 - Discussions underway and plans in place to implement section on the internet. David asked for an update from Communications Department regarding the new intranet therefore action to remain on schedule. | Joe McCrea | 22-Nov-18 | |
| 2 | 25-Oct-18 | 211/18 | Matters Arising - Section 75 (Questions from Members of the Public)<br>David Rogers asked for an update re: Section 75 to come to January Trust Board | Jonathan O'Brien | 24-Jan-19 | |
| 3 | 25-Oct-18 | 212/18 | New Minister for Suicide Prevention<br>Dr Adeyemo to invite Jackie Doyle-Price to our Suicide Conference 30th November 2018 | Dr Adeyemo | 22-Nov-18 | Complete |
| 4 | 25-Oct-18 | 218/18 | Service User Carer Council<br>Healthwatch Homelessness Project - tony asked for an update as to work that has been undertaken. Maria Neligan to follow up | Maria Nelligan | 22-Nov-18 | |
| 5 | 25-Oct-18 | 219/18 | Towards Oustanding Innovative Practice<br>Suzanne Robinson to look at funding to scale up Autographer Project | Suzanne Robinson | 22-Nov-18 | |
| 6 | 25-Oct-18 | 220/18 | Nurse Staffing Monthly Report August 2018 / Recruitment and Retention Initiatives<br>Maria Nelligan to look into personalised A/L arrangements | Maria Nelligan | 22-Nov-18 | |
| 7 | 25-Oct-18 | 224/18 | Mortality Surveillance Quarter 1 Report<br>Dr Adeyemo has commissioned work independently. Dr Adeyemo to bring a briefing back to November Trust board re: drugs and alcohol deaths and cuts | Dr Adeyemo | 24-Jan-19 | |
| 8 | 25-Oct-18 | 225/18 | PQMF Month 5<br>Suzanne Robinson to look into the prevalence of the number of days of DTOC within the report | Suzanne Robinson | 22-Nov-18 | |
| 9 | 25-Oct-18 | 228/18 | Assurance Report from Finance, Performance and Digital Committee<br>Update re: Digital Exemplar to come to November Trust Board | Suzanne Robinson | 22-Nov-18 | Agenda item |

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# REPORT TO TRUST BOARD

Enclosure No:4

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| Date of Meeting: | 22nd November 2018 | | |
| Title of Report: | CEO Board Report | | |
| Presented by: | Caroline Donovan, Chief Executive Officer | | |
| Author: | Caroline Donovan, Chief Executive Officer | | |
| Executive Lead Name: | Caroline Donovan, Chief Executive Officer | Approved by Exec | ☒ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| This report updates the Board on activities undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest. | Approval | ☐ |
| | Information | ☒ |
| | Discussion | ☐ |
| | Assurance | ☐ |

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| Seen at: | SLT ☐ Execs ☐<br>Date: | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☐<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☐<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Primary Care Integration Programme Board ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement.☒<br>2. To provide the highest quality services ☒<br>3. Create a learning culture to continually improve.☒<br>4. Encourage, inspire and implement research & innovation at all levels.☒<br>5. Maximise and use our resources intelligently and efficiently.☒<br>6. Attract and inspire the best people to work here.☒<br>7. Continually improve our partnership working. ☒ | | |
| Risk / legal implications:<br>Risk Register Reference | None | | |
| Resource Implications:<br><br>Funding Source: | None | | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | Staff Survey and Freedom to Speak Up Champions integrated with our diversity and inclusion strategy. Includes update on Stepping UP BAME programme, Freedom to Speak Up Champions and meeting of the Inclusion Council | | |
| STP Alignment / Implications: | Stepping Up BAME programme is Staffordshire wide. | | |
| Recommendations: | To receive for information | | |

| Version | Name/group | Date issued |
|---|---|---|
| 1.0 | Caroline Donovan | 14th November |
| | | |

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# Chief Executive's Report to the Trust Board
# 22nd November 2018

## PURPOSE OF THE REPORT

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

## LOCAL UPDATE

### 1. CONTINUING OUR STRATEGY OF BEING OPEN

Our latest Board Development session focused on being open. Our session on openness was led by our Freedom to Speak Up Guardian, Zoe Grant. Zoe updated the Board on plans for our Freedom to Speak Up Champions and we spent a fascinating session brainstorming how we can move to become truly outstanding in our approach and delivery of being open, allowing staff to raise concerns bringing together the various strands of our listening and responding to concerns and ideas.

We also had the opportunity to discuss the launch of the Trust's Freedom to Speak Up Champions. Working with Zoe, the Champions will help to promote a positive culture in which staff feel comfortable and supported to speak up about things that may concern them.

By having Freedom To Speak Up Champions across the Trust's localities and diverse staff and professional groups, the aim is to give staff a wide choice of who they may be most comfortable in speaking up to. The Champions will be supported by Zoe, and their role will be supporting staff to speak up and helping her identify themes and trends emerging from the front line.

The opportunity to become a Champion is available to all Combined staff.

Our second strand was a hugely enjoyable session led by our Director of Strategy and Development, Andrew Hughes, looking into the future and how we can ensure that our existing Strategic Priorities remain absolutely aligned with our future needs and strategy. The good news was that we considered them to remain fundamentally sound and fit for purpose, but we had a range of ideas and contributions for how we could refine them slightly to make them absolutely aligned with our future priorities and direction of travel.

### 2. TOWARDS OUTSTANDING AWAYDAY ON PERSON-CENTRED FRAMEWORK

Our Director of Nursing and Quality, Maria Nelligan, led a quality, compliance and person-centredness workshop. The day was an opportunity to meet and greet the newly appointed service managers and quality leads aligned to their new structures. CQC compliance was a key theme, staff were apprised of the core service actions and the relevance to the new structure.

The day also involved an update regarding the Freedom to Speak up / raising concerns issues and the recent action taken to address concerns. The FTSU champions were presented and discussions about managers' responsibilities were held.

There was space in the day to watch the BAME staff member's poem / story and an opportunity to reflect on how improvements can be further accelerated. The afternoon focused on the person centred framework and for patients and staff. The day ended with 2 workshops, focusing on the outstanding characteristics within 2 CQC domains.

## 3. INNOVATION NATION LIVE

Innovation Nation was our Trust's very first research and innovation conference and was a lively and forward-thinking event, which was well attended by staff from across the Trust. I was delighted to introduce the event and I hope that there will be more opportunities in the future to host future events, to nurture and celebrate our culture of research and innovation.

Held at North Staffordshire Conference Centre, the event was a great opportunity to share ideas and promote research findings with colleagues. Oral and poster presentations were delivered throughout the morning, with attendees having the chance to network over lunch and discuss all things research and innovation based.

Our guest speaker for the event was Dr Scott Border, Principal Teaching Fellow in Anatomy within Medicine at the University of Southampton. Scott discussed the pitfalls and promises of innovation – giving an honest account of the challenges faced during the innovation journey within Trusts.

The conference concluded with Dr Chris Link, R&D Director, thanking all those who took part and presented. The award for best presentation went to Dr Jenni Watson and Dave Jefferson from our ADHD CAHMS Team, for their insightful presentation about their ADHD pathway project titled: "How a questionnaire influenced a pathway".

We also launched a fabulous collection of initiatives celebrating nursing excellence and bringing our nursing strategy to life. You can download a copy of this collection via the Combined website.

## 4. NHS STAFF SURVEY UPDATE

The latest figures up to 16th November show that our staff survey response rate has risen to 46 per cent. The breakdown by staff working in each area is as follows:

| | % |
|---|---|
| Staff working in Workforce and Leadership | 100% |
| Staff working in Finance, Performance & Digital | 91% |
| Staff working in Nursing and Quality | 80% |
| Staff working in Estates | 69% |
| Staff working in Substance Misuse | 64% |
| Staff working in Medicine and Clinical Effectiveness | 58% |
| Staff working in Children and Young People | 50% |
| Chief Executives Office | 50% |
| Staff working in AMH Community | 40% |
| Staff working in Learning Disabilities | 39% |
| Staff working in AMH In Patient | 38% |
| Staff working in Neuropsychiatry and Old Age Psychiatry | 34% |

We are continuing to encourage all staff to complete the survey and stressing that we listen to all responses and take actions appropriately.

## 5. COMBINED FLUFIGHTERS UPDATE

A huge thank you to everyone who has had their flu vaccination. The latest figures show that, as of 15th November, 59.87% of our 75% target for patient facing / frontline staff have been vaccinated. This means we have vaccinated 761 patient facing / frontline staff amongst an overall total of just under 900 staff.

Our Flu Fighters Team have been busy vaccinating across the Trust since our campaign started on Friday 5 October, and these results are really important, as we are ensuring we are safer for our patients, ourselves and our relatives.

However, there is still work to be done. Our peer vaccinators are working relentlessly but staff need to be seriously considering having the vaccines.

A further Jabathon has been organised for 20th December, to coincide with giving out star prizes open to anyone who has had the vaccination, including the opportunity to win an iPad mini.

## 6. STEPPING UP BAME LEADERSHIP PROGRAMME A GREAT SUCCESS

Our leadership programme to empower black, Asian and minority ethnic (BAME/BME) health and care staff to embrace leadership roles in Staffordshire and Stoke-on-Trent is already proving a huge success. More than 20 existing and aspiring BAME leaders from across the local health and care system are looking to the future with a renewed zeal after becoming the first group to complete the Staffordshire Stepping Up programme.

Utilising the NHS Leadership Academy's Stepping Up programme, it is coordinated by North Staffordshire Combined Healthcare NHS Trust and forms part of the Organisational Development (OD) programme run by the Together We're Better health and care partnership Staffordshire and Stoke-on-Trent. As well as supporting the participants to further develop their leadership skills, it has also helped them to enhance their skills to assist with career progression.

Feedback from the participants has been overwhelmingly positive, with the next Staffordshire Stepping Up cohort underway in November, with a further cohort taking place in February 2019, I am excited to see where this continues. Our BAME leadership programme provides a safe space to discuss shared issues and experiences, and to develop confidence and skills to access these roles and is something that is very important to us as a Trust.

## 7. INCLUSION COUNCIL RAMPS UP

It was both a pleasure and a privilege to chair the second meeting of our Inclusion Council in the middle of the week. The Council is one of the important initiatives we have established to ramp up our activities and determination to make Combined truly inclusive and equal in the way we treat and support our staff and service users.

We heard some fantastic ideas from our newly established work stream leads and the energy in the room was palpable. To remind the Board, our five initial workstreams are:

- **Developing our HR Processes for inclusion** – including recruitment and selection; disciplinary and grievance; workforce equality info processes; bank and agency staff (building in inclusion from start to finish of the process)
- **Supporting the development of our BAME staff** – developing equal and inclusive access to career, leadership and education development opportunities
- **Reporting, learning and improving** following incidents and incidences of racist abuse and aggression (both preventing incidents as far as possible and responding better, and supporting people better when incidents do happen)

- **Culture of Inclusion** – developing clear standards of expected and unacceptable behaviour (policies, training, leadership styles, service user involvement ). Addressing how we treat each other day-to-day; inclusive treatment of colleagues; addressing micro-assaults and inequalities). Also considering religion and culture, food, etc.
- **Communication for inclusion** – delivering clear communication, including: feedback from staff (including trainees); BAME network; engaging with our agency staff; events; posters; BAME champions; app to gather staff experiences on exit – and starting with #WearRedDay #19Oct #ShowRacismTheRedCard

One of the most striking parts of the meeting was a presentation about the apparent disconnect between the proportion of applicants from BAME backgrounds for posts at Combined compared with the proportion eventually offered jobs. We agreed we should conduct a further deep dive into the processes and data underlying the presentation to see where and how we may need to improve our recruitment training and awareness of those appointing to posts - to see if unconscious bias is playing a part or what else we could do to redress the apparent imbalance.

We also agreed that though our initial particular focus for the first six months of the Inclusion Council's work will be primarily on the BAME agenda, it will be really important to bear in mind the need for our Inclusion programme to incorporate all aspects of inequality, for example in LGBT.

We also took the opportunity, as did a number of teams across the Trust, to celebrate Diwali with lights and food. It was a lovely way to mark the occasion.

I will continue to keep everyone updated on progress and you should see some fabulous outputs from the Council's work in the coming weeks and months.

## 8. BOARD DEVELOPMENT SESSION LED BY AQUA

Our latest Board Development session was led by colleagues from our partners AQuA (the Advancing Quality Alliance) and focused on our efforts to become truly outstanding in creating the right culture so that everyone fells part of our improvement journey to become outstanding in all we do and how we do it. As a Board it is essential that our culture is open and supportive. We recently asked AQuA to work with our front line staff to hear from them what their experiences of our culture. The feedback was positive which is encouraging with more to do in terms of communication style with our staff. Sometimes the language we are using is strategic and can be not as relevant to our front line staff so thank-you for the feedback and we will be working with our comms team to see how we can get better.

One of the major themes we discussed is the importance of ensuring that when people speak up, that they see that something positive has happened as a result of them doing so. Through Dear Caroline we share what actions we have taken but again we are going to see how we can strengthen messages about what has changed and include our freedom to speak up champions. What we would really like is for teams to be discussing these issues on a regular basis as part of their team meetings and looking at how things have improved as a result of being expressing views, some things can happen immediately, or sometimes the benefit can be many weeks or months down the line.

## 9. LAUNCH OF "ROSE CHAMPIONS"

Our determination to be amongst the very best in the NHS in our use of digital continues unabated and there is now a further opportunity for staff to play a leading role in our ROSE Digital Programme.

We're looking to recruit ROSE Champions to help us continue to improve our Lorenzo

system and work with us to make Combined a true NHS Digital Exemplar.

When we implemented our new Electronic Patient Record back in May 2017, our army of ROSE 'Super Users' were one of the most important factors in the successful deployment of the system - which drew praise from NHS Digital at the time as being one of the most successfully managed implementations they had seen in the NHS.

18 months on, we're looking to refresh our approach and as part of this we're looking to build on the 'Super Users" role and make it a "Champion" for digital excellence.

These will be hugely important roles and a great opportunity for individuals across the Trust to get dedicated skills training not just on Lorenzo, but also in Digital Technology in general.

Our new Champions will help develop our systems, support staff on the ground where they are struggling and work with the Executive and Digital Leadership teams to develop new digital solutions and training packages.

We'll provide all the necessary support and training to fulfil this role.

## 10. FINANCE TEAM SHORTLISTED IN TWO HFMA AWARDS CATEGORIES

Our Finance Team are no strangers to being shortlisted or winners at Awards, but this month they excelled even by their own high standards.

It was absolutely fabulous to see the shortlist for the national HFMA Healthcare Finance Awards. In a year when the HFMA received record numbers of nominations, Combined made the final shortlist in not one - but two - categories.

Our Executive Director of Finance, Performance and Digital - Suzanne Robinson - has been shortlisted in the category of Finance Director of Year.

And her Deputy - Mike Newton - is one of only four shortlisted for the post of Deputy Finance Director of the Year.

For Combined to have beaten off record competition to secure both of these accolades is truly remarkable and only goes to show what tremendous strength in depth we have throughout our Finance Team.

Fingers crossed for the announcement of winners and, very many congratulations to all concerned for this stunning success.

## 11. INTRODUCTORY MEETING WITH NEWCASTLE UNDER LYME BOROUGH COUNCIL

Myself and our Chairman, David Rogers attended a meeting with John Tradewell, CEO, Councillor Simon Tagg and Councillor Jill Waring of Newcastle-under-Lyme Borough Council. We had a positive meeting and discussed how we could be working closer together. They are keen to join our Alliance Board which is really positive.

## 12. MEIR COMMUNITY MEAL – AN EXAMPLE OF COMMUNITY SPIRIT

Community spirit was in full force in Meir as our Trust hosted a free lunch at the Meir Community Centre. Over 100 people attended the meal, from a range of different backgrounds – from local residents and workers in the area, GPs, community police, the fire service and members of the Local Authority were there to share a meal together.

Community events such as this, are key to our Meir Community Partnership, where we have developed co-located Health, Social care and Community practitioners, responding to individuals within five GP practices across the area.

In addition to the monthly meals, Meir Community Centre hold free Tea, Talk and Toast

sessions every Friday morning at 9 – 11am – championed by our STR Worker, John Clayton.

Sessions allow people to pop-in for a chat, and/or get any support they might need in a relaxed, friendly environment. Often we are able to sign-post people for support, which can reduce referrals and is a more informal, community orientated way to support.

## 13. DARWIN DRESS FEATURED IN STOKE SENTINEL

Regular visitors to Lawton House will have been greeted over the past few weeks with a fantastic display in our reception. The "Darwin Dress" is one of a set of really imaginative creations by a team led by Amanda Smith at the Darwin Centre.

The dress was originally produced to mark World Mental Health Awareness Day. The team began thinking about how mental health can be a hidden illness. That we may appear to be perfectly fine on the outside, but beyond the layers we may feel anxious, depressed, frightened or confused.

They discussed this and decided to make a dress mostly out of paper, because they thought it was a good medium to use, as it is fragile and well suited to the purpose. They also found quotes and wrote their own about mental health. The meaning behind the whole activity was to reinforce to others and themselves that mental health can be hidden and a message to all not to judge a book by its cover.

The dress is actually made from copies of The Sentinel newspaper and when the paper got to hear about it, they despatched one of their photographers down to take a picture of Amanda with the dress and featured it in the paper.

## 14. CHANGES TO THE BOARD AND EXECUTIVE TEAM

Lorien Barber, who has been a Non-Executive Director at Combined since 1 December 2016 has completed her term. Lorien has been a fantastic and highly valued member of the Board and it is with real sadness, but also with huge gratitude, that we say goodbye to her as a natural break of her two-year tenure period comes to a close and with her work commitments making it not possible for to continue to devote the amount of time she would like to the Trust.

Lorien brought to the Board a huge amount of insight, experience and talent, having worked for nearly 20 years in the voluntary sector. For seven years, she served as Director of North Staffs Users Group, the mental health campaign group and voice of service users locally. During that time, she was also elected as Co-Chair of the local Mental Health Partnership Board. More recently, she worked as Strategic Liaison Manager, connecting local health, social care and the voluntary sector at VAST, a charity providing services and support to voluntary and community groups, charities and social enterprises in Stoke-on-Trent and Staffordshire. She was also appointed as Partnership Manager at Macmillan to improve cancer support across Staffordshire and the Black Country.

Amongst the many contributions that Lorien has made to Combined, her period serving as the Chair of the People and Culture Development Committee has made a real impact on the day-to-day working lives of staff across the Trust and I know it is an area that is particularly important to her.

On a personal note, and as our Chair has also noted in his communication to staff, we will truly miss Lorien's wise advice, support as a colleague and insight. She really has been an embodiment of our Trust values of being Proud to CARE.

### 15. ON A PERSONAL NOTE

I have been appointed Chief Executive at Lancashire Care Foundation Trust, a provider of Mental Health & Community services across Lancashire.

As our Chairman has said, I will have worked as part of the Combined family for nearly 10 years by the time I leave and it has really felt like being part of a family. I am truly proud of what we have achieved together, dramatically improving the quality of the services we provide, establishing a culture of openness and compassion, and all the time sustaining financial balance.

It has been an honour and a wonderful privilege to be able to lead the Trust through such a period of change and improvement. I am immensely proud of what we have achieved together which has only been realised by our dedicated and committed staff working with Service Users, Carers and Partners. I will look forward to watching the Trust achieve its ambition to be Outstanding in all it does and how it does it. An enormous thank-you to everyone who has supported me on a personal level – I have made many wonderful friendships that I will always treasure.

## NATIONAL UPDATE

### 16. NHSI AND HEE ANNOUNCE NEW WORKING ARRANGEMENTS

NHS Improvement and Health Education England (HEE) have announced plans to work more closely together to ensure the national workforce system is aligned. This includes the role for both organisations in developing the mandate set by the Government on workforce planning, staff education and training, and the NHS Leadership Academy becoming part of the new People function, which will be hosted by NHS Improvement.

The Government's announcement of the five-year funding settlement and the development of the long-term plan has demonstrated the importance of national, regional and local organisations working together effectively to support the NHS.
The arrangement will build on the close working arrangement that NHS Improvement and HEE already have on workforce, including jointly overseeing the workstream on workforce for the NHS's long-term plan.

As part of this, NHS Improvement is moving towards integrating its national and regional functions with NHS England and it is shifting its focus from regulation to improvement. This includes the creation of a Chief People Officer role and a People directorate, which will be hosted by NHS Improvement and will be responsible for providing a cohesive approach to recruiting, retaining, deploying and developing the current NHS workforce.

The announcement confirms that:

- HEE will work jointly with NHS Improvement to develop its mandate for 2019/20 onwards. HEE's board will continue to sign-off the draft mandate, but as a new step the mandate will then need to be approved by NHS Improvement's Board to ensure it aligns with service requirements, before approval by the Secretary of State. This will ensure that workforce plans are more closely aligned with NHS service plans.
- Subject to any necessary consultations and any other necessary legal steps, from 1 April 2019 the NHS Leadership Academy will transfer from HEE to the new People function that will be hosted by NHS Improvement. This will maximise the natural fit between the work of the NHS Leadership Academy and the People function's responsibility for executive and non-executive leadership and talent across the NHS.

- Opportunities will be identified for HEE's regional teams to align with the seven integrated regional teams of NHS Improvement and NHS England, in order to continue to build on the strong collaborative working that already exists across the country in support of local health systems.

Ian Cumming, Chief Executive of Health Education England said:

"As set out in the draft workforce strategy HEE believes that closer alignment between service, financial and workforce planning is essential and I therefore welcome greater collaboration between the bodies responsible for these areas. At national, regional and local level NHS must have confidence that our organisations are working together on workforce challenges to support both day to day delivery and the long-term plan.

"The move of the NHS Leadership Academy to NHSI also allows the Academy to align even more closely with NHSI's responsibility for talent management."

Ian Dalton, Chief Executive of NHS Improvement, said:

"A strong workforce is critical to the future of the NHS. By integrating the work of Health Education England with NHS Improvement, we will develop a more coherent approach to workforce development across the NHS.

"I look forward to building a closer working relationship with Health Education England and welcoming colleagues from the NHS Leadership Academy from next April."

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# REPORT TO OPEN TRUST BOARD

Enclosure No:5

| | | | |
|---|---|---|---|
| Date of Meeting: | 22 November 2018 | | |
| Title of Report: | Person Centred Framework | | |
| Presented by: | Julie Anne Murray, Deputy Director of Nursing, AHP & Quality | | |
| Author: | Julie Anne Murray, Deputy Director of Nursing, AHP & Quality | | |
| Executive Lead Name: | Maria Nelligan, Director of Nursing & Quality | Approved by Exec | ☐ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| The Trust is coproducing a Person Centredness Framework with service users, carers and staff. This will consist of tools and approaches to help us to practically apply person-centred principles in all we do. The Framework will be underpinned by 6 person centredness principles; this paper details these principles and the approach used to devise them. This paper is being presented to all Trust committees as person-centredness applies to all staff, service users and carers with the framework being applied across all areas of Trust business. | Approval | ☐ |
| | Information | ☐ |
| | Discussion | ☒ |
| | Assurance | ☒ |

| | | | |
|---|---|---|---|
| Seen at: | SLT ☒ Execs ☐<br>Date: 13TH November 2018 | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☒<br>• Finance & Performance Committee ☒<br>• Audit Committee ☒<br>• People & Culture Development Committee ☒<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☒<br>• Primary Care Integration Programme Board ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement. ☒<br>2. To provide the highest quality services ☒<br>3. Create a learning culture to continually improve. ☒<br>4. Encourage, inspire and implement research & innovation at all levels. ☐<br>5. Maximise and use our resources intelligently and efficiently. ☒<br>6. Attract and inspire the best people to work here. ☒<br>7. Continually improve our partnership working. ☒ | | |
| Risk / legal implications:<br>Risk Register Reference | There is a risk that the Trust does not meet national standards in relation to person-centred care should the principles and framework not be utilised. | | |
| Resource Implications:<br><br>Funding Source: | No resource issues identified. | | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | Person-centredness promotes inclusion and therefore the principles and framework will support the Trust D&I strategy. | | |
| STP Alignment / Implications: | None identified | | |
| Recommendations: | To note the contents of the paper and the co-produced principles. | | |

| Version | Name/group | Date issued |
|---|---|---|
| 1 | Maria Nelligan | 16 Oct 2018 |
| 2 | BDC | 08 Nov 2018 |
| | FPD | 08 Nov 2018 |
| | PCD | 11 Nov 2018 |
| | AC | 05 Dec 2018 |
| | QC | 07 Dec 2018 |

## 1. Introduction

As a Trust we aspire to be truly person centred in all that we do in order to recognise and respect each and every one us, service users, carers and staff, as unique individuals. To support this we are co-producing a Person Centredness Framework, underpinned by Person Centredness principles, to ensure that people have the resources available to be person centred. This framework will be made up of tools and approaches to help us to practically apply person-centred principles in all we do. This work aligns to, and brings together, our Values, Quality Priorities and Behaviours Framework.

## 2. Background

The Trust has held 2 events with service user, carers and staff in relation to the Person Centredness Framework. The first person centredness event was held in November 2017 and was facilitated by Helen Sanderson Associates; this brought together service users, carers and staff to think about what person centredness means to us as individuals. The outcome of the first event was the identification of a number of themes that attendees felt were essential in order to be a truly person centred organisation. These were then consolidated into 6 Person Centredness Principles and at the follow up event in April 2018 these were agreed with service users, staff and carers; the Service User and Carer Council have also endorsed the principles.

## 3. Person Centredness Principles

**Setting the scene:**

1) We will respect each other as unique individuals. We will adapt to meet diverse needs and to promote open communication.

**Communication:**

2) We will take time to actively listen to each other. We will ask open questions to find out what is important to you and for you.

**Working together:**

3) We aim to instil hope when this is difficult to find. We will work in partnership with you valuing your contributions and life choices. We will encourage everyone to see their potential.

**Positive risk taking:**

4) We aim to support and enable positive change, growth and greater independence. Therefore, together, we will take well considered and well intentioned risk.

**Moving Forward:**

5) We will be flexible and adaptable to foster an environment that enables you to feel empowered to achieve your desired outcomes.

**Values Statement**

6) We are proud to **CARE (Compassionate, Approachable, Responsible and Excellent)** and we aspire to ensure that we do what we have agreed with you.

**4. Next Steps**

- Approval of Person Centredness Principles by all Trust Committees and Trust Board
- Task & finish group will be established to identify appropriate tools and resources for the Person Centredness Framework to practically apply person centredness in all that we do.

**5. Recommendations**

The Trust committees and Trust Board are asked to note the content of the report and approve the 6 person centred principles.

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# REPORT TO TRUST BOARD

Enclosure No: 6

| | | | |
|---|---|---|---|
| Date of Meeting: | 22nd November 2018 | | |
| Title of Report: | Innovation Nation Event 2018 | | |
| Presented by: | Dr Buki Adeyemo | | |
| Author: | Kerri Mason | | |
| Executive Lead Name: | Dr Buki Adeyemo | Approved by Exec | ☐ |

| Executive Summary: | | Purpose of report | |
|---|---|---|---|
| Innovation Nation was the Trust's first research and innovation conference and was a lively and forward-thinking event, well attended by staff from across the Trust. The team received positive verbal feedback on the day from attendees. | | Approval | ☐ |
| | | Information | ☒ |
| | | Discussion | ☐ |
| | | Assurance | ☐ |
| Seen at: | SLT ☒ Execs ☐<br>Date: | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☒<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☒<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Digital by Choice Board ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement.☐<br>2. To provide the highest quality services ☐<br>3. Create a learning culture to continually improve.☐<br>4. Encourage, inspire and implement research & innovation at all levels.☒<br>5. Maximise and use our resources intelligently and efficiently.☐<br>6. Attract and inspire the best people to work here.☐<br>7. Continually improve our partnership working. ☐ | | |
| Risk / legal implications:<br>Risk Register Ref | No current risk or legal implications, no current risks open on Risk Register related | | |
| Resource Implications:<br>Funding Source: | No resource implications | | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups) | No diversity or inclusion implications | | |
| Recommendations: | No Recommendations, feedback currently being collated to advise on future R&D and innovation events. | | |

# Innovation Nation Event 2018

## Background

Innovation Nation was the idea of Dr Rebecca Chubb, Locum Consultant (Older People's Community Health Team) in response to clinicians sharing that they would like to find out more about what is going on in research and innovation - exploring a platform to share good practice.

Supporting our Board Assurance Framework (BAF) objectives, and wider Trust objective to "Encourage, implement and inspire research and innovation at all levels", Innovation Nation aimed to showcase the work within the Trust, highlighting the mechanisms and support in place to encourage staff to get involved in innovation and research.

## The Event

On Wednesday 24 October 2018 the R&D Team and Dr Rebecca Chubb hosted Innovation Nation 2018. Innovation Nation was the Trust's first research and innovation conference and was a lively and forward-thinking event, well attended by staff from across the Trust.

Dr Scott Border, Principal Teaching Fellow in Anatomy within Medicine at the University of Southampton opened the session with an honest account of the challenges faced during an innovation journey, discussing the pitfalls and promises of innovation. Oral and poster presentations were delivered throughout the morning, with a networking lunch to discuss all things research and innovation.

A prize for best presentation was given to Dr Jenni Watson and Dave Jefferson from ADHD CAHMS Team, for their insightful presentation about their ADHD pathway development and journey titled: "How a questionnaire influenced a pathway". The conference concluded with Dr Chris Link, R&D Director thanking all those who took part and presented. Dr Link shared:

*"I thought the event was a fantastic celebration of the research which is going on within the Trust and a testament to the great ideas that staff have for improving services for patients. It demonstrated that research can arise from simple ideas and doesn't' necessarily require huge time commitments from team members, rather the results can lead to improved services and more effective and efficient patient-centred care".*

## Feedback and Next Steps

The team received positive verbal feedback on the day from attendees. A Survey Monkey feedback form was also sent out for staff to complete, with initial results looking positive. The R&D team will be working with the Communications Department to explore an Innovation Event booklet to showcase photos, presentations and poster from the day.

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# REPORT TO Trust Board

Enclosure No:7

| | | | |
|---|---|---|---|
| Date of Meeting: | 22/11/2018 | | |
| Title of Report: | Lorenzo Digital Exemplar Update | | |
| Presented by: | S Robinson –Director of Finance, Performance and Digital | | |
| Author: | D Hewitt – Chief Information Officer | | |
| Executive Lead Name: | Suzanne Robinson – Executive Director of Finance, Performance and Digital | Approved by Exec | ☒ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| This paper provides an update on the progress made since the Trust Board's approval of the Lorenzo Digital Exemplar Business Case in June 2018.<br><br>The Lorenzo Digital Exemplar (LDE) is a digital initiative for and co designed with Children and Young People (CYP) within the service. It is an online portal which brings together information for clinicians, carers, schools and community services; fully integrating with our Electronic Patient Record (Lorenzo). | Approval | ☐ |
| | Information | ☒ |
| | Discussion | ☐ |
| | Assurance | ☐ |

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

North Staffordshire Combined Healthcare NHS Trust

# Public Trust Board
# Lorenzo Digital Exemplar Update
# 22nd November 2018

## 1. Introduction

This paper provides an update on the progress made since the Trust Board's approval of the Lorenzo Digital Exemplar Business Case in June 2018.

The Lorenzo Digital Exemplar (LDE) is a digital initiative for and co designed with Children and Young People (CYP) within the service. It is an online portal which brings together information for clinicians, carers, schools and community services; fully integrating with our Electronic Patient Record (Lorenzo).

## 2. Progress

**Approval of Funding**

Following approval of the business case at Trust Board this was submitted to NHS Digital for final approval and release of the funding.

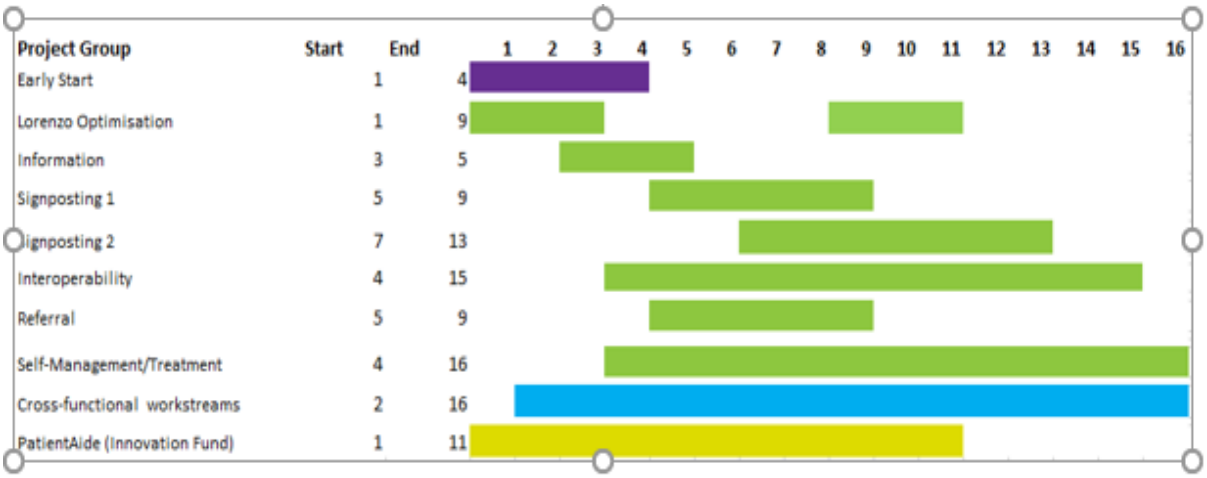
| | Approved NHSD £m |
|---|---|
| NHSD (via DXC) | 1.87 |
| Trust | 0.84 |
| Total | 2.71 |

The Trust received approval for the project from NHS Digital on the 14th September 2018.

**Scope and Timelines**

Funding was agreed for an early start of the LDE project and the Trust commenced the implementation on the 1st October 2018 (month 1 on the planned timetable). There are 8 key workstreams over a period of sixteen months concluding in September 2019.

| | Workstream | Action |
|---|---|---|
| 1 | Early Start | Early Start to initiate and fully scope project |
| 2 | Optimisation | Two phases of Lorenzo Optimisation one to make tactical improvements and a second to optimise end to end |
| 3 | Information | Information to create the Directory of service clients will use to access their Mental Health 'options' |
| 4 | Signposting | Two phases of signposting to configure and build rules in 'Open Health Connect' to enable referrals from the Directory of Service interface with Lorenzo and build information store of Directory of Service activity referral and treatment outcomes |
| 5 | Signposting | |
| 6 | Interoperability | Developing interoperability between existing and developed systems |
| 7 | Referral | Referrals submitted from the Directory of Service live |
| 8 | Self-management | Developing the self-management/treatment function |
| 9 | Cross-functional | Supporting activities across workstreams |
| 10 | PatientAide | PatientAide implementation under the Innovation fund |




**Implementation progress**

Since the official go live date the progress is moving at pace with the following key actions;

- The Change Control Notice and Memorandum of Understanding has now been signed and submitted to NHS Digital for formal commencement of the project.
- DXC have been linking with the CAMHS hub to develop the Target Operating Model and are at the refinement and progression stage of the development of the future state processes.
- The Trust and DXC have started the development of the decision support to the sign-posting process and are agreeing that the final decision as to where the sign-post someone lies with a clinician.
- Initial work has been undertaken with the Clinical Systems team around opportunities for the optimisation of the Trusts Lorenzo system including areas such as:
  - Clinic optimisation and reconfiguration
  - Clinical charting to display information in a more user-friendly format
  - Clinical observations to present information in a graphical format e.g. height / weight graphs
  - Links to quick reference guides from within the system and Inclusion of prompts within the system to provide advice to users regarding processes

**Risks**

| Risk | Risk articulation | Score | Mitigation |
|---|---|---|---|
| Funding | It is assumed that the costs for PatientAide will be funded through the innovation fund and will be available for the target 'go live' date. | 10 | A review of the innovation projects placed this development at the top of the list which has been agreed at the Lorenzo User Group. Confirmation expected December 2018 |
| Deliverability | Change management programme is not successful and clinical staff do not adopt new ways of working | 9 | Business change planning and delivery group that are overseeing the group. Leadership and project management from DXC and the Trust. Lead roles are currently under discussion with the Director of Operations. |
| Deliverability | The solution doesn't meet the needs of the target audience and does not have the required outcomes | 6 | The project has been co-produced with the directorate and CTP council. Expertise deployed from DXC. Clear delivery plan and milestones. |
| Deliverability | Insufficient Trust resources to | 8 | Lead roles are currently under discussion |

| | | | |
|---|---|---|---|
| | support the implementation phase | | with the Director of Operations. Funding agreed over 10 year period. |

**Next steps**

- Appointment of a business change lead and clinical lead from the Trust.
- Approval of the future state processes
- Commencement of the development of the information portal
- Continued optimisation of the Lorenzo EPR
- Expansion of engagement workshop and activities to include the wider CAMHs teams.

## 3. Recommendation

The Trust Board are asked to receive this paper for information.

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# REPORT TO OPEN TRUST BOARD

Enclosure No:8

| | | | |
|---|---|---|---|
| Date of Meeting: | 22nd November 2018 | | |
| Title of Report: | September 2018 Monthly Safer Staffing Report | | |
| Presented by: | Maria Nelligan, Executive Director of Nursing & Quality | | |
| Author: | Alastair Forrester, Head of Nursing & Professional Practice | | |
| Executive Lead Name: | Maria Nelligan, Executive Director of Nursing & Quality | Approved by Exec | ☒ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during September 2018 in line with the National Quality Board requirements. The performance relating to fill rate (actual numbers of staff deployed vs numbers planned) during September 2018 was 75% for registered staff and 103% for care staff on day shifts and 82% and 109% respectively on night shifts. Overall a 93% fill rate was achieved. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover and Ward manager supporting clinical duties. The data reflects that Ward Managers are staffing their wards to meet increasing patient needs as necessary. | Approval | ☐ |
| | Information | ☒ |
| | Discussion | ☐ |
| | Assurance | ☒ |

| | | | |
|---|---|---|---|
| Seen at: | SLT ☒ Execs ☐<br>Date: 13th November 2018 | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☒<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Digital by Choice Board ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement.☐<br>2. To provide the highest quality services ☒<br>3. Create a learning culture to continually improve.☐<br>4. Encourage, inspire and implement research & innovation at all levels.☐<br>5. Maximise and use our resources intelligently and efficiently.☒<br>6. Attract and inspire the best people to work here.☒<br>7. Continually improve our partnership working. ☐ | | |
| Risk / legal implications:<br>Risk Register Reference | Delivery of safe nurse staffing levels is a key requirement to ensuring that the Trust complies with National Quality Board standards. | | |
| Resource Implications:<br>Funding Source: | Temporary staffing costs.<br>Budgeted establishment and temporary staffing spend. | | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | None | | |
| STP Alignment / Implications: | None | | |
| Recommendations: | To receive the report for assurance and information | | |

| Version | Name/Group | Date |
|---|---|---|
| 1 | SLT | 13th Nov 2018 |
| 2 | Trust Board | 22nd Nov 2018 |

## 1 Introduction

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

## 2 Background

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

In addition to the monthly reporting requirements the Executive Director of Nursing & Quality is required to review ward staffing on a 6 monthly basis and report the outcome of the review to the Trust Board of Directors. A comprehensive annual report for 2017 was presented to April 2018 Board and the recommendations agreed. These are being progressed through the Safer Staffing Group.

## 3 Trust Performance

During September 2018 the Trust achieved a staffing fill rate of 75% for registered staff and 103% for care staff on day shifts and 82% and 109% respectively on night shifts. Taking skill mix adjustments into account an overall fill-rate of 93% fill was achieved. Where 100% fill rate was not achieved, staffing safety was maintained on in-patient wards by nurses working additional unplanned hours, cross cover, Ward Managers (WMs) and the multi-disciplinary team (MDT) supporting clinical duties and the prioritising of direct and non-direct care activities. Established, planned (clinically required) and actual hours alongside details of vacancies, bed occupancy and actions taken to maintain safer staffing are provided in Appendix 1. A summary from WMs of issues, patient safety, patient experience, staff experience and mitigating actions is set out below.

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

## 4 Care Hours per Patient Day (CHPPD)

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

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

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

## 5 Impact

WMs report the impact of unfilled shifts on a shift by shift basis. Staffing issues contributing to fill rates are summarised in Appendix 2. The report will be reviewed and summarised going forward on a quarterly basis.

### 5.1 Impact on Patient Safety

There were 2 incidents reported during September 2018 relating to ward nurse staffing issues that had a potential impact on patient safety as detailed in the table below. **There was no harm to patients reported for the month of September.**

| Ward | Incident |
|---|---|
| Ward 2 | One incident where observation levels were increased to maintain safety resulting in reduced staffing level within main ward area. |
| Ward 5 | One incident where it was challenging to maintain increased levels of observations for a period of approximately 1 hour. These were covered initially by the Site Manager and then through redeployment from other wards. |

### 5.2 Impact on Patient Experience

Staff prioritise patient experience and direct patient care. There was no impact on patient experience or direct patient care during September 2018 as a result of nurse staffing levels.

### 5.3 Impact on Staff Experience

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

- 134 staff breaks were cancelled (equivalent to approximately 2.9% of breaks).
- 6 supervisions, PDRs and mandatory training sessions were cancelled.

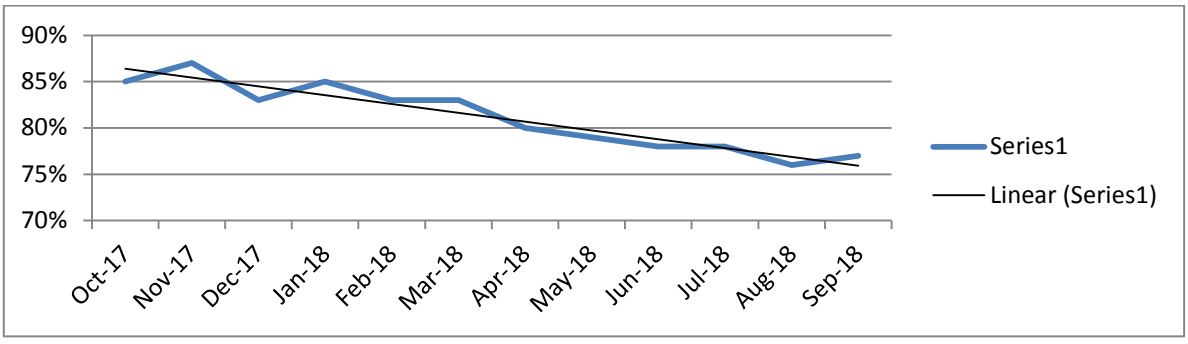
Any time accrued due to missed breaks is taken back with agreement of the Ward Manager.

### 5.4 Mitigating Actions

Ward Managers and members of the multi-disciplinary team have clinically supported day shifts to ensure safe patient care. Skill mix has been altered to backfill shortfalls. For example a total of 475 RN shifts were covered by HCSW where RN temporary staffing was unavailable. A total of 86 HCSW shifts were covered by RN staff where HCSW temporary staffing was unavailable. Additionally, as outlined in section 5.3, staff breaks have been shortened or not taken (time is given in lieu) and wards have cross covered to support safe staffing levels.

### 5.5 RN Staffing Recruitment

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




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

Health Education England has recently identified funding to support Trusts with Return to Practice campaigns. These campaigns target former registered nurses who have

left practice and allowed their nurse registration to lapse by providing academic and placement support to enable them to re-register with the NMC. The Head of Nursing & Professional Practice is working with the Trust Recruitment Lead and local Health Education Institutes to progress this campaign.

The Board will be aware that 29 newly qualified nurses have commenced with the Trust in October 2018. They are being supported by a robust preceptorship programme; this programme has been refined and strengthened annually since 2016 and, with the exception of one nurse, all newly qualified RNs have been retained in the Trust in the past 2 years.

The nursing career pathway has been strengthened and 4 Trainee Nursing Associates and 2 Trainee Advanced Nurse Practitioners commenced their training in September 2019. These are academic programmes which run alongside significant work based and placement learning. The education programme to support CPD and career progression for all RNs is also being strengthened. Additionally, a potential increase in Band 6 RNs is being considered as part of the Safer Staffing Mid-Year Review, currently being undertaken.

## 6. Summary

Safe staffing reporting indicated challenges in staffing wards during September 2018. Over the past 2 years a significant number of RN vacancies have been filled by newly qualified RNs; a further 29 newly qualified nurses joined the Trust in October 2018. The Trust continues to employ alternate strategies with the support of the HR and communication teams to attract RNs during this national shortage.

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

## 7. Recommendations

The Trust Board is asked to:

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

## Appendix 1 September 2018 Safer Staffing

| Sep-18 | Day | | | | Night | | | | DAY | | NIGHT | | CHPPD | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Registered Nurses | | Care Staff | | Registered Nurses | | Care Staff | | | | | | | | | | | | | | | | |
| Ward name | Clinically required Hours | Total monthly actual hours | Clinically required | Total monthly actual hours | Clinically required | Total monthly actual hours | Clinically required | Total monthly actual staff hours | Average fill rate - registered nurses (%) | Average fill rate - care staff (%) | Average fill rate - registered nurses (%) | Average fill rate - care staff (%) | Total Actual Hours PD | Cumulative Count over the month of Patients @ 23:59 | Care Hours Per Patient Day | RN Fill rate | HCSW Fill rate | Overall fill rate | Safe Staffing Maintained by | RN Vacancies | HCSW Vacancies | Bed Occupancy | Movement |
| Ward 1 | 1365.00 | 1059.94 | 1260.00 | 1669.99 | 666.00 | 347.43 | 732.60 | 1151.05 | 78% | 133% | 52% | 157% | 4228.41 | 384.00 | 11.01 | 69% | 142% | 105% | Nurses working additional unplanned hours, support of MDT and altering skill mix. | 6.40 | -5.59 | 91% | ↑ |
| Ward 2 | 1365.00 | 851.73 | 1620.00 | 1772.96 | 666.00 | 379.20 | 999.00 | 1212.00 | 62% | 109% | 57% | 121% | 4215.89 | 628.00 | 6.71 | 61% | 114% | 91% | Nurses working additional unplanned hours and altering skill mix. | 6.00 | 1.21 | 87% | ↑ |
| Ward 3 | 1365.00 | 1329.70 | 1215.00 | 1200.03 | 666.00 | 466.80 | 666.00 | 900.35 | 97% | 99% | 70% | 135% | 3896.88 | 517.00 | 7.54 | 88% | 112% | 100% | Nurses working additional unplanned hours, cancelling non-clinical activity and altering skill mix. | 0.60 | 2.07 | 82% | ↓ |
| Ward 4 | 1365.00 | 881.50 | 1215.00 | 1571.17 | 333.00 | 366.30 | 999.00 | 970.65 | 65% | 129% | 110% | 97% | 3789.62 | 435.00 | 8.71 | 73% | 115% | 97% | Nurses working additional unplanned hours, support of MDT and altering skill mix. | 6.20 | 0.00 | 97% | ↑ |
| Ward 5 | 1500.00 | 865.13 | 2010.00 | 1967.29 | 333.00 | 369.30 | 1332.00 | 1348.20 | 58% | 98% | 111% | 101% | 4549.92 | 391.00 | 11.64 | 67% | 99% | 88% | Nurses working additional unplanned hours, cancelling patient activity, support of MDT and altering skill mix. | 1.50 | -0.40 | 99% | ↑ |
| Ward 6 | 1365.00 | 947.27 | 1667.25 | 1885.38 | 333.00 | 349.87 | 1409.70 | 1397.20 | 69% | 113% | 105% | 99% | 4579.72 | 413.00 | 11.09 | 76% | 107% | 96% | Nurses working additional unplanned hours, support of MDT and altering skill mix. | 1.30 | 1.35 | 98% | ↑ |
| Ward 7 | 1365.00 | 853.98 | 1215.00 | 1471.00 | 333.00 | 355.20 | 999.00 | 927.45 | 63% | 121% | 107% | 93% | 3607.63 | 559.00 | 6.45 | 71% | 108% | 92% | Nurses working additional unplanned hours, support of MDT and altering skill mix. | 2.80 | 0.00 | 96% | ↓ |
| A&T | 960.00 | 882.96 | 2047.50 | 1680.07 | 666.00 | 421.80 | 999.00 | 1243.20 | 92% | 82% | 63% | 124% | 4228.03 | 150.00 | 28.19 | 80% | 96% | 90% | Nurses working additional unplanned hours, support of MDT and altering skill mix | 4.23 | 3.08 | 83% | ↔ |
| Darwin Centre | 960.00 | 982.91 | 1383.75 | 1381.90 | 333.00 | 333.00 | 699.30 | 683.20 | 102% | 100% | 100% | 98% | 3381.01 | 255.00 | 13.26 | 102% | 99% | 100% | Nurses working additional unplanned hours and altering skill mix. | 3.10 | 0.82 | 90% | ↓ |
| Edward Myers | 960.00 | 747.58 | 810.00 | 726.04 | 333.00 | 322.90 | 666.00 | 664.50 | 78% | 90% | 97% | 100% | 2461.02 | 323.00 | 7.62 | 83% | 94% | 89% | Nurses working additional unplanned hours and altering skill mix. | 3.30 | 0.20 | 67% | ↓ |
| Florence House | 605.00 | 498.07 | 900.00 | 642.00 | 321.60 | 333.07 | 321.60 | 321.60 | 82% | 71% | 104% | 100% | 1794.74 | 170.00 | 10.56 | 90% | 79% | 84% | Nurses working additional unplanned hours and altering skill mix. | 0.04 | 0.20 | 94% | ↓ |
| Summers View | 900.00 | 619.75 | 900.00 | 803.00 | 321.60 | 312.38 | 643.20 | 596.57 | 69% | 89% | 97% | 93% | 2331.7 | 294.00 | 7.93 | 76% | 91% | 84% | Nurses working additional unplanned hours and altering skill mix. | 2.36 | 0.80 | 100% | ↑ |
| Trust total | 14075 | 10521 | 16244 | 16771 | 5305 | 4357 | 10466 | 11416 | 75% | 103% | 82% | 109% | 43065 | 4519 | 9.53 | 77% | 106% | 93% | | 37.83 | 3.74 | | |

## Appendix 2 Staffing Issues

- At the end of September 2018, including PICU, there were 39.63 WTE RN vacancies in in-patients (this included 1.80wte RN vacancies at PICU). This is a reduction from August 2018 of 0.37 WTE vacancies. A significant decrease will be seen in October reporting as the newly qualified nurses have taken up post; the majority of these posts have been within in-patient areas. We continue to advertise for the remainder of the vacancies in a variety of part and whole time roles.

- At the end of September 2018, there were 3.74 WTE HCSW vacancies reported within in-patient wards. This is a reduction from August 2018 of 2.33 WTE. We are continuing to recruit to these vacancies.

- Ward teams are supported by Quality Improvement Lead Nurses, Nurse Practitioners and a Site Manager who are further supported by an on-call manager out of hours.

- RN night shift cover remained challenging during September 2018. This is a result of increasing night cover to 2 RNs on the acute wards (1, 2 and 3) however the number of vacancies on these wards has made this challenging to achieve. Staffing numbers have been maintained through the use of HCSW's.

- Occupancy has continued to increase on NOAP wards during September and this has also contributed to shortfalls, in the fill rate.

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# REPORT TO OPEN TRUST BOARD

Enclosure No:9

| | | | |
|---|---|---|---|
| Date of Meeting: | 22 November 2018 | | |
| Title of Report: | Safer Staffing Mid-Year Review 2018 (Jan-June 2018) | | |
| Presented by: | Maria Nelligan, Executive Director of Nursing & Quality | | |
| Author: | Julie Anne Murray, Deputy Director of Nursing, AHP & Quality | | |
| Executive Lead Name: | Maria Nelligan, Executive Director of Nursing & Quality | Approved by Exec | ☒ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| This Safer Staffing (SS) Mid-Year Review is a follow up from the 2017 SS Annual Report and a requirement of the NQB SS Guidance (2016). This review focuses on the progressions of workforce plans and has identified continued and sustained acuity, dependency and demand on Ward 6. | Approval | ☒ |
| | Information | ☐ |
| | Discussion | ☒ |
| | Assurance | ☐ |
| Seen at: SLT ☒ Execs ☐ Date: 13TH November 2018 | Document Version No. | |
| Committee Approval / Review | • Quality Committee x☐<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☒<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Primary Care Integration Programme Board ☐ | |
| Strategic Objectives (please indicate) | 1. To enhance service user and carer involvement.☐<br>2. To provide the highest quality services ☐<br>3. Create a learning culture to continually improve.☐<br>4. Encourage, inspire and implement research & innovation at all levels.☐<br>5. Maximise and use our resources intelligently and efficiently.☐<br>6. Attract and inspire the best people to work here.☐<br>7. Continually improve our partnership working. ☐ | |
| Risk / legal implications: Risk Register Reference | There is a risk to patient care and experience if safer staffing levels are not maintained. | |
| Resource Implications:<br><br>Funding Source: | Due to the change in shift patterns and opening of PICU, it was approved that the safe staffing budgeted establishments would be met within current resources. This had not yet been transacted as PICU is not due to open until 29 Oct 2018. In addition it has been identified that ward 6 require a further uplift and this will be discussed with commissioners. | |
| Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | None identified. | |
| STP Alignment / Implications: | Nil | |
| Recommendations: | Trust Board are asked to approve the recommendations which will be taken | |

| | forward by the Safer Staffing Group. | |
|---|---|---|
| Version | Name/group | Date issued |
| 1 | Maria Nelligan | 07 November 2018 |
| | SLT | 13 November 2018 |
| | | |
| | | |

## 1. Introduction

This report details the findings from the Mid-Year Safer Staffing review which follows on from the 2017 Annual Safer Staffing review, the recommendations from which the Board approved in April 2018.

This report was commissioned and overseen by the Executive Director of Nursing & Quality and undertaken in July 2018 in line with NHS England and National Quality Board (NQB) requirements.

### 1.1 Background

Since 2014 all Trusts have been required to undertake comprehensive staffing reviews and report to Board on Safer Staffing. Trusts are required to submit monthly safer staffing reports to NHS Digital (previously UNIFY). Trusts are also required to undertake a comprehensive annual safe staffing review (agreed by Trust Board in April 2018), followed by a six-monthly mid-year safe staffing review to ensure workforce plans are still appropriate.

In 2016 the National Quality Board (NQB) published updated guidance *'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable and productive staffing'.* This provides a set of expectations for nurse staffing; and an expectation that Trusts' measure and improve patient outcomes, people productivity and financial sustainability. This includes implementation of the Carter report (2016) recommendation of a new metric care hours per patient day (CHPPD) as the first step in developing a single consistent way of recording and reporting staff deployments. From April 2018 monthly reporting of CHPPD to NHS Improvement (NHSI) for mental health trusts commenced.

The National Quality Board (January 2018) recently published its first edition *'Safe, sustainable and productive staffing: An improvement resource for mental health'*. This improvement resource makes specific reference to adopting these expectations in mental health services. The annual safer staffing review undertaken in January 2018 met the requirements of this publication.

In October 2018 NHSI published *'Developing workforce safeguards: Supporting providers to deliver high quality care through safe and effective staffing'.* This strengthens requirements relating to governance and accountability in relation to Safer Staffing. Both this NHSI report and the NQB Mental health resource (2018) will inform safer staffing practice and reviews moving forward.

## 2. Progress with Workforce Plans since last SS Board report

The 2017 Safer Staffing Annual Report was presented to Trust Board in April 2018 when the proposed alterations to establishments, funded by the change in shift patterns were agreed. Due to the funding of this alteration also being dependant on the opening of PICU and Ward 5 moving to a mixed shift pattern (in line with the rest of the Trust) it was agreed that the proposed change to establishments would be implemented on the completion of both these initiatives. In the meantime wards continue to staff to recommended staffing levels utilising temporary staffing to meet shortfalls.

The transacted alteration in establishments has been completed in = November 2018 as the PICU opened at the end of October 2018.

In line with other wards Ward 5 staff have moved to the mixed shift pattern.

**4. Workforce plans**

The NQB requirement for the Mid-Year SS review is to ensure workforce plans are still appropriate following on from the previous Annual SS review (NQB, 2016). This Mid-Year review examined the workforce plans identified and agreed within the 2017 Annual Review including staffing level adjustments and development of new roles.

**4.1 Safer staffing levels**

The 2017 Annual SS review recommended a number of alterations to Ward staffing levels and these were agreed by Board in April 2018. It was identified within the Annual Review that the alterations could be funded by the move to a mixed shift pattern which occurred in January 2018. The table below outlines the proposed alterations and comments on their continued appropriateness at Month 7.

| **2017 Annual Review recommendations agreed by the board April 2018** | | **Still appropriate?** |
|---|---|---|
| Ward 1 | Once Ward 1 has transitioned to a general acute AMH ward it is recommended that the daily staffing numbers are reduced from 6-6-4 to 5-5-3.<br>Completed November 2018. | Yes |
| Ward 2 | Due to the workload related to the temporary Place of Safety HCSW staffing should be increased from 3 to 4 on days and from 2 to 3 at nights; this would give staffing of 7/7/5.<br>Completed November 2018. | Yes |
| Ward 5 | A shortfall in staffing establishment in relation to safer | Yes |

| | | |
|---|---|---|
| | staffing had been identified for Ward 5 in previous reviews. This continues to be the case and therefore the staffing on ward 5 is recommended to be uplifted to 6-6-4.<br>Completed November 2018. | |
| Ward 6 | Due to a sustained increase in acuity, dependency and bed occupancy an increase in staffing establishment of 6-6-4 plus a twilight.<br>Completed November 2018 (see below for updated recommendation). | Yes* |
| Ward 7 | Due to a sustained increase in acuity, dependency and bed occupancy an increase in staffing establishment of 6-6-4.<br>Completed November 2018. | Yes |
| Darwin | Due to a sustained increase in acuity, dependency and bed occupancy an increase in staffing establishment of 6-6-4.<br>Completed November 2018. | Yes |
| Summers View | Previous staffing reviews identified a short-fall in headroom on Summers View. Due to this, the current budgeted establishment allows for staffing of 3-3-3 however the centre requires 4-4-3.<br>Completed November 2018. | Yes |

*further increase required

This Mid-Year SS review identified that Ward 6 has required a sustained increase in staffing, above the previously recommended safer staffing levels, for the past 10 months (since December 2017, appendix 1). This means that the ward has required a minimum of 1 extra member of staff on every shift during this time. Therefore a deep-dive into Ward 6 was undertaken with the Modern Matron and Ward Manager (appendix 2).

This identified that the acuity and dependency on Ward 6 has continued to increase requiring the staffing levels to also increase. Initially this increase in staffing was based on professional judgement however Ward 6 have been using SafeCare, linked to the evidence based Hurst Tool, since January 2018 and this confirms that a minimum of 1 extra member of staff has consistently been required throughout this time (further information relating to SafeCare can be found in section 6).

Additionally it was highlighted that there are challenges with discharging people from the ward to appropriate placements; currently there are 2 people awaiting placements that can support their complex needs. People with this level of complexity are often on long term enhanced observations of at least 1:1. The placements that people with this level of complex need are moving to often require

additional funding resource to meet the person's needs. In the interim, whilst the person remains on Ward 6, the Trust is funding the additional staffing needs.

**It is recommended that Ward 6 staffing baseline is increased by an additional HCSW each shift to overall staffing levels of 7/7/5. It is also recommended that the Director of Nursing & Quality, Medical Director and Director of Finance raise this through 2019-20 Contract Negotiations and through CQRM.**

### 4.2 New roles

#### 4.2.1 Nursing associate role

This role will support the Trust in 'growing our own' workforce by supporting committed non-registered staff to develop within the organisation. This promotes career development and alliance with the organisation. In line with the 2017 SS Annual Report 4 Trainee Nursing Associates (TNAs) commenced their training in September 2018 and will be due to complete the programme in 24 months. There is the potential for a further cohort of TNAs in March 2019 and this is being explored as part of the directorate workforce transformation planning.

#### 4.2.2 Advanced Nurse Practitioner

The 2017 SS Annual Report also recommended the development of Advanced Nurse Practitioners within workforce plans. A further 2 Trainee Advanced Nurse Practitioners (ANPs) commenced their training within the Trust in September 2018. This is in addition to the 4 Trainee ANPs already in training; all of the current Trainee ANP posts are within community services. From 2019 it is expected that the Advanced Clinical Practice Masters Degree, a prerequisite for qualified ANPs, will be available through an apprenticeship route. This will give the Trust the opportunity to consider increasing the number of ANPs and also Advanced Clinical Practice within Allied Health Professions.

The 2017 SS Annual Report recommended that an ANP post specialising in Eating Disorders (ED) was recruited to Darwin. The directorate considered this recommendation and it was agreed that an ANP was needed within the structure but that focus should be broader than Eating Disorders. The Directorate have attempted to recruit to this post and are currently reconsidering the role with the support of the DoN.

It was also recommended that workforce plans for in-patient wards should include the development of trainee advanced clinical practitioners through the apprenticeship framework to strengthen the MDT and succession plan. This is being taken forward by the directorates within their workforce transformation plans.

#### 4.2.3 Band 2 Apprenticeships

It was also recommended that Band 2 apprenticeship roles were developed within in-patient wards. This would ensure that the nursing career pathway had the potential to start at entry level into care work and provide education and development to a level where non-registered staff are in a position to apply for trainee nursing associate or pre-registration nurse training. The new directorates are taking this forward within their transformation planning, supported by the Head of Nursing & Professional Practice.

### 4.2.4 Activity Workers across 7 days

To improve patient care and experience, in relation to meaningful engagement, it was recommended that Activity Worker cover was extended across 7 days. Progress is as follows:

- Older Peoples wards have implemented this
- LD in-patients are on a minimum of 1:1 staffing therefore it was agreed that additional activity worker support was not required at weekends
- Within Darwin unit there is normally a significant portion of young people who have weekend leave and therefore additional activity support can be absorbed within the existing staff team.
- The acute mental health wards are reviewing their existing non-registered establishment to identify how a structured activity programme can be delivered across 7 days.

## 5. Extending Safer Staffing to Community

The NQB required trusts to extend safer staffing reviews to community services. The Trust has taken a phased approach to this with Access and Home Treatment being included within the 2017 annual review and Mental Health Liaison being included in this Mid-Year SS review. The Deputy Director of Nursing met with the Team Manager and Modern Matron to undertake the review and there are no alterations recommended to the Mental Health Liaison team staffing at this time; details of the review meeting are included in appendix 3.

Following on from the 2017 Annual Review it has been noted that Access and Home Treatment Team staffing is currently challenging. These challenges followed on from the extension of Home Treatment to a 24/7 from February 2018. This was to support the wider health and social care economy as part of the system wide winter planning. The staffing of the team is being considered as part of the Urgent Care Pathway work and the functions of the team in relation to service specifications are being considered as part of the remodelling.

The reviews of the wider community teams staffing will be incorporated into the new directorates transformation planning. This will include care pathways, multi-disciplinary working, care management and the teams required to support this. The Director of Nursing & Quality will lead this in conjunction with the Director of Operations.

**6. SafeCare implementation**

The SafeCare module of Healthroster has been implemented during 2018. This module enables the accurate measurement of 'real time' safe staffing across in-patient areas using the Keith Hurst 'National Mental Health Safe Staffing Framework' (2015). The 'Safecare' platform extracts information from the Healthroster system and combines this with patient acuity data which is entered three times a day by the nurse in charge of each ward. The system then calculates whether the ward is safely staffed. Data collected from the system over an extended period can also be used to provide a longer term accurate picture of safe staffing levels across different ward types, using the nationally recognised Keith Hurst modelling tool in the Mental Health Safe Staffing Framework (2015).

It is this tool that has been triangulated with professional judgement to inform the recommendation in relation to Ward 6 staffing levels being increased by an additional HCSW per shift.

**8. Finance**

The recommended alterations to establishments, made within the 2017 Annual Safer Staffing Report and agreed by Board in April 2018, have been transacted in November 2018.

The 2018 pay award and latest data in relation to proportion of staff opting for the mixed shift pattern have been taken into account and this enables the transaction to be completed with a minimal shortfall of £12k identified. This is in-line with what was identified within the 2017 Safer Staffing Annual report and approved by the Board, when it was agreed that this minimal short-fall would be funded; this will be addressed by finance.

**9. Conclusion**

Due to the current national shortage of registered nurses and the increasing dependency and acuity of service users it has continued to be challenging to maintain safe staffing levels during 2018.

This Mid-Year SS review focussed upon the workforce plans identified within the 2017 Annual Safer Staffing Review including the progress of Ward 5 moving to a

mixed shift pattern and the planned opening of PICU in October 2018. Both of these initiatives were needed to allow the changes in ward establishments to be transacted; these transactions will be completed in November 2018.

New roles have been developed with 4 Trainee Nursing Associates and a further 2 Trainee Advanced Nurse Practitioners commencing their training in September 2018.

The review continued the extension of SS reviews into the community and covered the Mental Health Liaison Team. It was also noted that the Access and Home Treatment (HT) Team staffing has been challenging since the introduction of 24/7 HT from February 2018 to support the local health and social care economy.

The review also identified the sustained increase in acuity, dependency and occupancy in Ward 6 and recommends additional staffing of 1 non-registered member of staff per

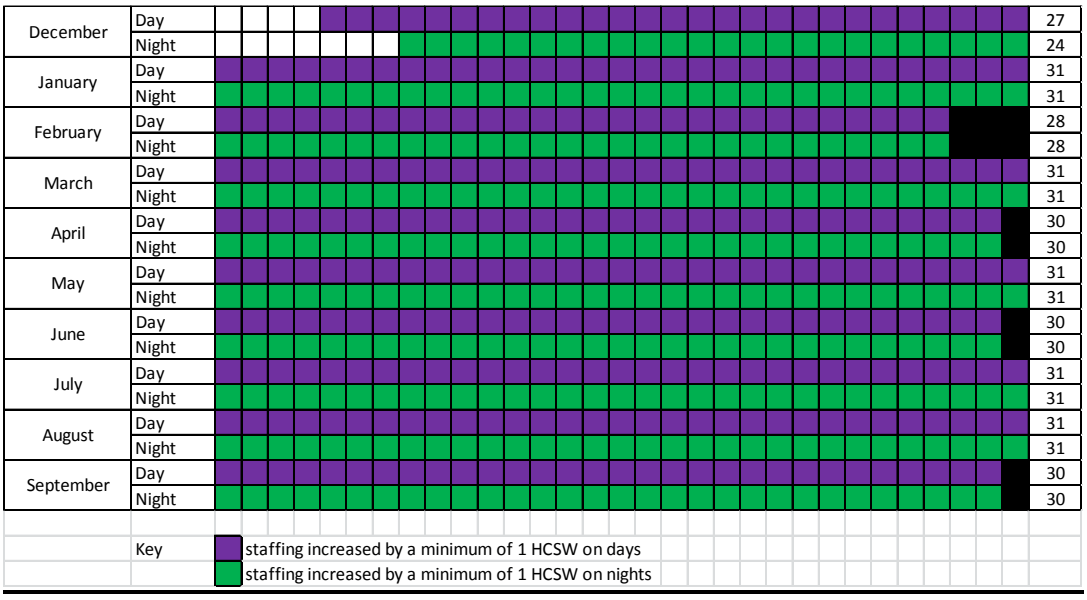
## 10. Recommendations

The Board is asked to:

- Note the progress in implementing safer staffing recommendations
- Approve the recommendations to
    - o increasing Ward 6 staffing and liaising with commissioners regarding sustained increase in occupancy, acuity and dependency
    - o maintaining Mental Health Liaison staffing at its current level

## 11. Appendices

### 11.1 Appendix 1 Ward 6 Elevated Staffing December 2017-September 2018



## 11.2 Appendix 2 Ward 6 Mid-year Safer Staffing Review

- The team are multi-disciplinary including nursing, medic, OT, physio, psychology, activity workers and assistant practitioner (discharge coordination) and Trainee Nursing Associate. Additionally there is administrative support within the team.
- RN cover is challenging with staff turnover; currently 2 Band 6 vacancies and 1 Band 5 and there are also 3 RNs on maternity leave. These are in the recruitment process and block booked agency is being used to backfill one post. One RN has also been redeployed from Ward 7 to support the maternity backfill.
- Seven day activity programme is delivered by the activity workers
- The ward has had occupancy of 90% (January-June 2018); this is above the 85% occupancy recommended by the Royal College of Psychiatrists
- The team were recently awarded AIMS accreditation and an overall rating of 'Good' from the 2017 CQC visit
- It is planned to further enhance the environment to be increasingly dementia friendly; the proposal includes Rempod designs for 2 rooms and increasing the size of the clinic room. The Ward Manager has submitted the proposed alterations to Serco for costing however the response to this has been delayed due to the change from Carillion.
- Mandatory training and supervision compliance is challenging due to the on-going and sustained increase in acuity and dependency as the patient needs are prioritised however the team have achieved 94% compliance with Mandatory Training and 92% compliance with supervision in September 2018
- The ward team moved to a mixed shift pattern in January 2018 with staff expressing their individual preferences. This is working well and will be reviewed in January 2019.
- There are challenges with discharging people from the ward to appropriate placements; currently there are 2 people awaiting placements that can manage their individual complexities. People with this level of complex needs are often on enhanced observations of at least 1:1 for the long-term. The placements that people are moving to are often expensive and require additional funding resource to meet the person's needs. In the interim the Trust is funding the additional staffing needs whilst the person remains on Ward 6.
- The sustained increase in occupancy, coupled with increased acuity and dependency, means that the Ward has required a minimum of one additional HCSW per shift (days and nights) since December 2017. Prior to this there were extended periods where this was the case from April to November 2017 (e-rostering implemented in April 2017 has enabled this to be tracked).

## 11.3 Appendix 3 Narrative from the Mental Health Liaison Safer Staffing Review

- The team were multi-disciplinary including nursing, medic, social work and psychology; a part-time OT post has been developed and is currently out to recruitment. Additionally there is administrative support within the team.
- There are sufficient staff to meet the roster demands
    - (4/4/2) for the UHNM element including a Band 6 registered practitioner on every shift
    - In the past 12 months the team have included CAMHS cover and following a period of training and development all practitioners are now competent in assessing young people
    - The team provide Older Peoples Community Hospital (Bradwell and Haywood) in-reach 9-5 Mon-Fri
- The team are part of the regional RAID network and utilise this to benchmark and share best practice; the team have also registered with the Royal College of Psychiatrists to go through the PLAN accreditation (Psychiatric Liaison Accreditation Network)
- The team provide training to UHNM staff to promote a better understanding of MH and parity of esteem
- Supervision and reflective practice are embedded within the team with a cascade model of supervision; supervision compliance is currently 87%
- The majority of the team are based in UHNM; following improvements made to the environment in 2017 the current team base is appropriate for their needs
- There are currently a small cohort of bank workers who provide bank cover for the team; the team are working with the Temporary Staffing Service to strengthen this by increasing the number available whilst balancing this with maintaining competence
- A competency based framework has been developed to ensure that team members are competent within their role; this is being rolled out from October 2018
- Shift patterns have recently been altered, with the agreement of the team, to meet the current needs of the service
- The team are clear on escalation processes and use appropriately
- Waiting time targets are consistently met with current compliance of 97.3% for A&E (1hr), 100% for FAEU/portals/urgent wards (4hrs) and 92% for all other referrals (24hrs).
- New roles have been introduced to strengthen the MDT with both a Trainee Nursing Associate and Trainee Advanced Nurse Practitioner commencing in September 2018

## 12. References

House of Commons Health Committee Report. (2018). The Nursing Workforce. https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/353/353.pdf

National Quality Board. (2013). How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing, midwifery and care staffing capacity and capability. NHS England.

National Quality Board. (2016). Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time. NHS England.

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# REPORT TO TRUST BOARD

Enclosure No:10

| | | | |
|---|---|---|---|
| Date of Meeting: | 22 November 2018 | | |
| Title of Report: | Q2 Serious Incident report | | |
| Presented by: | Dr Buki Adeyemo, Medical Director | | |
| Author: | Jackie Wilshaw. Head of Patient and Organisational Safety | | |
| Executive Lead Name: | Dr Buki Adeyemo, Medical Director | Approved by Exec | ☐ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| This report provides the Trust with information relating to the nature and status of SI's currently open and the trend data for Q1 and Q2 2018/19. The report also includes information regarding themes, learning and change arising from Serious Incident investigations.<br>There are 6 and 12 month updates to completed SI actions plans (Closing the loop) also the quarterly Duty of Candour report is included. | Approval | ☐ |
| | Information | ☐ |
| | Discussion | ☐ |
| | Assurance | ☒ |

| | | | |
|---|---|---|---|
| Seen at: | SLT ☐ Execs ☐<br>Date: | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☐√<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Digital by Choice Board ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement.☐<br>2. To provide the highest quality services ☐√<br>3. Create a learning culture to continually improve.☐√<br>4. Encourage, inspire and implement research & innovation at all levels.☐<br>5. Maximise and use our resources intelligently and efficiently.☐√<br>6. Attract and inspire the best people to work here.☐<br>7. Continually improve our partnership working. ☐ | | |
| Risk / legal implications:<br>Risk Register Reference | nil | | |
| Resource Implications:<br><br>Funding Source: | nil | | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | Consideration of Equality and Inclusion issues is given during the SI investigation processes and the analysis provided in this report. There have been no issues raised with regards to D+I during these processes. | | |
| STP Alignment / Implications: | N/A | | |
| Recommendations: | The Trust continues to monitor all incidents on a weekly basis and this report demonstrates compliance with Trust policies and processes. | | |

| Version | Name/Group | Date Issued |
|---|---|---|
| | CSIG | 15/10/2018 |
| | | |

## 1. Purpose of the report

This report provides assurance to the Quality committee of the Trust processes relating to Serious Incidents (SIs) and Duty of Candour. The report covers the period from 1st July to 30th September 2018 (Quarter 2, 2018/19) and details the following:

- The status of SIs currently open and trend data for Q1 2018/19 and Q2 2018/19.
- Serious Incidents by category reported by quarter.
- Themes, learning and change arising from Serious Incident investigations.
- 6 and 12 month updates to completed SI actions plans (Closing the loop)
- The quarterly Duty of Candour report.

## 2. Serious Incidents Q2

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

Table 1.

| StEIS Incident category | Q1 | Q2 | Q3 | Q4 | Total 2017/18 | Q1 | Q2 | Q3 | Q4 | Total 2018/19 |
|---|---|---|---|---|---|---|---|---|---|---|
| Apparent/actual abuse | 0 | 1 | 2 | 2 | 5 | 2 | 0 | | | 2 |
| Unexpected potentially avoidable injury causing serious harm: this is subdivided as shown below | | | | | | | | | | |
| Apparent/actual/suspected self-harm criteria meeting SI criteria | 1 | 0 | 2 | 2 | 5 | 2 | 2 | | | 4 |
| Slip, trip, fall | 2 | 6 | 3 | 3 | 14 | 1 | 6 | | | 7 |
| Unexpected potentially avoidable injury causing serious harm | 0 | 0 | 0 | 0 | 0 | 3** | 0 | | | 3 |
| Disruptive, aggressive behaviour meeting SI criteria | 0 | 0 | 0 | 0 | 0 | 1 | 1 | | | 2 |
| Unexpected potentially avoidable death: This is subdivided as shown below | | | | | | | | | | |
| Pending review | 4 | 10 | 8 | 11 | 33 | 7 | 14 | | | 21 |
| Apparent/actual/suspected self-harm criteria meeting SI criteria (suspected suicide) | 3 | 6 | 2 | 5 | 16 | 10 | 3 | | | 13 |
| Total | 10 | 23 | 17 | 23 | 73 | 26 | 26 | | | 52 |

During Q2, 26 incidents were reported into StEIS and have undergone or are in the process of undergoing SI investigation.

The tables below shows the incidents reported in Q2 by team and by directorate.

Table 2. Incidents by team

| Team | July 18 | August 18 | September 18 | total |
|---|---|---|---|---|
| Acute Home Treatment | | 1 | | 1 |
| Ashcombe | 1 | | | 1 |
| CDAS | | 1 | 1 | 2 |
| Early Intervention | | | 1 | 1 |
| Greenfield Centre | | 1 | 1 | 2 |
| Mental Health Liaison | 1 | | | 1 |
| One Recovery (Newcastle) | 1 | 2 | | 3 |
| One Recovery (Leek) | 1 | | 2 | 3 |
| One Recovery Burton | | 2 | | 2 |
| Sutherland Centre | | 1 | 1 | 2 |
| Ward 2 | 1 | | 1 | 2 |
| Ward 3 | 1 | | | 1 |
| Ward 4 | 1 | 3 | | 4 |
| Ward 5 | | | 1 | 1 |
| **Grand Total** | **7** | **11** | **8** | **26** |

Table 3. Incidents by directorate

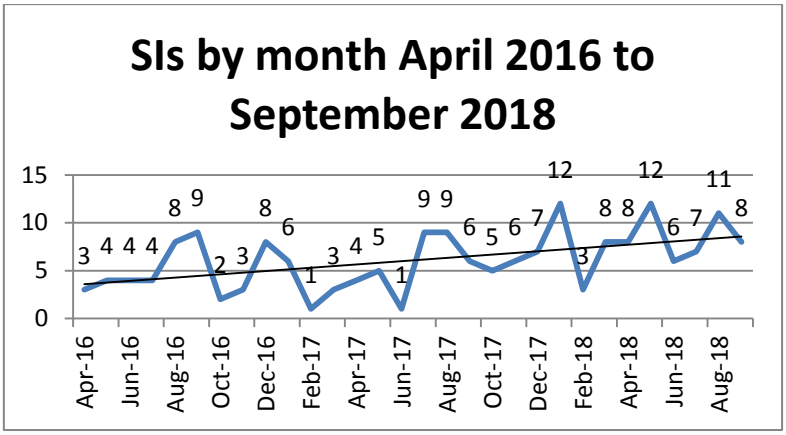
| **Directorate** | **July 18** | **August 18** | **September 18** | **Grand Total** |
|---|---|---|---|---|
| Adult Com | 1 | 3 | 3 | 7 |
| Adult IP | 2 | | 1 | 3 |
| NOAP | 2 | 3 | 1 | 6 |
| Sub Misuse | 2 | 5 | 3 | 10 |
| **Grand Total** | **7** | **11** | **8** | **26** |

The main points to note are:

- There were 7 serious incidents reported for the Adult Community Directorate. There were 6 unexpected, potentially avoidable deaths and 1 incident of serious self-harm. Of the deaths reported, 1 person was known to mental health and substance misuse services; a joint investigation will be undertaken with the Adult Community Directorate taking the lead. There were 10 unexpected, potentially avoidable deaths in the Substance Misuse Directorate.
- In the NOAP Directorate, there were 5 incidents of slip, trip fall (4 of the incidents were on ward 4) and one unexpected death of a person who had been seen by the Mental Health Liaison Team in October 2017.
  There were 3 incidents in the Adult Inpatient Directorate. There was 1 incident involving a fracture following a slip, trip, fall and 1 incident of fracture following a patient on patient assault. There was 1 unexpected death of a male recently discharged from the ward. This person was also known to substance misuse services; however the cause of death has not yet been determined.

### 3. Themes and Trends

The graph below shows the number of Serious Incidents reported monthly from April 2016 to September 2018.




The numbers of slip, trips, falls has increased in Q2 with 6 fractures reported. Of these incidents 4 were fractures sustained on ward 4. The ward has implemented a number of initiatives to reduce falls, however the frail nature of the elderly people on ward 4 means that falls are more likely to result in fractures than falls which occur in other patient cohorts. The total number of unexpected deaths has remained the same in Q2 with 17 deaths reported; however the number of suspected suicides has fallen in Q2.There were 10 unexpected deaths where death by suicide was suspected in Q1 whereas there were 3 suspected suicides in Q2. This represents a return to the general average of 2017/18.The Trust continues to work alongside partner agencies in the Stoke-on-Trent and Staffordshire Suicide Prevention Strategy group. The Trust is hosting a system-wide suicide prevention conference on 30th November 2018. There will be national and international speakers and the event is open to all people across the wider health and social care community, colleges and universities and 3rd sector agencies.

The number of unexpected deaths 'pending review' has increased in Q2. This category represents the area of greater increase in unexpected deaths during the time frame April 2017 to September 2018. It is noted that the incidents listed as 'pending review' are generally incidents which relate to the deaths of people who have received input from the Trust substance misuse services. These deaths tend to be in relation of people who have longer term problems of drug or alcohol addiction. The use of drugs or alcohol may also feature in the unexpected deaths of people in mental health services. However in these cases, the use of drugs or alcohol may not be in relation to issues of addiction and may be single or unpredictable, chaotic use therefore the consideration for dual diagnosis services would not be appropriate.

## 4. Learning from Serious Incidents

4.1 Quarter 2 learning.

Recommendations and learning from investigations are disseminated upon completion of the SI investigation. The learning that was found from this quarter and the previous Q1 investigations is outlined below:

- A review and strengthening of the triage process for the CMHTs when receiving new referrals in order to ensure that each referral is given due consideration of patient need/further information requested.
    - This review will also address improvements in the escalation process for managing concerns in relation to people awaiting assessments in the CMHTs.
    - Also included is a review of the waiting times for first appointments, with particular monitoring of the impact of cancelled appointments. This follows an incident where a GP's escalating concerns were not managed by one of the County CMHTs.
- In CAMHS, an out-of-hours referral pathway will be developed and shared across all 'front-door' portals in order to ensure that the pathway is followed by non-CAMHS clinicians. This will also be used as a reminder document regarding the use of 'leave beds' for CAMHS staff
- Following an incident in the community involving staff from the Trust and the police, a meeting will be facilitated to explore the events of the incident and to further closer working relationships.
- The CMHTs will review the practice regarding "depot clinics" and how these clinics fit as part of the wider MDT care package. This review will include
    - Clinical need and capacity as well as performance target discussion to be reflected in caseload supervision with a mechanism for recording this and the actions taken
    - Improved quality of clinical note entries which should reflect the interaction and appraisal by a specialist mental health professional.
- An incident occurred where staff understanding of terminology used regarding care management/care coordination/standard care was inconsistent and resulted in a person not receiving support. There is a need to ensure that staff understanding of patient care needs are properly understood by all. Discussions with clinical team held and further clinical team discussions are planned by the community directorates .
- Substance Misuse Services reviewed their approach to the management of high risk individuals who disengage from services. Discussions held regarding strengthening staff understanding of the need to ensure that issues are bought to the attention of the MDT and engagement plans are formulated.
- The Home Treatment Team has been tasked with improving documentation regarding the rationale for decisions made with regards to care plans and risk assessments. These decisions should be clearly written in clinical notes and communicated across other clinical teams where necessary

4.2 Independent Review Panel

During this quarter, the Trust has received the independent panel review report following the serious self-harm attempt and subsequent death of a person admitted to ward 3. This report has been submitted to commissioners and members of the panel and the Medical Director and Director of Nursing will meet with the commissioners to discuss the report on 10th October 2018. The Clinical

Director and Associate Director for Adult Inpatient Services will also meet with the family of the deceased person to discuss the report findings.

The learning and recommendations from this report are outlined below:

- Recommendation 1: When informed that a person known to a service is potentially in distress, teams should be reminded to attempt to contact them in order to ascertain their well-being and level of potential risk.
- Recommendation 2: All updated/new Policies to be communicated across the Trust via the Communications Team.
- Recommendation 3: Trust to enhance training in the management of the patient using suspended ligatures, to include role play and scenarios.
- Recommendation 4: The Trust will implement its plans to fit “reduced ligature doors” on acute ward bedroom doors, including the fitting of door top ligature alarms.
- Recommendation 5: Staff will be reminded that people admitted to wards should be risk assessed for possible self-harm/suicidal intention as per Trust policy and a decision made regarding temporary removal of the means to harm themselves.
- Recommendation 6: Scrutiny of all paper-based charts to be strengthened as part of the matron’s monthly audit to ensure correct documentation is in use. Matron’s audit should include a review of the observation checklist documentation/clinical notes post changes in clinical presentation.
- Recommendation 7: Training in the care and support of people with a diagnosis of personality disorder should be strengthened for all frontline clinical staff in the Adult Inpatient and Community Directorates

Each recommendation and subsequent action is allocated to the relevant directorate and to an identified role within the directorate i.e. service manager

As in previous reports there were a number of investigation were no recommendation for change were made.

### 4.3 Closing the loop

As part of the determination to strengthen Trust processes, the Patient + Organisational Safety Team (P+OST) have developed and implemented an overarching action plan from SI investigations. This action plan will be reviewed by P+OST at 6 and 12 monthly intervals post incident in order to ensure that the learning from investigations has been embedded into practice. Assurance from this process will be through the Clinical Improvement and Safety Group (CSIG).

During Q2, incident action plans where the 6 month completion dates fell within the quarter have been reviewed by the directorate governance leads and the P+OS Team: areas outstanding at 6 months are outlined below.

- Completion of next of kin details. This is not always completed on referral to the services and impacts on the Trust ability to contact bereaved families and/or to involve families and carers in investigations post incidents. Reminders to staff /practice notes were issued however collection of this information is not always obtained and where the next of kin details are not listed, there may be no rationale documented i.e. patient refusal.

## 5. Duty of Candour (Quarter 2 report)

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

In the case of SIs, it is not always possible to immediately determine which, if any of the deaths under investigation meet the Duty of Candour requirements. However should any investigation identify causal links between patient harm and service delivered, the Duty of Candour process would be initiated and a letter outlining the issues sent to the patient or next of kin. As a secondary measure SI investigations have been added to the mortality surveillance group agenda for discussion as part of the mortality surveillance process.

The table below shows the incidents that were initially reported as potentially meeting the DoC requirements.

| | Moderate + incidents reported | Moderate+ incidents downgraded after review | Moderate+ incident. Managed via SI process | Moderate incident but does not meet DoC criteria | Incident meeting DoC requirement | Moderate+ incident. Managed through the MS process |
|---|---|---|---|---|---|---|
| July 18 | 42 | 31 | 6 | 5 | 0 | 0 |
| Aug 18 | 40 | 19 | 10 | 8 | 0 | 1 |
| Sept 18 | 21* | 13 | 5 | 1 | 0 | 0 |
| **total** | 103 | 63 | 21 | 14 | 0 | 1 |

*2 incidents are currently undergoing review in order to determine if the requirement under DoC is met.

During Q2 no incidents met the criteria for reporting under the Duty of Candour requirements. The ongoing SI investigations may determine that incidents meet the DoC criteria as part of the investigative process however the initial investigations do not indicate this.

## 6. Conclusion

- The Trust continues to monitor all incidents on a weekly basis and this report demonstrates compliance with Trust policies and processes.
- The number of unexpected deaths has remained the same as in Q1 however the number of incidents where suicide is suspected has reduced.
- The number of falls meeting SI criteria has increased during Q2 despite the ongoing implementation of a number of falls reduction initiatives. The age and physical frailty of the client group on ward 4 appears to be a contributory factor.
- The learning from investigations, as outlined above, is cascaded across the Trust through a variety of governance processes. From the internal team and directorate processes across to full Trust cascade and through the Learning Lessons framework. This is to ensure that the learning from investigations is not completed in isolation and that a positive learning culture is maintained, through supporting staff with the opportunity to reflect and share learning.

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# REPORT TO: Trust Board

Enclosure No:11

| | | | |
|---|---|---|---|
| Date of Meeting: | 22 November 2018 | | |
| Title of Report: | Q2 Mortality Surveillance Report | | |
| Presented by: | Dr Buki Adeyemo, Executive Medical Director | | |
| Author: | Jackie Wilshaw, Head of Patient & Organisational Safety | | |
| Executive Lead Name: | Dr Buki Adeyemo, Executive Medical Director | Approved by Exec | ☐ |

| Executive Summary: | | Purpose of report | |
|---|---|---|---|
| This report provides the Trust with assurance as to the mortality surveillance process with regards to the scrutiny of people open to Trust services who have died of natural causes before the age of 75 years | | Approval | ☐ |
| | | Information | ☒ |
| | | Discussion | ☐ |
| | | Assurance | ☒ |
| Seen at: | SLT ☐ Execs ☐<br>Date: | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☐√<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Primary Care Integration Programme Board ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement.☐<br>2. To provide the highest quality services ☐√<br>3. Create a learning culture to continually improve.☐√<br>4. Encourage, inspire and implement research & innovation at all levels.☐<br>5. Maximise and use our resources intelligently and efficiently.☐<br>6. Attract and inspire the best people to work here.☐<br>7. Continually improve our partnership working. ☐ | | |
| Risk / legal implications:<br>Risk Register Reference | Nil | | |
| Resource Implications:<br><br>Funding Source: | Nil | | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | Issues relating to Equality, Diversity and Inclusion were not identified during the MS process or the writing of this report | | |
| STP Alignment / Implications: | N/A | | |
| Recommendations: | For information/assurance | | |

| Version | Name/group | Date issued |
|---|---|---|
| 1 | CSIG | 15/10/2018 |
| | | |
| | | |

## 1. Introduction

In 2017 the National Quality Board published new guidance on learning from deaths. As a result there is a need to ensure that the Trust can be confident that all unexpected deaths are reported and investigated appropriately. Additionally, information contained within its databases must be accurate and comply with the Trust standard of transparency and accountability. This report is for the Q2 reporting period 2018/19 and provides information for the time frame July 2018 to September 2018.

## 2. Trust Reporting and Data Collection

The table below shows the number of deaths reported monthly during Q2. These deaths will be reviewed by the mortality surveillance group following completion of the investigation process.

| Month | Total number of deaths recorded on Lorenzo | Total number of deaths – out of service | Reported as SI | Open to services at the time of death- natural causes | Substance Misuse Deaths | | | LD Deaths |
|---|---|---|---|---|---|---|---|---|
| | | | | | North Staffs | Stoke | Staffs | |
| July 18 | 24 | 9 | 2 | 13 | 0 | 0 | 2 | 1 |
| Aug 18 | 15 | 2 | 7 | 6 | 2 | 1 | 2 | 0 |
| Sep 18 | 15 | 6 | 6 | 3 | 2 | 1 | 0 | 0 |

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

During Q2 the mortality surveillance group reviewed the care of 22 people (meetings took place on 3 July, 31 July and 4 September). The analysis of these deaths is shown in the table below.

| Meeting Date | Identifier | Death category | Level of care | Death occurred as a result of problems in healthcare | Duty of Candour applies | Domain |
|---|---|---|---|---|---|---|
| 3 July 18 | 37 | EN1 | Good | No | No | Physical Health |
| | 38 | EN1 | Good | No | No | Physical Health |
| | 39 | EU | Good | No | No | Drugs and Alcohol |
| | 69 | EN1 | Good | No | No | Physical Health |
| | 76 | UN1 | Good | No | No | Physical Health |
| 31 July 18 | 40 | EN1 | Good | No | No | Physical Health |
| | 41 | EN1 | Good | No | No | Physical Health |
| | 42 | EN1 | Good | No | No | Physical Health |
| | 43 | UN2 | Good | No | No | Physical Health |
| | 63 | UN2 | Good | No | No | Drugs and Alcohol |
| 3 Sep 18 | 44 | UN2 | Good | No | No | Drugs and Alcohol |
| | 45 | UN1 | Good | No | No | Physical Health |
| | 46 | UN1 | Good | No | No | Drugs and Alcohol |
| | 47 | EU | Good | No | No | Drugs and Alcohol |
| | 48 | EN1 | Good | No | No | Physical Health |
| | 49 | UN1 | Adequate | No | No | Drugs and Alcohol |
| | 50 | UN2 | Good | No | No | Drugs and Alcohol |
| | 51 | UN2 | Good | No | No | Drugs and Alcohol |
| | 52 | UN1 | Good | No | No | Physical Health |
| | 53 | UN2 | Good | No | No | Drugs and Alcohol |
| | 54 | EN1 | Good | No | No | Physical Health |
| | 55 | UN1 | Good | No | No | Physical Health |

The definitions for the death category are shown below:

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

There is no national guidance on the criteria for the level of care determination. However the Mortality Surveillance Group considered that good care had been provided where there was evidence of the staff providing a good level of support, had responded quickly and appropriately to situations where deterioration in physical health was noted. Adequate care was determined to be care where the basic standards of expected support were given. In part these determinations are dependent upon the quality of the documentation contained within the Mortality Surveillance review tools and the electronic patient records. Feedback to the Directorate/Team on the quality of documentation will be sent in order to improve future clinical entries.

## 3. LeDeR

The Trust is required to report all deaths of people with Learning Disabilities to a national reviewing board based at the University of Bristol. The deaths are then allocated to regional offices for review. Since November 2017, the Trust has reported eight deaths for review under the LeDeR process. To date only one case has been fully reviewed. The person was found to have received good care and no issues were raised for the Trust. However the remaining deaths are still in the review process and there has been no further information for the Trust. The Patient & Organisational Safety Team have requested that the Trust representative to the regional LeDeR panel feedbacks as to the timeliness of the process.

## 4. Conclusion

The Trust continues to monitor the deaths of people whose deaths are outside of the Serious Incident process. The monthly Mortality Surveillance Group receives and reviews investigations in order to provide assurance as to the quality of the care provided by the Trust. The group identifies any learning from the reviews and offers recommendations for practice when required. In the deaths reviewed during Q2, there was no evidence of deficits in the healthcare provided by the Trust which may be considered to have contributed to the death of any individuals.

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# REPORT TO OPEN TRUST BOARD

Enclosure No:12

| | | | |
|---|---|---|---|
| Date of Meeting: | 22 November 2018 | | |
| Title of Report: | Overarching Report summarising Mental Health Act Compliance Visits and Learning Outcomes Quarter 1 & Quarter 2 2018 /19 | | |
| Presented by: | Dr Dennis Okolo, Associate Medical Director | | |
| Author: | Sandra Storey, Associate Director of MACE | | |
| Executive Lead Name: | Dr Buki Adeyemo, Executive Medical Director | Approved by Exec | ☒ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| The Care Quality Commission (CQC) has a duty as the regulatory authority under the Mental Health Act 1983 (MHA) to monitor how mental health services exercise their powers and discharge their duties when patients are detained under the MHA or are subject to Community Treatment Orders (CTOs) or guardianship. In carrying out its monitoring role the CQC will carry out a series of unannounced visits and meet with patients. They focus on protecting patients' rights and autonomy.<br><br>During the year the CQC exercised its function in this regard by carrying out unannounced Mental Health Act reviewer assurance visits to Trust services.<br><br>The purpose of this briefing paper is to provide an overview of the services visited, to highlight the key learning from those visits and an overarching summary of the actions taken to date to improve compliance with the MHA. | Approval | ☐ |
| | Information | ☒ |
| | Discussion | ☐ |
| | Assurance | ☒ |

| | | | |
|---|---|---|---|
| Seen at: | SLT ☐ Execs ☐<br>Date: | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☒<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☐<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Primary Care Integration Programme Board ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement.☒<br>2. To provide the highest quality services ☒<br>3. Create a learning culture to continually improve.☒<br>4. Encourage, inspire and implement research & innovation at all levels.☒<br>5. Maximise and use our resources intelligently and efficiently.☒<br>6. Attract and inspire the best people to work here.☒<br>7. Continually improve our partnership working. ☐ | | |
| Risk / legal implications:<br>Risk Register Reference | None applicable directly from this report | | |
| Resource Implications:<br><br>Funding Source: | N/A<br><br>N/A | | |
| Diversity & Inclusion Implications: | There are no direct impact of this report on the 10 protected characteristic of | | |

| | | |
|---|---|---|
| (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | the Equality Act | |
| STP Alignment / Implications: | N/A | |
| Recommendations: | To receive for assurance | |
| Version | Name/group | Date issued |
| | | |
| | | |

**Quality Committee and Trust Board Meeting**

| | |
|---|---|
| **Date of meeting:** | **22 November 2018** |
| **Report title:** | **Overarching Report summarising Mental Health Act Compliance Visits and Learning Outcomes<br>Quarter 1 & Quarter 2 2018 /19** |
| **Presented by:** | **Dr Buki Adeyemo, Executive Medical Director** |
| **Author:** | **Sandra Storey, Associate Director MACE** |

## 1. Introduction

The Care Quality Commission (CQC) has a duty as the regulatory authority under the Mental Health Act 1983 (MHA) to monitor how mental health services exercise their powers and discharge their duties when patients are detained under the MHA or are subject to Community Treatment Orders (CTOs) or guardianship. In carrying out its monitoring role the CQC will carry out a series of unannounced visits and meet with patients. They focus on protecting patients' rights and autonomy.

During the year the CQC exercised its function in this regard by carrying out unannounced Mental Health Act reviewer assurance visits to Trust services.

The purpose of this briefing paper is to provide an overview of the services visited, to highlight the key learning from those visits and an overarching summary of the actions taken to date to improve compliance with the MHA.

## 2. Focus

Dates of Trust services visited during Quarter 1 & Quarter 2, 2018/19:

- Ward 1
- Darwin Centre
- Florence House

**3. Summary Table of Findings From Each Visit**

| Service | Section 58 Capacity to consent to treatment/admission | Section 17 leave | Section 132 – patient rights. | DOLs | Blanket Restrictions | Care Planning / Risk Assessment | No Nearest Relative | Safeguarding |
|---|---|---|---|---|---|---|---|---|
| Ward 1 | ✓ | ✓ | | | ✓ | ✓ | | |
| Darwin | ✓ | ✓ | | | ✓ | ✓ | | |
| Florence | ✓ | | | | | | | |

## 4. High Level Summary Outcome of Each Visit

- Capacity to consent to treatment:
  - Detail of discussions regarding consent and capacity for MH treatment.
- Section 17 leave:
  - Detail of discussions regarding risk and rationale for authorising leave.
- Care Planning and risk assessment:
  - Evidence of person centred planning.
- Blanket restriction:
  - Review of blanket restrictions.
- Care Plan and risk assessment:
  - Review of activities programme.
  - Review of care plan.
- Section 17 leave:
  - Recording leave arrangements on Lorenzo.
- Individual patient issues:
  - Discussions regarding capacity and consent.
  - Access to facilities.
- S58 Capacity to Consent for Treatment:
  - Detail of discussion regarding consent for patient to be treated under s58
- Other:
  - Patient raised concerns about noise during the night (phone ringing, doorbell).
- Other:
  - Patient weekly community meetings to identify lead for actions.

## 5. Learning and Action

Individual responses are sent to the CQC for each service visited detailing actions and timescales for completion.

While specific action has been taken in response to individual visits, general learning points have been shared across the Trust in order to raise awareness and continue to improve practice.

| | |
|---|---|
| Section 17 Leave | • Staff reminded that Section 17 leave forms need completing in detail, which includes how many staff are required, gender and status of staff.<br>• A copy of the authorised Section 17 leave form is now printed from Lorenzo, patient signs the form and then re-entered on Lorenzo. A record will also be made if patient declines a copy.<br>• Monitoring of leave discussed in ward round to inform future leave arrangements.<br>• Compliance monitored via monthly ISM audit. |
| Risk Assessments and Care Planning | • Care plans need to demonstrate completed in collaboration with patients. Agenda item for staff meetings.<br>• Compliance monitored via monthly ISM audit. |
| Blanket Restrictions / Searching | • Trust Search Policy has been updated and includes process for recording on Lorenzo.<br>• Train the trainer 'Search training' is taking place in line with the policy. |
| Section 58 - Consent to Treatment / Capacity | • On-going work with teams to promote the use of the Consent form on Lorenzo. To be used for recording of all consent and capacity decisions.<br>• Compliance monitored via monthly ISM audit.<br>• Forms introduced into Lorenzo for using the Gillick competency framework. |

## 6. Recommendations

- To receive for information and assurance purposes and discuss as required.
- To note that actions are monitored by the Mental Health Law Governance Group, alongside consideration of any emerging themes and trends.

North Staffordshire Combined Healthcare NHS Trust

# REPORT TO: TRUST BOARD

Enclosure No:13

| | | | |
|---|---|---|---|
| Date of Meeting: | 22nd November 2018 | | |
| Title of Report: | Smoke Free Progress Report | | |
| Presented by: | Dr Buki Adeyemo, Executive Medical Director | | |
| Author: | Amanda Miskell, Consultant Nurse, Physical Health (PH) | | |
| Executive Lead Name: | Dr Buki Adeyemo, Executive Medical Director | Approved by Exec | ☒ |

| Executive Summary: | | Purpose of report | |
|---|---|---|---|
| To provide the Board an update in relation to the "Smoke Free" arrangements within the Trust. | | Approval | ☐ |
| | | Information | ☐ |
| | | Discussion | ☒ |
| | | Assurance | ☒ |
| Seen at: | SLT ☐ | Date: | |
| | Execs ☐ | Date: | |
| Committee Approval / Review | • Quality Committee ☒<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☐<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Digital by Choice Board ☐ | | |
| Strategic Objectives (please indicate) | 1. To enhance service user and carer involvement. ☐<br>2. To provide the highest quality services. ☒<br>3. Create a learning culture to continually improve. ☒<br>4. Encourage, inspire and implement research & innovation at all levels. ☐<br>5. Maximise and use our resources intelligently and efficiently. ☒<br>6. Attract and inspire the best people to work here. ☐<br>7. Continually improve our partnership working. ☒ | | |
| Risk / legal implications: Risk Register Ref | None | | |
| Resource Implications:<br><br>Funding Source: | Purchase of E cigs as a pilot arrangement and ongoing Nicotine Replacement (NRT) costs. | | |
| Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups) | There is no direct impact on protected characteristics in relation to the completion of this report. | | |
| STP Alignment/Implications | N/A | | |
| Recommendations: | For Information/Discussion/Assurance | | |

| Version | Name/group | Date issued |
|---|---|---|
| V1 | Maria Nelligan | 13/11/2018 |
| V2 | Trust Board | 22/11/2018 |

1. **Purpose of the report**
   This report will update and provide assurances in relation to the progress made since the Q1 and Q2 report were received at October Trust Board meeting.

2. **Update on position**
   All in-patient areas are now smoke free.

3. **Smoke Free Task & Finish (T&F) Group**
   The Task & Finish Group has now concluded. The Directorates will now take leadership of continuing to implement the Smoke Free Policy and related procedures.

4. **Policy**
   The Smoke Free Policy has been developed and following governance approval and ratification the policy is now available on SID (Intranet). It is the responsibility of the Directorates to ensure staff follow the policy and attend training and access support in implementing the policy.

5. **LESTER Tool**
   Physical Health Training continues in line with the LESTER tool which includes smoking and cessation interventions. Lorenzo has been updated so that all physical health assessments include a question regarding smoking habits and an offer of brief interventions including referral for NRT.

6. **Commissioning for Quality & Innovation (CQUIN)**
   Following further discussion with Commissioners and at CQRM. Full payment will be received in relation to the smoke free interventions CQUIN.

7. **Dear Caroline's**
   From this point onward Directorates will be responsible for advising and responding to responses to Dear Caroline's or any other communication requests including Freedom of Information.

8. **Incidents**
   The reporting of incidents increased significantly in October and decreased slightly going into November. On scrutiny there appears to be an increase in incidents which are related to individual patients' admission. This is clear for both Wards 1 and 3. A reported fire incident on Ward 3 was not related to smoking. The Health & Safety Advisor and Fire Officer have visited the acute wards and discussed incidents and concerns with staff and patients.

   It needs to be highlighted that as we move into the colder, wetter months, patients will be reluctant to leave shelters and reception areas to smoke. Teams will continue to monitor this.

9. **Progress Internally**
   There continues to be challenges, however consistency regarding compliance with policy and procedures must continue.

This includes a review of all patients who are regularly smoking on and off the wards and potentially causing harm to staff and other patients. Consideration needs to be given to discharging patients where there is non-compliance with the policy and involving the Police where an offence has been committed.

**10. Search Policy & Training**

Ward 3 continues to have significant issues with some patients concealing and sharing ignition sources and tobacco products. The Trust`s Fire Officer and Patient & Organisational Safety Team are awaiting a response in relation to the legal framework of people smoking in a public place.

**11. E-cigs and Vending Machine**

The initial one off purchase of the above is coming to an end and the IPC/PH team are evaluating this intervention. The vending machine should be on site by end of November and information regarding purchase by patients on discharge have been distributed.

**12. Staff Views**

A survey has been developed to consider opinion regarding the different support mechanisms that have been utilised throughout the “towards/smoke free” journey. This will be circulated electronically as soon as the survey concludes.

**13. Recommendations**

The Board is asked to note and comment on the Smoke Free progress report - November 2018.

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Combined Healthcare
NHS Trust

# REPORT TO: TRUST BOARD

Enclosure No:14

| | | | |
|---|---|---|---|
| Date of Meeting: | 22 November 2018 | | |
| Title of Report: | Director of Infection Prevention & Control (DIPC) Q2, (July – September 2018) Report | | |
| Presented by: | Maria Nelligan, Executive Director of Nursing & Quality/DIPC | | |
| Author: | Amanda Miskell, Consultant Nurse, Physical Health/Deputy DIPC | | |
| Executive Lead Name: | Maria Nelligan, Executive Director of Nursing & Quality/DIPC | Approved by Exec | ☒ |

| Executive Summary: | | Purpose of report | |
|---|---|---|---|
| To provide the Board with assurance in relation to the IPC arrangements within the Trust. The report will also give an overview of the Influenza campaign and NICE guidance for 2018/2019, Cleanliness and Patient Led Assessment of the Clinical Environment (PLACE). | | Approval | ☐ |
| | | Information | ☒ |
| | | Discussion | ☐ |
| | | Assurance | ☒ |
| Seen at: | SLT ☒ Execs ☐<br>Date: | Document Version No. | V1 |
| Committee Approval / Review | • Quality Committee ☒<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☐<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Primary Care Integration Programme Board ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement.☐<br>2. To provide the highest quality services ☒<br>3. Create a learning culture to continually improve.☐<br>4. Encourage, inspire and implement research & innovation at all levels.☐<br>5. Maximise and use our resources intelligently and efficiently.☒<br>6. Attract and inspire the best people to work here.☐<br>7. Continually improve our partnership working. ☐ | | |
| Risk / legal implications:<br>Risk Register Reference | None | | |
| Resource Implications:<br><br>Funding Source: | Vaccinations, bank shifts, additional resources and incentives.<br><br>Influenza budget | | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | There is no direct impact on protected characteristics in relation to the completion of this report. | | |
| STP Alignment / Implications: | None | | |
| Recommendations: | For receive the report for assurance | | |

| Version | Name/group | Date issued |
|---|---|---|
| V1 | Maria Nelligan | 03/10/2018 |

## 1. Purpose of the report

This report will update and provide assurances for quarter two (Q2) on IPC including the Influenza vaccination campaign, cleanliness and PLACE. The Board will also be apprised of the Trust`s position in relation to Health Care Acquired Infections (HCAIs) and other relevant issues.

## 2. Health Care Acquired Infections (HCAI)

During the Q2 period there were no HCAIs to report, in relation to Blood Stream Infections, MRSA Bacteraemia or C-difficile.

MRSA screening continues to result in a zero return in terms of positive results, and no exceptions have been reported externally in relation to the Safety Thermometer for Catheter Associated Urinary Tract Infections (CAUTIs).

## 3. Influenza campaign and NICE guidance publication (NG103)

In February 2018 the World Health Organisation (WHO) agreed on the recommended composition of the Trivalent and Quadrivalent influenza vaccine for the northern hemisphere 2018-2019 influenza season as:

- An A/Michigan/45/2015 (H1N1)
- An A/Singapore/INFIMH-16-0019/2016 (H3N2)
- A B/Colorado/06/2017-like virus (B/Victoria).
- A B/Phuket/3073/2013. **(Quadrivalent addition)**

PHE guidance suggests the use of Quadrivalent vaccine (QIV) for all Health & Social Care staff aged 18 to 65 years. The Trust currently has 2 members of staff aged 65+ and the Trivalent vaccine will be available for them if not already vaccinated in Primary care.

Following advice from Public Health England (PHE) early 2018, the IPC Team commenced the preparedness for the 2018/19 Influenza vaccination campaign. The vaccines were ordered directly from NHS supply chain via UHNM Pharmacy rather than via Team Prevent. This is in response to the amount of vaccines carried out by Peer Vaccinators during the 2017/18 campaign and the logistics associated with receiving from a third party.

For the 2018/19 programme, the co-ordinating IPC Team has ordered 1050 Quadrivalent vaccines for this year to achieve at least our CQUIN of 75% by February 2019. This is broken down from the **Immform** (National reporting arrangements) categories, and a final spreadsheet has been developed to monitor and record activity. This will be used to update the Trust, Immform and NHSI weekly on performance.

From reviewing the data with Workforce, there are **1638 staff** including Bank currently employed in the organisation. The Directorates have been filtered as follows:

- Business Development & Strategy
- Chief Executive office
- Estates
- Finance, Performance & Digital
- MACE
- N&Q
- Operations (Corporate)
- Workforce & leadership

Those staff on long term sick (36), have been removed, they will be added back as they return when we review activity at the end of each month. This also applies to maternity leave/adoption and relevant starters/leavers. A list of Bank staff that haven't completed any shifts in the last 3 months (43/157) have also been removed. Again this will be monitored monthly.

Therefore our total number of frontline staff for vaccination is currently **1163**. This consists of:

- 470 Registered Nurses
- 55 Doctors
- 457 Support Staff
- 45 Corporate who are patient facing
- 136 other professionals

For the 75% CQUIN we will need to vaccinate or receive declaration forms for **873** frontline staff. We will vaccinate any other staff that request the vaccine including Student Nurses, Social Workers and Volunteers.

In line with the requirements from NICE NG 103 which was published in August 2018, the Trust has also implemented the following:-

- The Trust has a dedicated staff team with responsibility for implementing a Communication Strategy to increase awareness and uptake.
- The Trust is using the Communications Team, local broadcast media and social media.
- The co-ordinating IPCT are receiving and publicising support from high-profile organisational leaders, including the DIPC and staff representatives.
- The Trust will publicise flu vaccine uptake rates and the comparative performance of individual Directorates within the organisation. This will be done within the context of national targets such as CQUIN.
- The IPCT have agreed approaches for information sharing for off-site access to Flu vaccination. This is offered to allow timely, accurate and consistent recording of people's vaccination status.

- The IPCT are providing information about the effectiveness and safety of the Flu vaccine on a regular basis, and it is also included on all consent and decline forms with anonymous reasons for opting out. This will be used to inform future Flu vaccination programmes.
- The Trust is using staff incentives that fit with the organisation's culture and the values of its employees (20 x £10 love to shop vouchers) via a "golden ticket".
- The IPCT are training peers to vaccinate their co-workers, to encourage uptake and challenge barriers, such as myths that the flu vaccine can give you flu. This also includes signing a Patient Group Directive (PGD) and competency sign off.
- The team are using prompts and reminders in various printed and digital formats. Include information about on or off site vaccination locations and times.
- The team are now using systems linked to named staff records to monitor uptake and to target prompts and reminders.
- The Trust is promoting Flu vaccination to ALL front-line health and social care staff as a way to:

  - protect the people they care for
  - protect themselves and their families
  - protect their co-workers
  - meet professional expectations such as the British Medical Association's position statement, the General Medical Council's guidance on good medical practice and the Royal College of Nursing's duty of care statement.

  The IPCT have also:

- Extended on-site vaccination clinic hours to fit in with staff work patterns, including Jabathon and dial/email a jab!
- Using outreach or mobile services to offer flu vaccination in areas and at times where large numbers of staff congregate, such as shift changeovers meetings and training.
- Publicising information about mobile Flu vaccination services.

**4. Outbreaks**

There have been no outbreaks to report. However it must be noted that the local community is experiencing an increase in gastrointestinal illness suggestive of small round structured virus outbreaks, for example Norovirus. This is expected as we move into quarter 3. The majority of the work carried out by the IPC team at Combined is preventative rather than reactive.

**5. Infection Prevention & Control Group**

The Infection Prevention and Control Group (IPCG) meets bi-monthly, and the last meeting took place in September 2018.

The Chair`s summary comprises:

- Q1 DIPC presented to members and Chair.
- IPCG Terms of Reference (ToR) reviewed and approved.
- Additional training events continue following the identification of some staff cohorts on a 3 year rather than an annual programme. Compliance should be above 85% by Q3.
- Trail continues on Edward Myers Unit in relation to vascular devices for detox and aseptic technique packs to prevent infection.
- Preparedness for water works to be carried out including procurement of mobile sinks, patient cleansing systems, hand wipes etc.

## 6. Recommendations

The Board is asked to note the DIPC Quarter 2 Report for 2018/19.

From the office of Dale Bywater
Executive Regional Managing Director – Midlands and East

Cardinal Square – 4th Floor
10 Nottingham Road
Derby
T: 0300 123 2605
E: nhsi.enquiries@nhs.net
W: improvement.nhs.uk

13th November 2018

All Midlands & East Provider CEOs & Chairs

***Sent by email***

Dear Colleagues

As winter approaches I wanted to remind you all of the importance of maintaining high standards of infection control across all of our provider organisations. It is imperative that every Board has focus and grip on the infection, prevention and control agenda all year round. It is my expectation that each Board is receiving regular assurance reports in relation to their compliance with the complete Hygiene Code, in addition to the trajectory for C Dif and MRSA. Boards have a duty under the Hygiene Code to ensure robust infection control practices and procedures are in place, along with appropriate and timely cleaning when outbreaks occur and are declared over. Every opportunity to deep clean all clinical areas should be taken when capacity pressures allow in order to eradicate infection risks associated with environments that are not thoroughly clean.

You may be aware that across the region we have seen the emergence of some extremely resistant organisms for which there are limited antibiotic treatment options. This means it is really important that we follow good infection control practice and have in place high standards of cleaning to maintain the safety of patients and flow throughout the system.

I am aware that your flu campaigns are now in progress and I would like to thank you for your leadership in encouraging staff to take up the offer of vaccination to protect themselves and others. Early indications suggest that uptake is higher this year than it was at the same point last year in a number of our organisations. What we do know is the providers with strong executive leadership supporting the campaign have the highest level of uptake so your continued support of this is much appreciated.

Finally, thank you for your continued support and I'm sure we all agree that this is an important priority. If any of you wish to have any Board development sessions in regard to responsibilities under the Hygiene Code than please don't hesitate to contact Siobhan Heafield, Regional Nurse: siobhanheafield@nhs.net or Dr Debra Adams, Senior Infection Control Lead: debra.adams2@nhs.net who will be happy to discuss with you any support that may be of help.

Yours sincerely

D Bywater

Dale Bywater
**Executive Regional Managing Director – Midlands & East**

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# REPORT TO: TRUST BOARD

Enclosure No:15

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|---|---|---|---|
| Date of Meeting: | 22 November 2018 | | |
| Title of Report: | Patient Led Assessment of the Care Environment (PLACE) 2018 | | |
| Presented by: | Anne Melville, Head of Facilities | | |
| Author: | Anne Melville, Head of Facilities | | |
| Executive Lead Name: | Maria Nelligan, Executive Director of Nursing and Quality | Approved by Exec | ☒ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| The Trust PLACE assessments have been completed in accordance with national guidelines with at least 50% Patient Representation and an independent validator on each assessment. | Approval | ☒ |
| | Information | ☐ |
| | Discussion | ☒ |
| | Assurance | ☐ |

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|---|---|---|---|
| Seen at: | SLT ☒ Execs ☐<br>Date: | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☒<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☒<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Digital by Choice Board ☐ | | |
| Strategic Objectives (please indicate) | 1. To enhance service user and carer involvement. ☒<br>2. To provide the highest quality services ☒<br>3. Create a learning culture to continually improve. ☐<br>4. Encourage, inspire and implement research & innovation at all levels. ☐<br>5. Maximise and use our resources intelligently and efficiently. ☒<br>6. Attract and inspire the best people to work here. ☐<br>7. Continually improve our partnership working. ☒ | | |
| Risk / legal implications: Risk Register Reference | N/A | | |
| Resource Implications:<br><br>Funding Source: | N/A | | |
| Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | No issues with regards to protected characteristics during the PLACE process. | | |
| STP Alignment / Implications: | N/A | | |
| Recommendations: | To receive for approval | | |

| Version | Name/Group | Date |
|---|---|---|
| V1 | Infection Prevention and Control Group | 17 September 2018 |
| V2 | SLT | 22 November 2018 |

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PROUD TO CARE

## 1. Introduction

The Patient Led Assessment Care Environment (PLACE) for NSCHT has been completed in line with the target dates set by NHS Digital in the following areas:

Harplands Hospital
Darwin Centre
Florence House
A&T Summer View
Dragon Square

PLACE aims to promote the principles established by the NHS Constitution that focus on areas that matter to patients, families and carers:

- Putting patients first;
- Active feedback from the public, patients and staff;
- Adhering to basics of quality care;
- Ensuring services are provided in a clean and safe environment that is fit for purpose

PLACE assesses a number of non-clinical aspects of the healthcare premises identified as important by patients and the public.

- Cleanliness
- Food and Hydration
- Privacy, dignity and wellbeing
- Condition, appearance and maintenance
- Dementia: how well the needs of patients are met
- Disability: how well the needs of patients with a disability are met

## 2. Scope

This report presents keys finding of NSCHT PLACE 2018

All assessments have been completed in accordance with the PLACE guidelines and with a team of at least 50% representation from Health Watch, Sikh Community, Service User Care Council (SUCC) or Patient representative on each team. This year we had a total 14 patient assessors engaged in the PLACE assessments.

Two training sessions were delivered for our Patient representatives prior to the assessments taking place.

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

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

Again this year, there have been are a few minor changes to the questions asked throughout the domains and these may have had an impact on the assessment when comparing against previous year's results.

## 3. Trust's overall score for 2018:

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

### Cleanliness

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

### Food and Hydration

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

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

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

### Privacy and Dignity

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

### Condition, Appearance and Maintenance

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

### Dementia

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

**Disability**

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

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

***Florence House*** *– A well maintained bright, clean and modern building. The building is very accessible and the staff are very engaged and friendly. Particularly like the facility for gardening/vegetable beds in the external court yard.*

***B4/5 Dragon Square*** *– A clean and well maintained unit with very friendly and caring staff.*

***A & T Unit*** *– The unit improves year on year. New furniture recently purchased was noted including the new areas created for social spaces in the unit.*
*The decoration is much brighter which seems to have led to a much calmer environment for clients. The unit is a credit to all staff involved.*

***Summer View*** *– A modern building that is a clean and well maintained where the staff produce the food to an excellent standard. There is a very calm atmosphere in the unit.*
*The staff are well trained in their job roles and this reflects well on the service users who seem happy and well looked after.*
*.*
***Darwin*** *– The unit has improved year on year. The unit is very clean and staff work hard to make the unit homely as at the same time insuring it's a safe place to be.*
*The pictures are lovely and particularly like the picture on the external fence in the front garden.*
*Would like to see clients engaged in the proposed plans for the rear garden area.*

***Harplands Hospital****– A well maintained building which is clean, bright and well light. Good decorative condition internally. Well maintained grounds externally.*
*Patients are treated with dignity and respect; they could see that the Trust is continually developing this site for and with patients.*
*Visited the Tony Scott garden and this is a wonderful area for patients but would benefit from having a shaded area.*

## 5. NSCHT PLACE 2018 results compared to the National Average and National Average Score per MH/LD site.

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

## 6. Conclusion

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

We have achieved scores well above the National average scores and the National average scores per Mental Health/Learning Disability sites in all domains. *See Appendix 1*

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

Clinical Leads, Support Services, Infection Prevention Control Team and on- going audits will continue to monitor, our internal performance to enable us to maintain the environmental standards.

***Anne Melville***
***Support Services Advisor***
***10/9/18***

***Appendix 1***

PLACE-2018 Rate ranking data againt o

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# REPORT TO Trust Board

Enclosure No:16

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|---|---|---|---|
| Date of Meeting: | 22 November 2018 | | |
| Title of Report: | Performance & Quality Management Framework Month 6 | | |
| Presented by: | Suzanne Robinson, Director of Finance, Performance & Digital | | |
| Author: | Vicky Boswell, Associate Director of Performance | | |
| Executive Lead Name: | Suzanne Robinson, Director of Finance, Performance & Digital | Approved by Exec | ☒ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| On a quarterly basis the Finance, Performance & Digital Committee and the Trust Board receive an Enhanced Performance & Quality Report which considers the national and regulatory oversight performance positon. This report is produced and presented on a quarterly basis.<br><br>The report provides:<br>• Performance and Quality Management Framework (PQMF)<br>An overview of performance for September 2018 covering Contracted and internal Key Performance Indicators (KPIs) and Reporting Requirements.<br>In addition to the performance dashboards a full database (Divisional Drill-Down) has been made available to Directorate Heads of Service and Clinical Directors to enable them to interrogate the supporting data and drive directorate improvement. This is summarised in the supporting PQMF dashboard.<br>• Single Oversight Framework Report<br>This report provides information on the Quality of Care, Operational Performance and Finance & Use of Resources metrics relevant to Mental Health Trusts for Quarter 1 and 2 2018/19. Performance is assessed based on national standards where available or the development of proxy measures to replicate what is published on the Model Hospital site.<br>• Five Year Forward View for Mental Health<br>This dashboard presents the NHSE performance assessment by Stoke and North Staffs CCG against the priority areas identifies within the Five Year Forward View for Mental Health. It contains the data published nationally by NHSE. A report is provided to SLT on a quarterly basis setting out performance based on proxy reports developed to replicate the nationally reported position to provide the most recent view of performance. | Approval | ☐ |
| | Information | ☒ |
| | Discussion | ☐ |
| | Assurance | ☐ |

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| Seen at: | SLT ☒ Execs ☐<br>Date: | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☐<br>• Finance & Performance Committee ☒<br>• Audit Committee ☐<br>• People & Culture Development Committee ☒<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Digital by Choice Board ☐ | | |

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|---|---|
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement.☐<br>2. To provide the highest quality services ☒<br>3. Create a learning culture to continually improve.☐<br>4. Encourage, inspire and implement research & innovation at all levels.☐<br>5. Maximise and use our resources intelligently and efficiently.☒<br>6. Attract and inspire the best people to work here.☒<br>7. Continually improve our partnership working. ☐ |
| Risk / legal implications:<br>Risk Register Ref | In Month 6 there are 1 target related metrics rated as Red and 4 as Amber: all other indicators are within expected tolerances.<br>All areas of underperformance are separately risk assessed and a rectification plan is developed, overseen by the relevant sub-committee of the Trust Board. |
| Resource Implications:<br><br>Funding Source: | There are potential contractual penalties if the Trust is not able to meet reporting requirements or performance standards. A Data Quality Improvement Plan is agreed with commissioners to address data quality issues that may impact on performance. |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups) | The PQMF includes monitoring of ethnicity as a key national requirement. The Trust is seeking to ensure that all Directorates are recording in a timely way the protected characteristics of all service users to enable monitoring of service access and utilisation by all groups in relation to the local population.<br>A new diversity and inclusion report is being developed to monitor trust performance on closing service user and workforce equality data gaps. |
| STP Alignment / Implications | Reporting from Month 7 will reflect the Locality restructuring in support of STP alignment. This will include a breakdown of activity and performance according to North Staffs and Stoke localities.<br>Some of the Board KPIs (Early Intervention and CYP Eating Disorders waiting times) support the delivery of the 5 Year Forward View for Mental Health [5YFV] and are monitored through the STP Mental Health work stream. The Trust's performance as nationally reported against 5YFV targets is set out in this report to provide Board and Committee oversight. |
| Recommendations: | The committee is asked to<br>• Receive the report as outlined<br>• Note the Management action and committee oversight |

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# Enhanced Performance Report
# Quarter 2 – September 2018
# Public Trust Board



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PROUD TO CARE

# Enhanced Performance Report Quarter 2 – September 2018

## 1. Introduction

On a quarterly basis the Finance, Performance & Digital Committee and the Trust Board receive an Enhanced Performance & Quality Report which considers the national and regulatory oversight performance positon.

## 2. Performance Overview

**Section 1 – Monthly Performance & Quality Management Framework (PQMF)**

The report provides an overview of performance for September 2018 covering Contracted Key Performance Indicators (KPIs) and Reporting Requirements. In addition to the performance dashboards a full database (Divisional Drill-Down) has been made available to Directorate Heads of Service and Clinical Directors to enable them to interrogate the supporting data and drive directorate improvement. This is summarised in Appendix 1.

**Section 2 – Single Oversight Framework: Q2 Quality of Care and Operational Metrics**

NHS Improvement (NHSI) published the updated Single Oversight Framework (SOF) in November 2017. This report provides information on the Quality of Care, Operational Performance and Finance & Use of Resources metrics relevant to Mental Health Trusts for Quarters 1 and 2 2018/19. Performance is assessed based on national standards and targets where available, or the development of proxy measures to replicate what is published on the Model Hospital site.

The report is informed by an analysis of Model Hospital, NHSE or NHS Digital published national data to identify areas of comparatively high or relatively poor performance.

A Trust wide SOF report using the latest local data is reported on a monthly basis to SOT.

**Section 3 – Five Year Forward View for Mental Health**

This dashboard presents the NHSE performance assessment by Stoke and North Staffs CCG against the priority areas identifies within the Five Year Forward View for Mental Health (FYFV). This reports on the latest published national reports (Quarter 4 2017/18).

A monthly Trust wide and CCG report using the latest local data as proxy measures is reported (on day 15 for the previous month) to the Senior Operational Team (SOT). This ensures that the Trust is using the most recent intelligence to enable analysis and actions to be taken in advance of the nationally published data.

## 3. Update on Report Development

### Trustwide and Locality Directorate Vital Signs Dashboard

Following the implementation of the new locality directorate structure, a suite of new Vital Signs Dashboards are under development. These are summary performance reports of high value national and trust targets. There will be a report on the Trustwide position and more granular reporting in the form of a dashboard for the 4 x Directorates (Stoke and North Staffs Community, Acute & Urgent Care and Specialist Services). The Vital Signs dashboard will be used to support performance monitoring and management.

### Report Automation and Self-Service Reporting

Progress has been made towards the Performance Information goal of automation of processes and a new, self-service reporting environment.

There are currently several reports available, including a 'Current Waiters' report, detailing patients currently on waiting lists. These reports are designed to be accurate, timely and always available, and support with the delivery of services.

The selection of available reports will increase over time, with the next report aiming to highlight patients with missing demographics, such as ethnicity, employment and settled accommodation status, in time for them to updated at their next appointment or contact. The trust is measured on these metrics nationally and locally, and a proactive approach to capturing this data will result in performance improvement.

Work streams are in place to increase the amount of data the Performance team feeds back to the service areas and to improve validation processes. Initially looking at Care Home Physio activity, data is to be provided from the system to the clinical team, who will assess the results, making changes in Lorenzo before day 15 to ensure optimal performance is reported.

By providing data this way, the performance team is aiming to encourage a more pro-active response to data quality issues across the Trust, encouraging a more timely approach to recording data, and reduce the manual impact on the Performance Information team. This method also enables more insight and analysis to be provided back to clinical services.

## 4. Section 1 – Monthly Performance & Quality Management Framework (PQMF)

### Introduction to Performance Management Report

The report provides an overview of performance for September 2018 covering Contracted Key Performance Indicators (KPIs) and Reporting Requirements.

In addition to the performance dashboards a full database (Divisional Drill-Down) has been made available to Directorate Heads of Service and Clinical Directors to enable them to interrogate the supporting data and drive directorate improvement. This is summarised in Appendix 1.

### Executive Summary – Exception Reporting

The following performance highlights should be noted:

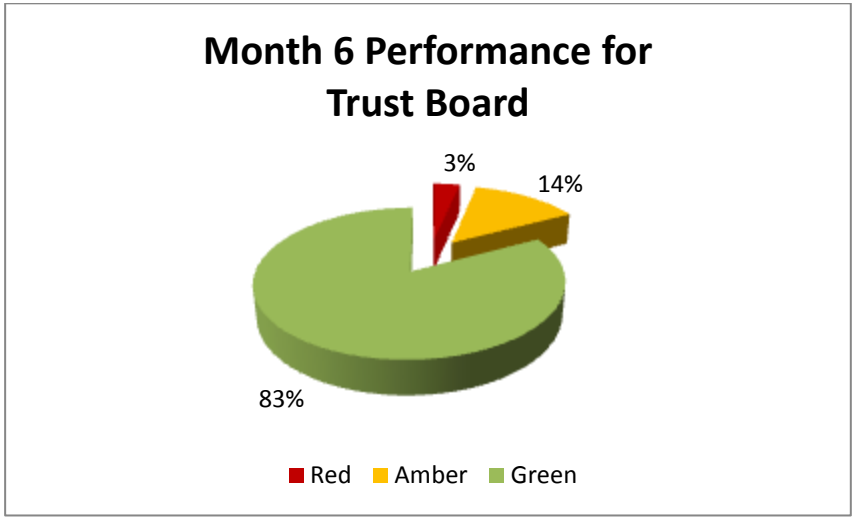
Access and Waiting Times:

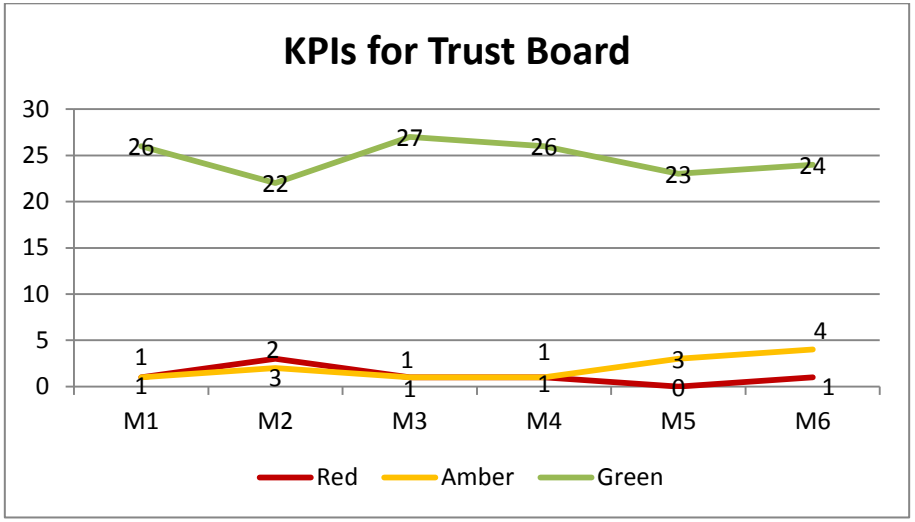
- 87.5% of clients referred for treatment through the Early Intervention team have been treated within 2 weeks (Target 50%)
- 100% of CAMHS Urgent Cases referred with suspected Eating Disorder started treatment within 1 week of referral (Target 95%)
- 60.3% of IAPT patients are moving to recovery (Target 50%)

CPA compliance:

- 98% of those on a Care Programme Approach (CPA) have received a follow up contact within 7 days of discharge (Target 95%)

In Month 6 there are 0 target related metrics rated as **Red** and 4 as **Amber**, all other indicators are within expected tolerances.




## Updated metrics and targets

The following measures and targets have been updated for Month 6:

- Sickness absence percentage figures for June confirmed, provisional data received for July, August and September 2018.

## Exceptions - Month 6

| KPI Classification | Metric | Exec/Op Lead | Target | M5 | M6 | Trend | Commentary |
|---|---|---|---|---|---|---|---|
| **CCG** | **IAPT:**<br><br>The proportion of people who have depression and/or anxiety disorders who receive psychological therapies | Exec Dir of Ops | **19.0% p/a** (4.75% p/qtr) | **GREEN Qtr 1 4.8%** | **AMBER Qtr 2 4.6%** | ↘ | **4.6% at Qtr 2 from 4.8% at Qtr 2**<br><br>Although the Trust is on target to achieve its annual performance, it has not met the required 4.75% quarterly target during quarter 2. (July 1.63%, August 1.52% September 1.46% respectively).<br><br>This equates to 13 cases under target on the data submitted locally to the CCG. The trust is contractually bound to report previous month's activity by day 15, although nationally NHS Digital refreshes the data to allow for late data entry. The Trust is aiming to replicate this process for the IAPT metrics in our data submissions. **If the Trust had re-run the data at the time of writing this report, performance would have exceeded target and the number of cases would be 12 over target**.<br><br>A proposal to adopt a flex and freeze approach to reporting to allow for late data entry is under development and the aim will be to agree this with commissioners for Q3 reporting. |
| **CCG** | **CPA Review:**<br><br>The proportion of those on Care Programme Approach (CPA) for at least 12mnths having formal review within 12mnths | Exec Dir of Ops | **95.0%** | **AMBER 93.8%** | **AMBER 93.4%** | ↘ | **93.4% at M6 from 93.8% at M5**<br><br>AMH Community – 94.6% at M6 the same as at M5<br>LD – 95.0% at M6 from 100.0% at M5<br>NOAP – 88.9% at M6 from 81.8% at M5<br>C&YP – 52.6% at M6 from 64.3% at M5<br><br>▪ AMHC - 94.6% (1,230/1,300) patients with a 12 month review recorded).<br>▪ NOAP - 88.9% (4 out of 36 patients not reviewed)<br>▪ CYP - 52.6% (10 out of 19 patients not reviewed)<br><br>This measure has been consistently achieved year to date and has dipped during the last 2 months. All Directorates have action plans in place to ensure that the standard is achieved in M7 and sustained going forward. |

<table>
<tr><th>KPI Classification</th><th>Metric</th><th>Exec/Op Lead</th><th>Target</th><th>M5</th><th>M6</th><th>Trend</th><th>Commentary</th></tr>
<tr><td>CCG</td><td>7 day Follow Up:<br><br>The proportion of those receiving follow up within 7 days of discharge (all patients)</td><td>Exec Dir of Ops</td><td>90.0%</td><td>AMBER<br>87.3%</td><td>AMBER<br>83.5%</td><td>↘</td><td>83.5% at M6 from 87.3% at M5<br><br>This was a new contractual requirement introduced in M4 to ensure that all patients discharged from an inpatient admission receive a 7 day follow up, both CPA and non CPA. For patients on a CPA, 98% were followed up within 7 days.<br><br>106 of the 127 patients discharged in M6 were followed up within 7 days, 21 patients were not followed up within the timescale.<br><br>• AMHIP - 92 of the 110 patients had recorded follow ups, 18 patients were not followed up within the timescale<br>• NOAP – 14 of the 17 patients had recorded follow ups, 3 patients were not followed up within the timescale<br><br>Weekly monitoring has been strengthened and inpatient and community staff have been reminded of the requirements of the SOP in respect of discharge planning and follow up. The inpatient wards have strengthened the process of notifying community teams of impending discharges.</td></tr>
<tr><td>National</td><td>Agency:<br><br>% Year to Date agency spend compared to Year to Date agency ceiling</td><td>Dir of Workforce</td><td>0.0%</td><td>GREEN<br>-2.0%</td><td>AMBER<br>2.0%</td><td>↗</td><td>2.0% above ceiling at M6 from -2.0% under at M5<br><br>Agency spend is £24k above the agency ceiling year to date. The majority of expenditure relates to medical locum where there is a national shortage Agency spend is forecast to be within the agency ceiling by M8.<br><br>
<table>
<tr><th>Agency Type</th><th>Sept 18 (£000)</th><th>% of Total</th></tr>
<tr><td>Medical</td><td>129</td><td>73%</td></tr>
<tr><td>Nursing</td><td>36</td><td>20%</td></tr>
<tr><td>Other Clinical</td><td>0</td><td>0%</td></tr>
<tr><td>Non Clinical</td><td>11</td><td>7%</td></tr>
<tr><td>Total</td><td>176</td><td>100%</td></tr>
</table>
</td></tr>
</table>

## 5. Section 2 – Single Oversight Framework : Q2 Quality of Care and Operational Metrics

| Metrics | Frequency | 18/19 Target | National Average | 2018/19 Q1 | 2018/19 Q2 | 2018/19 Q3 | 2018/19 Q4 |
|---|---|---|---|---|---|---|---|
| **Section 1: Quality of Care** | | | | | | | |
| Written complaints rate | Quarterly | N/A | | 9.4 | 10.0 | | |
| Occurrence of any Never Event | Monthly | 0 | | 0.0 | 0.0 | | |
| Patient Safety Alerts not completed by deadline | Monthly | 0 | | 0.0 | 0.0 | | |
| Mental Health Scores from Friends and Family test - % positive | Monthly | N/A | | 88.3% | 84.6% | | |
| Admissions to adult facilities of patients under 16 years old | Monthly | 0 | | 0.0 | 0.0 | | |
| CPA follow up - proportion of discharges from hospital followed up within 7 days | Monthly | 95.0% | 95.8% | 98.9% | 96.9% | | |
| % Clients in settled accomodation (target based on Q1 2018/19 national average) | Monthly | 31.4% | 31.4% | 20.1% | 23.5% | | |
| % Clients in employment (target based on Q1 2018/19 national average) | Monthly | 7.8% | 7.8% | 1.3% | 1.5% | | |
| **Section 2: Operational Performance** | | | | | | | |
| People with a first epsiode of psychosis begin treatment with a NICE- recommended care package within two weeks of referral | Monthly | 53.0% | 82.0% | 83.3% | 84.2% | | |
| Data Quality Maturity Index (DQMI) - MHSDS dataset score | Quarterly | 95.0% | | 96.1% | Awaiting | | |
| Improving Access to Psychological Therapies (IAPT) - Proportion of people completing treatment who move to recovery | Monthly | 50.0% | 51.60% | 65.6% | 65.5% | | |
| Improving Access to Psychological Therapies (IAPT) - Waiting time to begin treatment<br>**i) within 6 weeks**<br>**ii) within 18 weeks** | Monthly<br>Monthly | 75.0%<br>95.0% | 89.2%<br>99.1% | 100.0%<br>99.9% | 99.9%<br>100.0% | | |
| Inappropriate out-of-area placements for adult mental health services.<br><br>Baseline M9 2017/18 of 150 bed days - ratio of bed days each month compared to baseline<br><br>Total no. patients have spent out of area in period<br>Total no. bed days have spent out of area in period | Monthly | <100% | | 35.3%<br><br><br>9.0<br>53.0 | 42.7%<br><br><br>7.0<br>64.0 | | |

| Single Oversight Framework (SOF) – Noteworthy points |
|---|
| This report provides information on the Quality of Care, Operational Performance and Finance & Use of Resources metrics relevant to Mental Health Trusts for Quarters 1 and 2 2018/19. Performance is assessed based on national standards and targets where available, or the development of proxy measures to replicate what is published on the Model Hospital site.<br><br>The report is informed by an analysis of Model Hospital, NHSE or NHS Digital published national data to identify the latest national average/ median position and areas of comparatively high or relatively poor performance. This will be further enhanced in future reports.<br><br>Performance exceptions and noteworthy points are summarised below: |

| Metric | Performance Exceptions: Actions |
|---|---|
| **Clients in Employment:**<br>% clients in employment (count of patients who have an employment status that has been updated within the last 12 months) | The Trust is underperforming as the SOF counts as valid only when the status has been reviewed in the last 12 months. In order to improve performance, a SOP has been developed to ensure that the status is actively reviewed each year and the review recorded correctly in Lorenzo.<br>A self-serve operational management report is also in development to highlight patients with missing demographics, such as ethnicity, employment and settled accommodation status, in time for them to update at their next appointment or contact. |
| **Clients in Settled Accommodation:**<br>% of clients in settled accommodation (count of patients who have an accommodation status that has been updated within the last 12 months) | |

| Metric | To note |
|---|---|
| **Data Quality Maturity Index (DQMI):**<br>The DQMI provides healthcare data submitters with timely and transparent information about their data quality. It is an overall score calculated for each provider; it is defined as the average of the percentage of valid and complete entries in each field of each dataset and is proportional to the coverage. The core data items including NHS number date of birth, gender, ethnicity, postcode, speciality and consultant.<br><br>A target has not been set in the SOF and the Trust target is based on the national average in Q1 2018/19. | The latest published figures for Quarter 1 shows Trust performance at 96.1% (based on the latest published data at Q4 2017/18).<br><br>Out of the 72 Mental Health Trusts who submit MHSDS data NSCHT is currently:<br>▪ 6th highest regionally (NHS England Midlands and East)<br>▪ 22nd nationally |

**Early Intervention in Psychosis (EIPS) : DQ issue**

There is a national imperative to ensure that our MHSDS submissions of EIPS data conform to the UNIFY submissions. The table below sets out the difference in submissions from April to September based on a rolling 3 month period.

| | | Referrals on EIP pathway entering Treatment | | | Referrals on EIP pathway entering Treatment - % waiting 2 weeks or less | | |
|---|---|---|---|---|---|---|---|
| | **Rolling 3 Month Period** | **MHSDS** | **UNIFY** | **Var** | **MHSDS** | **UNIFY** | **Var** |
| NSCHT | Apr - Jun 2018 | 20 | 20 | 0 | 50% | 80% | (30%) |
| | May - Jul 2018 | 18 | 20 | 2 | 67% | 80% | (13%) |
| | Jun – Aug 18 | 19 | 22 | 3 | 79% | 86% | (7%) |
| | Jul - Sep 2018 | 24 | 25 | 1 | 83% | 88% | (5%) |

The validated position for September demonstrated a discrepancy of 1 case between Unify and MHSDS data for numbers entering treatment and a 5% variance on waiting time data.

The Performance team and the EIP service are working closely to ensure that there are no issues with the submission in October and going forward.

The EIPS is developing a clear SOP to be implemented across CAMHS & adult community and inpatient services to ensure that there is an immediate (on the day) onward referral to EIPS once psychosis is suspected or identified. This will help to ensure data alignment between the submissions.

**Cardio-metabolic assessment and treatment:**

This measure aims to ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas:
a) inpatient wards
b) early intervention in psychosis services (EIPS)
c) community health services (people on care programme approach)
The target is to achieve 90%

This KPI will be assessed at the end of November for EIPS and at the end of Q4 for inpatient and community services as part of an annual CQUIN Audit.

**Out of Area Beds**

The aim of the target is to demonstrate a reduction in total numbers of bed days patients (adult acute) have spent inappropriately out of area against rolling annual baseline, working towards elimination of inappropriate out of area placements by 2020/21.

In the SOF dashboard there are 3 data lines reported:

- Baseline M9 2017/18 of 150 bed days - ratio of bed days each month compared to baseline (SOF indicator)
- Number of patients placed out of area

| | |
|---|---|
| The rationale for this is to support the commitment in the Five Year Forward View for Mental Health to eliminate inappropriate placements (due solely to local acute bed pressures) for non-specialist adult acute care by 2021.<br><br>The data source for this will be the CAP monthly data collection of acute out of area placements. | ▪ Number of bed days out of area<br><br>The figures reported in the SOF dashboard are more accurate to those reported on the PQMF, due to the impact of the 15 day cut off point. |

## 6. North Staffs CCG : 5 Year Forward View for Mental Health Dashboard

### Quarter 4 2017/18

NHS North Staffordshire Combined Healthcare NHS Trust

| Indicators* | Reporting Period | Indicator Value | Standard met / on track | Trend** |
|---|---|---|---|---|
| **NORTH STAFFS CCG** | | | | |
| **Children and Young People (CYP) Mental Health** | | | | |
| % of CYP accessing treatment by NHS funded community services (at least two contacts) | 2017/18 | N/A | N/A | N/A |
| % of CYP with eating disorders seen within 1 week (urgent) | Q4 2017/18 | 33.3% | N/A | |
| % of CYP with eating disorders seen within 4 weeks (routine) | Q4 2017/18 | 100.0% | N/A | |
| Number of bed days for CYP under 18 in Child and Adolescent Mental Health tier 4 wards | Q4 2017/18 | 968.0 | N/A | |
| Number of admissions of CYP under 18 in Child and Adolescent Mental Health tier 4 wards | Q4 2017/18 | 5.0 | N/A | |
| Bed days of CYP under 18 in adult in-patient wards | Q4 2017/18 | N/A | N/A | N/A |
| Number of CYP under 18 in adult in-patient wards | Q4 2017/18 | N/A | N/A | N/A |
| CYP Mental Health actual CCG spend - exluding learning disabilities and eating disorders | 2017/18 | £1.6m | N/A | N/A |
| CYP Mental Health actual CCG spend - eating disorders | 2017/18 | £422k | N/A | N/A |
| **Adult Mental Health: common mental health problems (Improving Access to Psychological Therapies services)** | | | | |
| IAPT access rate: proportion of people with depression/anxiety entering NHS funded treatment during reporting period | Q4 2017/18 | 3.7% | | |
| IAPT % of all referrals that are for older people 65+ | Q4 2017/18 | 9.7% | N/A | N/A |
| IAPT recovery rate: % of people that attended at least 2 treatment contacts and are moving to recovery | Q4 2017/18 | 58.0% | | |
| IAPT recovery rate for black or minority ethnic (BME) groups | Q4 2017/18 | 25.0% | | |
| IAPT % of people receiving first treatment appointment within 6 weeks of referral | Q4 2017/18 | 94.0% | | |
| IAPT % of people receiving first treatment appointment within 18 weeks of referral | Q4 2017/18 | 99.0% | | |
| IAPT actual CCG spend | 2017/18 | £2.2m | N/A | N/A |
| **Early Intervention in psychosis (EIP)** | | | | |
| % of people who started treatment within 2 weeks of referral - All ages | Q4 2017/18 | 77.8% | | |
| EIP actual CCG spend | 2017/18 | £419k | N/A | N/A |
| **Acute hospital mental health liaison** | | | | |
| A&E and Ward Liaison mental health actual spend | 2017/18 | £380k | N/A | N/A |
| **Suicide Prevention** | | | | |
| Suicide: age-standardised death rate per 100,000 population - Age: 10+ | 2014-2016 | 8.2 | N/A | |
| Hospital admissions for self-harm: age standardised rate per 100,000 - Age: 10-24 | Q4 2017/18 | 138.0 | N/A | |
| Hospital admissions for self-harm: age standardised rate per 100,0000 - Age: 25 + | Q4 2017/18 | 42.7 | N/A | |
| % of population of England with access to liaison and diversion services - All ages | Q4 2017/18 | 100.0% | N/A | |
| **Meeting commitment to increase mental health funding** | | | | |
| CCG spend on MH as a % of CCG base allocations | 2017/18 | 16.4% | N/A | N/A |
| Mental Health actual spend in 2016/17 | 2016/17 | £41.8m | N/A | N/A |
| Mental Health actual spend in 2017/18 | 2017/18 | £45.7m | N/A | N/A |
| MH investmet standard achieved? | 2017/18 | Y | N/A | N/A |

NHS
North Staffordshire
Combined Healthcare
NHS Trust

# Stoke-on-Trent CCG : 5 Year Forward View for Metal Health Dashboard

## Quarter 4 2017/18

NHS North Staffordshire Combined Healthcare NHS Trust

| Indicators* | Reporting Period | Indicator Value | Standard met / on track | Trend** |
|---|---|---|---|---|
| **STOKE-ON-TRENT CCG** | | | | |
| **Children and Young People (CYP) Mental Health** | | | | |
| % of CYP accessing treatment by NHS funded community services (at least two contacts) | 2017/18 | N/A | N/A | N/A |
| % of CYP with eating disorders seen within 1 week (urgent) | Q4 2017/18 | 77.8% | N/A | |
| % of CYP with eating disorders seen within 4 weeks (routine) | Q4 2017/18 | 88.9% | N/A | |
| Number of bed days for CYP under 18 in Child and Adolescent Mental Health tier 4 wards | Q4 2017/18 | 1116.0 | N/A | |
| Number of admissions of CYP under 18 in Child and Adolescent Mental Health tier 4 wards | Q4 2017/18 | 11.0 | N/A | |
| Bed days of CYP under 18 in adult in-patient wards | Q4 2017/18 | N/A | N/A | N/A |
| Number of CYP under 18 in adult in-patient wards | Q4 2017/18 | N/A | N/A | N/A |
| CYP Mental Health actual CCG spend - exluding learning disabilities and eating disorders | 2017/18 | £2.8m | N/A | N/A |
| CYP Mental Health actual CCG spend - eating disorders | 2017/18 | £590k | N/A | N/A |
| **Adult Mental Health: common mental health problems (Improving Access to Psychological Therapies services)** | | | | |
| IAPT access rate: proportion of people with depression/anxiety entering NHS funded treatment during reporting period | Q4 2017/18 | 4.4% | | |
| IAPT % of all referrals that are for older people 65+ | Q4 2017/18 | 7.4% | N/A | |
| IAPT recovery rate: % of people that attended at least 2 treatment contacts and are moving to recovery | Q4 2017/18 | 66.0% | | |
| IAPT recovery rate for black or minority ethnic (BME) groups | Q4 2017/18 | 47.0% | | |
| IAPT % of people receiving first treatment appointment within 6 weeks of referral | Q4 2017/18 | 99.0% | | |
| IAPT % of people receiving first treatment appointment within 18 weeks of referral | Q4 2017/18 | 100.0% | | |
| IAPT actual CCG spend | 2017/18 | £2.3m | N/A | N/A |
| **Early Intervention in psychosis (EIP)** | | | | |
| % of people who started treatment within 2 weeks of referral - All ages | Q4 2017/18 | 58.3% | | |
| EIP actual CCG spend | 2017/18 | £628k | N/A | N/A |
| **Acute hospital mental health liaison** | | | | |
| A&E and Ward Liaison mental health actual spend | 2017/18 | £1.0m | N/A | N/A |
| **Suicide Prevention** | | | | |
| Suicide: age-standardised death rate per 100,000 population - Age: 10+ | 2014-2016 | 9.0 | N/A | |
| Hospital admissions for self-harm: age standardised rate per 100,000 - Age: 10-24 | Q4 2017/18 | 159.1 | N/A | |
| Hospital admissions for self-harm: age standardised rate per 100,0000 - Age: 25 + | Q4 2017/18 | 44.5 | N/A | |
| % of population of England with access to liaison and diversion services - All ages | Q4 2017/18 | 91.0% | N/A | |
| **Meeting commitment to increase mental health funding** | | | | |
| CCG spend on MH as a % of CCG base allocations | 2017/18 | 15.3% | N/A | N/A |
| Mental Health actual spend in 2016/17 | 2016/17 | £55.2m | N/A | N/A |
| Mental Health actual spend in 2017/18 | 2017/18 | £59.6m | N/A | N/A |
| MH investmet standard achieved? | 2017/18 | Y | N/A | N/A |

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| 5 Year Forward View for Mental Health: Noteworthy points |
|---|
| These dashboards present the NHSE performance assessment by Stoke and North Staffs CCG against the priority areas identifies within the Five Year Forward View for Mental Health. This reports on the latest published national reports (Quarter 4 2017/18).<br><br>In view of the late publication of the national data (currently 6 months in arrears) a local dashboard has been developed using proxy measures to replicate the national measures. This will be reported on day 15 following month end in line with Trust reporting requirements. It should be noted that the data will not match the nationally published dashboard as this may represent data refreshes after the reporting period has ended. It is proposed that this local dashboard is provided to SLT on a monthly basis going forward, and the FPD Committee and Board will receive the published national position. |

| Metric | Performance Exceptions: Actions |
|---|---|
| **IAPT access rate: proportion of people with depression/anxiety entering NHS funded treatment**<br><br>(Exception report for Stoke CCG as the Trust provides Stoke Healthy MINDs IAPT) | In 2018/19 the Trust is on target to achieve its annual performance, although it was reported in the M7 PQMF report that it has not met the required 4.75% quarterly target during quarter 2. This equates to 13 cases under target on the data submitted locally to the CCG. If the trust had re-run the data at the time of writing this report, performance would have exceeded target and the number of cases would be 12 over target.<br>The trust will be replicating the national reporting methodology of NHS Digital in the future and will refresh the PQMF report to allow for late data entry. If the trust had re-run the data at the time of writing this report, performance would have exceeded target and the number of cases would be 12 over target. |
| **IAPT recovery rate for black or minority ethnic (BME) groups**<br><br>(Exception report for Stoke CCG as the Trust provides Stoke Healthy MINDs IAPT) | The national recovery rate on NHS Digital is 48.2% (National Digital Executive Summary- last publication) which is the slightly above the reported position for Stoke CCG (47%).<br><br>The Healthy Minds IAPT service has been marketing the service across the BAME community, working closely with the Trust's Equality Lead to establish the community profile and prevalence rates for people in Stoke who have a BAME background so that the service can understand the demographic profile of the community. The service has strong relationships with third sector organisations and specialist providers including the Asylum Seeker Program workers to ensure that people are informed about the pathways for ease of access to the local IAPT service. There have been several leaflets developed to represent the local community, an information translation service is used to support information sharing and therapists actively engage telephone or face to face interpreter services to help meet the service users communication needs. The number of people who have accessed the service has steadily increased, data suggests that 5% of BAME community accessed the service 2017/18 and this has increased to 6.5% 2018/19 to date. |

## 7. Recommendations

The Trust Board is asked to:

- Receive the report as outlined
- Note the Management action and committee oversight

# Appendix 1 - Month 6 PQMF Dashboard

**Month:** **September**
**6**
**Key:-**

## PQMF Report

| | |
|---|---|
| CCG | NHS Standard Contract Reporting |
| National | NHS Improvement metric (Unify) |
| Trust Measure | Locally monitored metric |

| | | | |
|---|---|---|---|
| ↗ | Trend up (positive) | ↘ | Trend down (negative) |
| ↘ | Trend Down (positive) | ↗ | Trend Up (negative) |
| ↔ | No change | ↘ | Trend Down (Neutral) |
| | | ↗ | Trend Up (Neutral) |

| | Metric | Frequency | Standard | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NHSI | Early Intervention in Psychosis - A maximum of 2 week waits for referral to treatment (Target 17/18-50%, 18/19-53%) | Monthly | 53% | 75.0% | 75.0% | 100.0% | 75.0% | 90.0% | 87.5% | | | | | | |
| | Early Intervention in Psychosis - A maximum of 2 week waits for referral to treatment (North Staffordshire CCG) (Target 17/18-50%, 18/19-53%) | Monthly | 53% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 75.0% | | | | | | |
| | Early Intervention in Psychosis - A maximum of 2 week waits for referral to treatment (Stoke-on-Trent CCG) (Target 17/18-50%, 18/19-53%) | Monthly | 53% | 50.0% | 66.6% | 100.0% | 66.6% | 88.8% | 100.0% | | | | | | |
| NHSI | CAMHS - % of CYP with ED (Routine Cases) referred with a suspected ED that start treatment within 4 weeks of referral (North Staffs and Stoke CCG) | Monthly/Quarterly | 95% | | | 100.0% | | | 100.0% | | | | | | |
| | CAMHS - % of CYP with ED (Routine Cases) referred with a suspected ED that start treatment within 4 weeks of referral (North Staffs CCG) | Monthly/Quarterly | 95% | | | 100.0% | | | 100.0% | | | | | | |
| | CAMHS - % of CYP with ED (Routine Cases) referred with a suspected ED that start treatment within 4 weeks of referral (Stoke CCG) | Monthly/Quarterly | 95% | | | 100.0% | | | 100.0% | | | | | | |
| NHSI | CAMHS - Number of CYP with ED (Urgent Cases) referred with a suspected ED that start treatment within 1 week of referral (North Staffs and Stoke CCG) | Monthly/Quarterly | 95% | | | 100.0% | | | 100.0% | | | | | | |
| | CAMHS - Number of CYP with ED (Urgent Cases) referred with a suspected ED that start treatment within 1 week of referral (North Staffs CCG) | Monthly/Quarterly | 95% | | | 100.0% | | | 100.0% | | | | | | |
| | CAMHS - Number of CYP with ED (Urgent Cases) referred with a suspected ED that start treatment within 1 week of referral (Stoke CCG) | Monthly/Quarterly | 95% | | | 100.0% | | | 100.0% | | | | | | |
| CCG | Compliance with 18 week waits (Referral to Treatment or Intervention) | Monthly | 92% | 90.5% | 86.8% | 93.5% | 93.9% | 93.9% | 91.7% | | | | | | |
| CCG | AMH Community | Monthly | 92% | 90.1% | 87.3% | 92.7% | 92.6% | 89.3% | 89.5% | | | | | | |
| CCG | LD | Monthly | 92% | 92.3% | 87.5% | 90.9% | 100.0% | 93.8% | 95.0% | | | | | | |
| CCG | NOAP | Monthly | 92% | 92.5% | 93.2% | 95.0% | 95.3% | 95.7% | 90.8% | | | | | | |
| CCG | C&YP | Monthly | 92% | 82.4% | 65.2% | 90.6% | 91.9% | 97.9% | 96.5% | | | | | | |
| CCG | Zero tolerance RTT waits over 52 weeks for incomplete pathways | Monthly | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | |
| CCG | MH Liaison Team response to A&E referrals within 1 hour | Monthly | 95% | 94.8% | 93.0% | 98.0% | 95.0% | 97.9% | 97.3% | | | | | | |
| CCG | Patients will be assessed within 12 weeks of referral to the Memory Assessment service | Monthly | 95% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | | | | | |
| CCG | Number of people seen for crisis assessment within 4 hours of referral | Monthly | 95% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | | | | | |
| National | Percentage of inpatient admissions that have been gatekept by crisis resolution/ home treatment team | Monthly | 95% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | | | | | |

| | Metric | Frequency | Standard | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| National/CCG | Overall safe staffing fill rate | Monthly | No Target | 93.7% | 93.4% | 94.1% | 93.7% | 93.6% | 93.4% | | | | | | |
| National | Mental health delayed transfers of care (target NHSI) | Monthly | 7.5% | 5.5% | 9.1% | 7.6% | 7.8% | 7.8% | 5.9% | | | | | | |
| CCG | Emergency Readmission rate (30 days). Percentage of patients readmitted within 30 days of discharge. | Monthly | 7.5% | 6.0% | 4.8% | 4.8% | 6.5% | 7.5% | 6.4% | | | | | | |
| NHSI | Total **bed days** patients have been Out of Area | Monthly | No target | 4.0 | 0.0 | 22.0 | 2.0 | 67.0 | 2.0 | | | | | | |
| Trust Measure | Adult | Monthly | No target | 4.0 | 0.0 | 22.0 | 2.0 | 67.0 | 2.0 | | | | | | |
| Trust Measure | Older Adult | Monthly | No target | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | | | | | | |
| NHSI | Ratio of days Out of Area to baseline (Baseline set at M9 2017/18 figure of 150 bed days, as per SOF guidance, shown as 100%. The ratio of days each month to this baseline figure is then expressed as a percentage.) | Monthly | <100% | 2.7% | 0.0% | 14.7% | 1.3% | 44.7% | 1.3% | | | | | | |
| Trust Measure | Total patients Out of Area | Monthly | No target | 2.0 | 0.0 | 6.0 | 2.0 | 4.0 | 1.0 | | | | | | |
| Trust Measure | Adult | Monthly | No target | 2.0 | 0.0 | 6.0 | 2.0 | 4.0 | 1.0 | | | | | | |
| Trust Measure | Older Adult | Monthly | No target | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | | | | | | |
| Trust Measure | Total bed days - PICU | Monthly | No target | 252.0 | 441.0 | 715.0 | 547.0 | 252.0 | 93.0 | | | | | | |
| Trust Measure | Total patients - PICU | Monthly | No target | 5.0 | 4.0 | 4.0 | 12.0 | 6.0 | 5.0 | | | | | | |
| **SAFE** | | | | | | | | | | | | | | | |
| CCG | Number of patients 16/17 years old admitted to Adult Psychiatric wards | Monthly | 0.0 | 1.0 | 1.0 | 1.0 | 0.0 | 0.0 | 0.0 | | | | | | |
| NHSI | Admission to adult facilities of U16s | Monthly | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | | | | | | |
| CCG | Bed Occupancy (incl home leave) - Trust | Monthly | 85% | 90.7% | 89.0% | 87.8% | 85.4% | 89.7% | 89.7% | | | | | | |
| CCG | Bed Occupancy (incl home leave) - AMHIP | Monthly | 90% | 89.7% | 77.8% | 89.5% | 91.1% | 89.7% | 86.4% | | | | | | |
| CCG | Bed Occupancy (Including Home Leave)-Trust excluding AMHIP | Monthly | 85% | 90.6% | 94.9% | 85.9% | 79.6% | 88.0% | 90.4% | | | | | | |
| CCG | LD | Monthly | 85% | 79.7% | 83.6% | 90.6% | 81.7% | 80.3% | 81.9% | | | | | | |
| CCG | Neuro | Monthly | 85% | 88.2% | 102.0% | 91.8% | 93.1% | 96.5% | 99.1% | | | | | | |
| CCG | Old Age Psychiatry | Monthly | 85% | 91.5% | 95.9% | 83.4% | 78.4% | 88.2% | 96.9% | | | | | | |
| CCG | C&YP | Monthly | 85% | 98.7% | 95.1% | 85.1% | 68.3% | 84.7% | 66.6% | | | | | | |
| CCG | IAPT: The proportion of people who have depression and/or anxiety disorders who receive psychological therapies | Quarterly | 19% per annum (4.75% per quarter) | | | 4.8% | | | 4.6% | | | | | | |
| NHSI / CCG | IAPT : The number of people who are moving to recovery. Divided by the number of people who have completed treatment minus the number of people who have completed treatment that were not at caseness at initial assessment | Monthly | 50% | 69.3% | 71.7% | 67.8% | 70.3% | 66.0% | 60.3% | | | | | | |
| NHSI / CCG | Improving Access to Psychological Therapies (IAPT) Programme: the percentage of service users referred to an IAPT programme who are treated within 6 weeks of referral | Monthly | 75% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 99.8% | | | | | | |
| NHSI / CCG | Improving Access to Psychological Therapies (IAPT) Programme: the percentage of service users referred to an IAPT programme who are treated within 18 weeks of referral | Monthly | 95% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | | | | | |
| CCG | IAPT: Patients wait no longer than 90 days between 1st and 2nd treatment | Monthly | <10% | 26.1% | 17.9% | 17.8% | 15.1% | 6.8% | 4.4% | | | | | | |
| CCG | Place of Safety Assessments | Monthly | No Target | 22 | 24 | 22 | 25 | 27 | | | | | | | |
| National | The proportion of those on Care Programme Approach (CPA) for at least 12mnths having formal review within 12mnths *NHSI* | Monthly | 95% | 95.3% | 96.5% | 97.1% | 97.0% | 93.8% | 93.4% | | | | | | |
| NHSI | The proportion of those on Care Programme Approach (CPA) receiving follow-up contact within 7 days of discharge | Monthly | 95% | 100.0% | 97.9% | 98.7% | 96.3% | 96.4% | 98.0% | | | | | | |
| Trust Measure/CCG | (ALL PATIENTS) The proportion of those receiving follow up within 7 days of discharge | Monthly | Internal-No Target CCG-90% | 91.2% | 85.2% | 91.0% | 80.2% | 87.3% | 83.5% | | | | | | |
| NHSI/CCG | Never Events | Monthly | 0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | | | | | | |
| National | Patient Safety Alerts not completed by deadline | Monthly | 0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | | | | | | |
| CCG | Mixed Sex Accommodation Breach | Monthly | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | |

| | Metric | Frequency | Standard | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **CARING** | | | | | | | | | | | | | | | |
| National | Inpatient Scores from Friends and Family Test – % positive | Monthly | No Target | 90.8% | 84.9% | 89.2% | 89.8% | 87.0% | 77.0% | | | | | | |
| National | Staff Friends and Family Test - % recommended - care | Quarterly | No Target | | | No data | | | No data | | | | | | |
| National | Percentage of complaints responded to in line with timescale agreed with complainant | Monthly | 95% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | | | | | |
| National | Written complaints rate | Quarterly | No Target | | | 9.4% | | | 10.0% | | | | | | |
| CCG | Duty of Candour Each failure to notify the Relevant Person of a suspected or actual Reportable Patient Safety Incident | Monthly | 0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | | | | | | |
| **ORGANISATIONAL HEALTH** | | | | | | | | | | | | | | | |
| National | % Year to Date Agency Spend compared to Year to Date Agency Ceiling | Monthly | 0% | -45.0% | -39.0% | -23.0% | -12.9% | -2.0% | 2.0% | | | | | | |
| National | Sickness Absence Percentage: Days lost | Monthly | 4.95% | 2.8% | 2.6% | 3.3% | 2.3% | 2.5% | 2.5% | | | | | | |
| National | Staff Turnover (% FTE) | Monthly | >10% | 0.6% | 0.8% | 0.5% | 0.9% | 1.2% | 1.6% | | | | | | |

NHS
North Staffordshire
Combined Healthcare
NHS Trust

# REPORT TO OPEN TRUST BOARD

Enclosure No:17

| | | | |
|---|---|---|---|
| Date of Meeting: | 22ND November 2018 | | |
| Title of Report: | Being Open Report: An Evaluation and Analysis of Dear Caroline, Freedom to Speak up and Raising Concerns activity (October 2017 to September 2018) | | |
| Presented by: | Caroline Donovan, Chief Executive | | |
| Author: | Kerry Smith, Associate Director of Workforce | | |
| Executive Lead Name: | Jonathan O'Brien, Director of Operations | Approved by Exec | ☒ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| The Being Open report provides a combined report of Dear Caroline, FSUG and Raising Concerns submissions, reporting on their collective activity providing details regarding the themes, trends and patterns for assurance at Trust Board. It provides a full summary of activity covering a 12 month period for October 2017 – September 2018 and a detailed quarterly review for the period of July 2018 – September 2018. | Approval | ☐ |
| | Information | ☒ |
| | Discussion | ☐ |
| | Assurance | ☒ |

Combined Being Open Key themes – October 2017 – September 2018
Top three themes:

- Policies, Procedures and Processes
- Service Changes
- Other

Combined Being key themes – July 18 – September 18
Top themes:

- Policies, Procedure and Processes
- Service Changes
- Quality and Safety
- Staffing Levels'

<u>Next Steps</u>

It is proposed that the Trust will:

- Continue to utilise all four mechanisms to support staff to raise concerns and issues
- Support the ongoing development of an open and transparent culture through development and embedding of the Trust Values and supporting Behaviours Framework
- Continuation of the Freedom to Speak Up Guardian role including further strengthening of approach/ development of a range of Freedom to Speak Up Champions to further support the FSUG role.
- Continue and strengthen communication to the wider Trust to help promote speaking to managers, professional leads, trade union representatives as well as the more formal routes that are available.

| | | | |
|---|---|---|---|
| Seen at: | SLT ☒ Execs ☒<br>Date: 8th and 13th November 2018 | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☐<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☒<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Digital by Choice Board ☐ | | |

| | |
|---|---|
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement.☐<br>2. To provide the highest quality services ☒<br>3. Create a learning culture to continually improve.☒<br>4. Encourage, inspire and implement research & innovation at all levels.☐<br>5. Maximise and use our resources intelligently and efficiently.☐<br>6. Attract and inspire the best people to work here.☒<br>7. Continually improve our partnership working. ☐ |
| Risk / legal implications:<br>Risk Register Reference | N/A |
| Resource Implications:<br><br>Funding Source: | Management Time<br><br>N/A |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | All staff are actively encouraged to access the abovementioned mechanisms to raise concerns and can do so either electronically, in writing or where requested via telephone/face to face meeting. |
| STP Alignment / Implications: | None |
| Recommendations: | • Receive the report for assurance<br>• Support the proposed next steps<br>• Receive an update report quarterly |

# Being Open Report:
# An Evaluation and Analysis of Dear Caroline, Freedom to Speak up and Raising Concerns activity (October 2017 to September 2018)

## 1. Introduction

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

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

The Being Open report provides a combined report of the abovementioned mechanisms reporting on their collective activity providing details regarding the themes, trends and patterns for assurance at Trust Board. It provides a full summary of activity covering a 12 month period for October 2017 – September 2018 and a detailed quarterly review for the period of July 2018 – Sept 2018. Furthermore, to allow greater comparison and review the high level themes developed by the National Freedom to Speak Up Guardian have been adopted and allocated to all submissions across each of the abovementioned mechanisms. Further detailed drill downs are available.

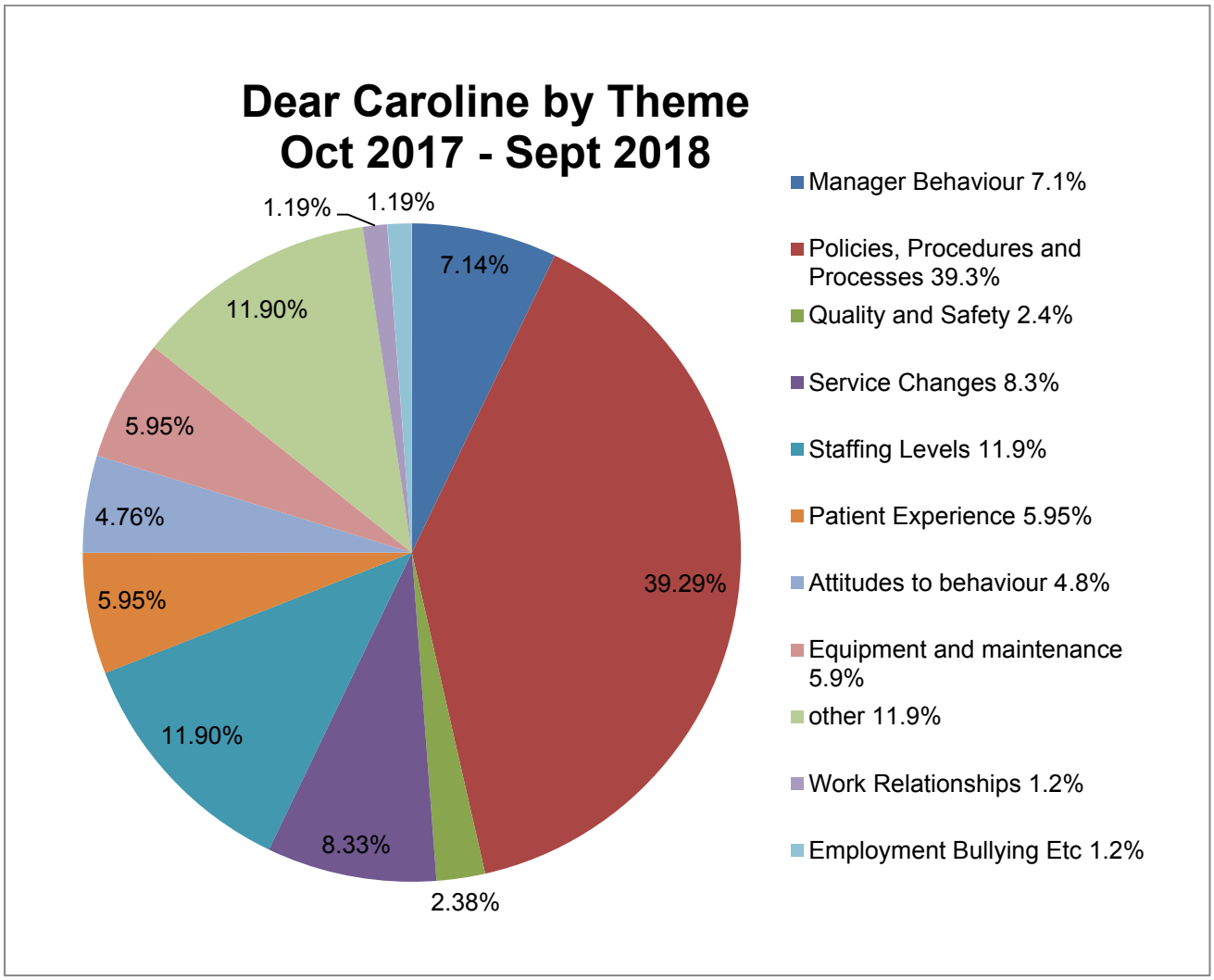
The high level themes recommended by the FSUG include:

- Attitudes and behaviours
- Equipment and maintenance
- Staffing levels
- Policies, procedures and processes
- Quality and safety
- Patient experience
- Performance capability
- Service changes
- Other
- Employment Bullying etc.
- Manager Behaviour
- Work Relationships

## 2. Summary of activity and themes (12 month – October 2017 – September 2018 )

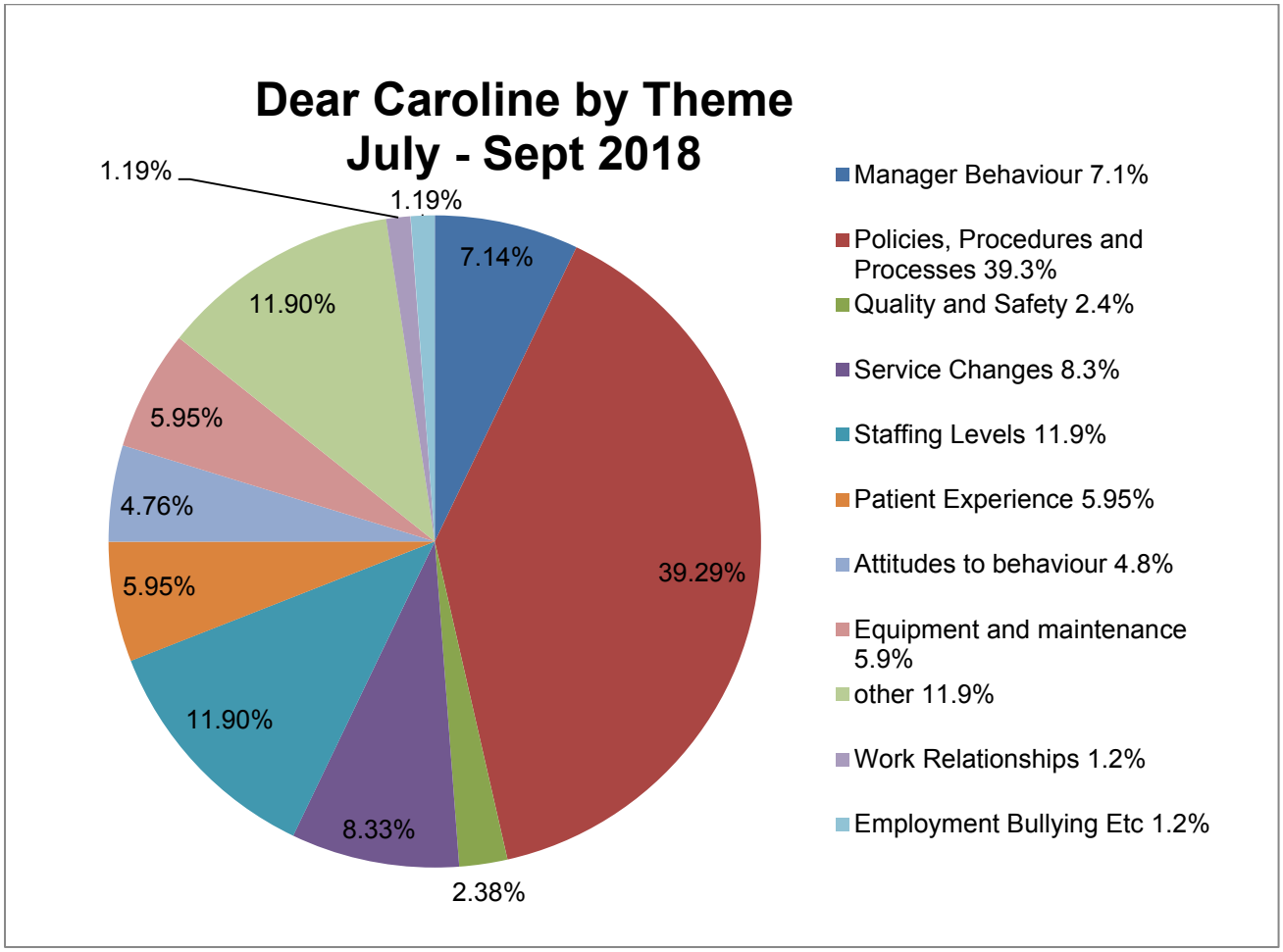
### 2.1 Dear Caroline (DC) Activity

Between October 2017 to September 2018, a total of 92 DC submissions have been received and 27 submissions between July 2018 – September 2018. The pie chart below details themes by percentage over the 12 month period.




Over the 12 month period submissions relating to Policies, procedures and processes (39.3%) other (11.9%) and Staffing Levels (11.9%) have been raised most frequently. Repeat themes include concerns with regards to staffing shortages within AMH Inpatient and AMH Community Services, car parking fines, E-rostering implementation concerns, Lorenzo implementation concerns, a variety of workforce reward and recognition suggestions, concerns relating to culture and manager leadership behaviors and concerns/suggestions regarding the Trust Smoke Free initiative.

The pie chart below details themes by percentage for the quarter July 2018 – Sept 2018.




Between July and September 2018, themes are fairly disparate. The most common concerns raised are with regards to policies, procedures, and processes (39.2%) which cover a wide variety of matters the most common being E-rostering, Lorenzo, Trac (online recruitment system), Learning Management System (LMS) and No Smoking Policy.

Additional repeat themes include 'other' (11.9%) which includes a variety of submissions including recruitment and retention suggestions, CEO Blog, request for an extension to the Harplands Café Opening times and additional staff room request. Patient experience which incorporates submissions relating to future plans for ward areas, the RAID service and access to water dispensers within clinical settings. Finally, Manager Behaviour relates to submissions concerning perceived Line Manager Role Modelling/Behaviours.

Staffing Levels (11.9%) also featured with concerns being raised regarding the staffing levels in AMH Inpatients Ward 1, inpatients generally and the Access and Home Treatment Team, AMH Community Directorate.

It is important to note that compliments, positive feedback, and helpful suggestions regarding improving our services have also been received via Dear Caroline; examples include compliments about staff members/teams, positive feedback regarding CEO Blog and suggestions to improve service user and staff facilities, Dear Caroline and the Lorenzo IT system.

### 2.2 Freedom to Speak Up Guardian Activity

From October 2017 – September 2018, 6 submissions have been received by the Freedom to Speak Up Guardian within the last 12 months and 4 submissions within the quarter from July – September 2018. The submissions relate to the AMH Community (3 submissions) one relates to manager behavior and two related to perceived high caseloads which is connected to Patient/Safety and staffing concerns. One submission relates to CYP with regards to alleged behaviour of an agency member of staff.

### 2.3 Raising Concerns Activity

From October 2017 to September 2018, 4 submissions have been received and 1 submission for the period July 2018 – September 2018. Previous submissions relate to a concern regarding the use of the Meridian Tool within the AMH Community Directorate, one relates to the culture and leadership style of a Senior Manager who is no longer employed by the Trust, the third submission relates to the perceived leadership style, morale and staff engagement within a team in the AMH Community Directorate. The most recent submission relates to concerns regarding the Quality and Safety of an AMH Community Team.

### 2.4 Grievance and Dispute Activity

From October 2017 to September 2018, a total of four grievances have been raised and no further submissions were raised during the period July 2018 – September 2018.

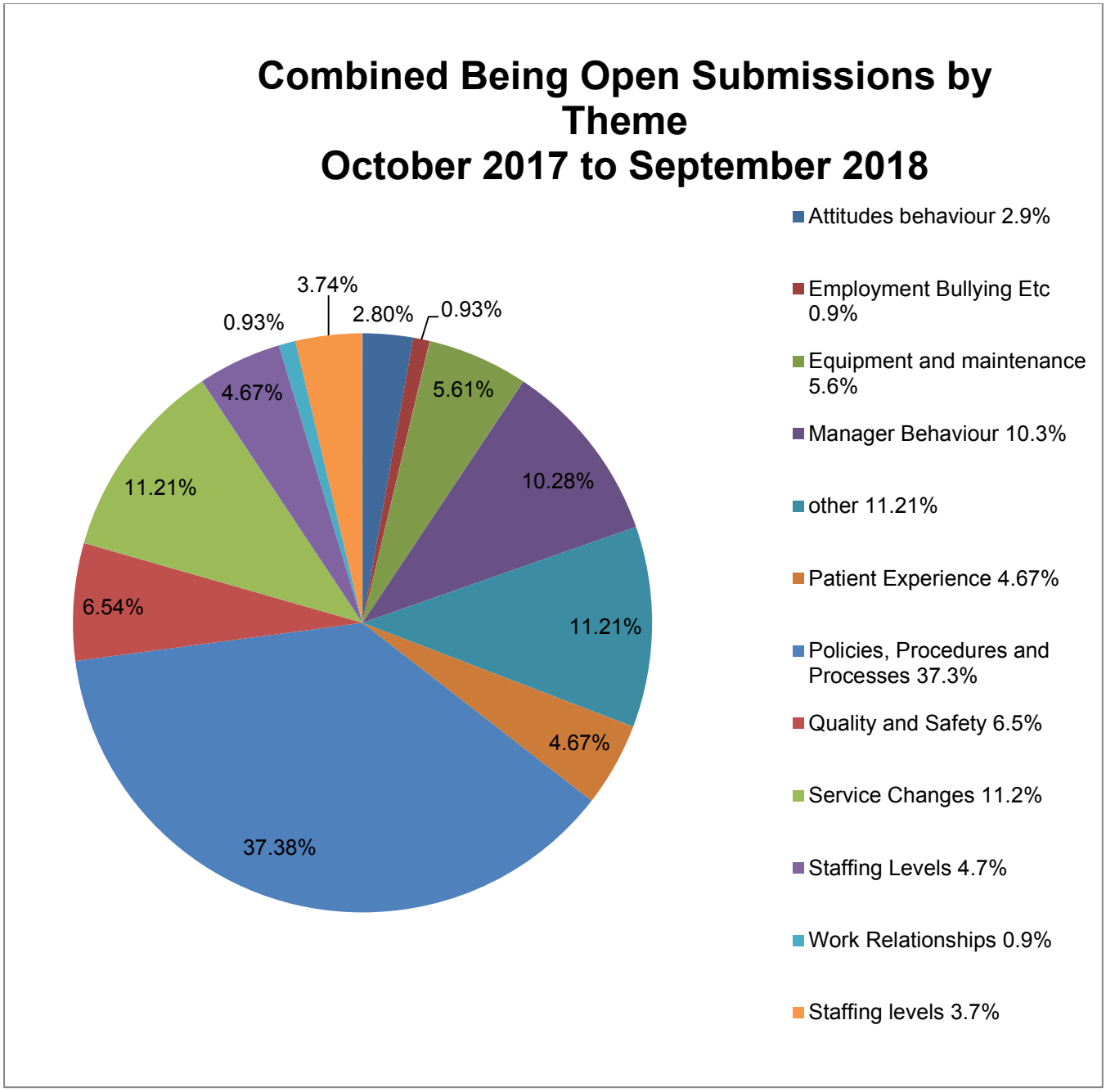
Overall, grievances raised relate in the main to the Corporate function (Estates Team with 2 submissions) and have an overarching classification of Manager Behaviour theme pertaining to a TUPE process and a request to take on additional duties/manager behaviour. Additionally one collective grievance was received which concerned historical break patterns within the LD Directorate and a further grievance within the Substance Misuse Directorate concerning a Management of Change and Job Banding challenge. All matters continue to be managed in accordance with the Trusts Grievance policy and procedure.

## 1. Combined Being Open Key Themes

#### 1.1. High level: 12 month theme analysis

In order to assess the themes that emerge from Dear Caroline, FSUG, Grievances and Raising Concerns each submission is assigned a summary category where possible for further evaluation. Please note the submissions have been categorised to allow analysis against the recommended FSUG national themes.

It is important to note, however, that the submissions have been categorised based on the primary concern and some of the submissions are multi-faceted. The chart below shows the distribution of submissions, with further detail provided below for the top 3 reasons which include Policies, Procedures and Processes (37.3%), Staff Levels (16.7%) and Service Changes (10.6%).




### 1.1.1. Policies, Procedures and Processes (37.4%)

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

Repeat submissions have been made regarding Trust Policies including suggestions regarding service improvement, Lorenzo, E-rostering, LMS, Trac recruitment, dress code and No Smoking Policy.

### 1.1.2. Other (11.2%)

This category combines a variety of submissions including Cycle to work suggestions, CEO Blog, Christmas incentives, Recruitment and Retention incentives, café opening times, parking at Harplands site.

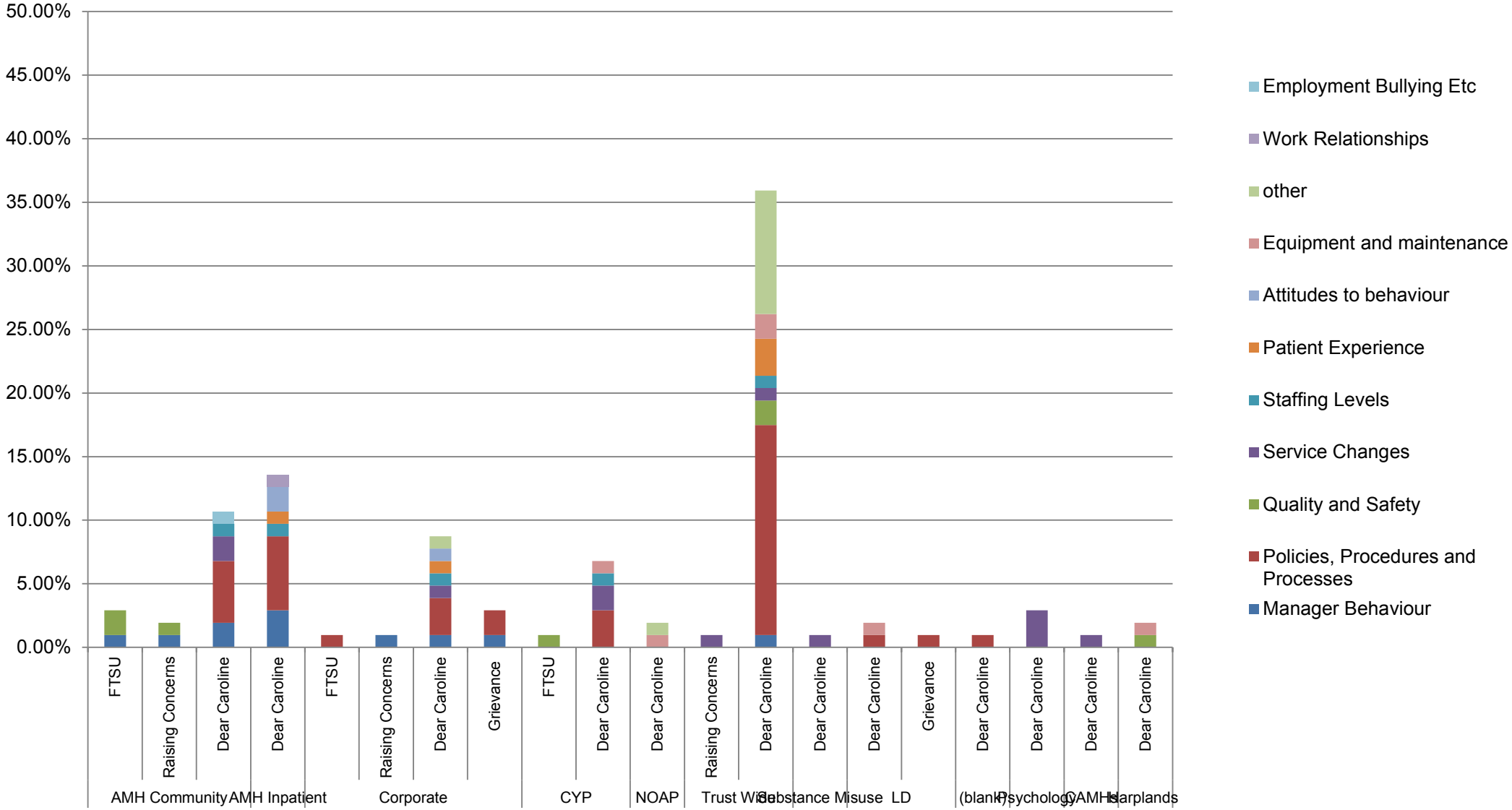
#### 1.1.3. Service Changes (11.2%)

A number of submissions have been received concerning the locality restructure and supporting management of change process, concerns regarding Care Coordination, Psychology services and planned changes within CYP Directorate. Also concerns regarding service changes to Section 75 staff and Substance Misuse service.

### 1.2. High Level: Quarterly Directorate Themes and activity (July – Sept 2018)

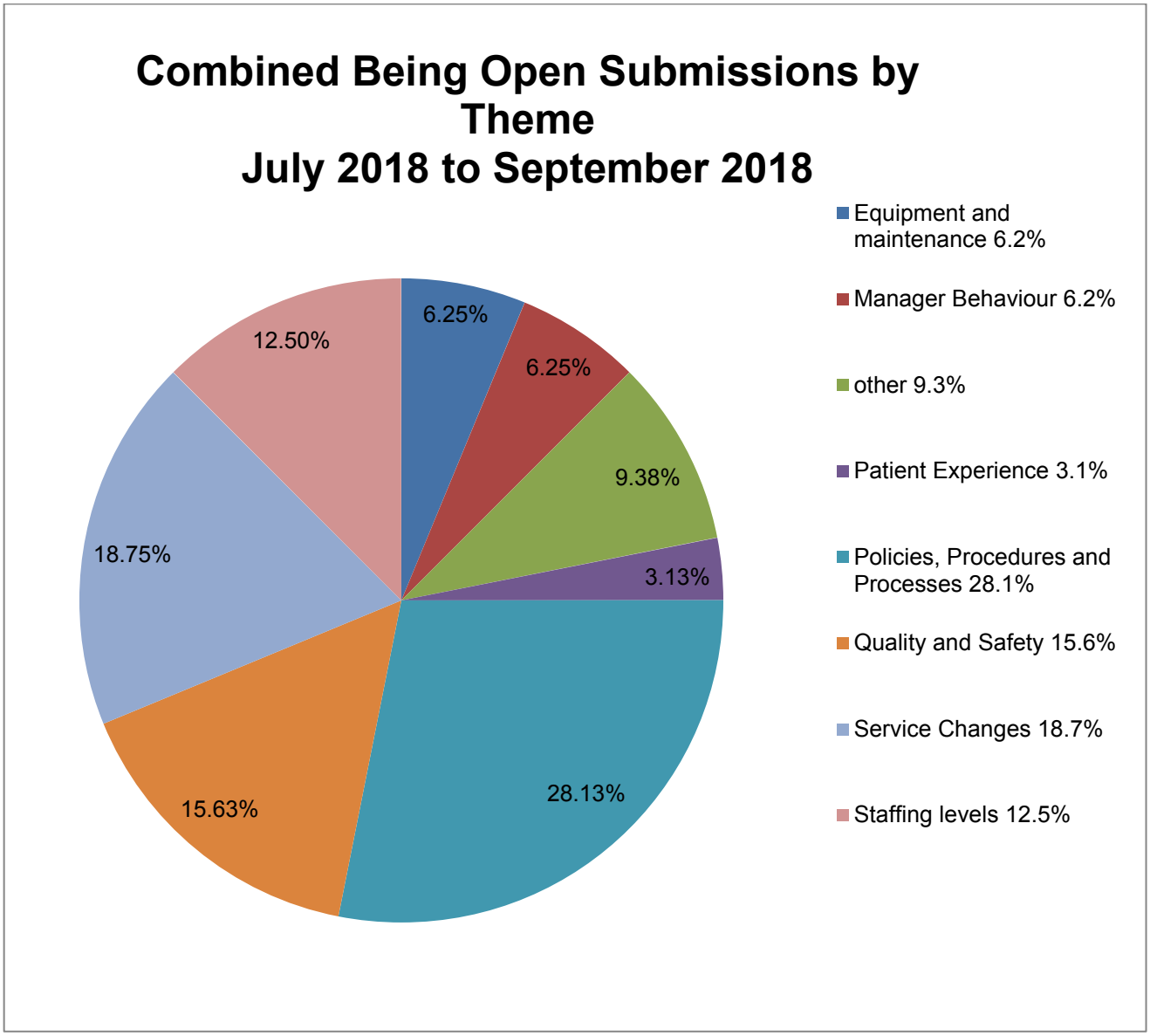
For all Directorates/areas, the graph below details themes including Dear Caroline (DC), FSUG, Raising Concerns (RC) and Grievance (Gri) themes. Broadly, themes within AMH Inpatients, AMH Community and CYP are aligned to overall Trust wide themes.

# Openness Report - All Submissions by Theme, Type and Directorate
# October 2017 - September 2018



### 1.2.1. Being Open Combined High level Quarterly Theme Update (1 July 2018 – September 2018)

Following the last Being Open report submissions for DC's have significantly increased (27 submissions compared to 9 submissions) whilst Grievance, FSUG and Raising Concerns have reduced when compared to the same time frame in 2017. Themes continue to be varied as previously highlighted.




### 1.2.2. Policies, Procedures and Processes (28.1%)

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

Submissions have been made regarding Trust Policies and process relate to topics including the new inpatient e-rostering system, Lorenzo, Trac, Dear Caroline, Recruitment and retention, the Dress Code Policy, No-Smoking Policy and communication suggestions.

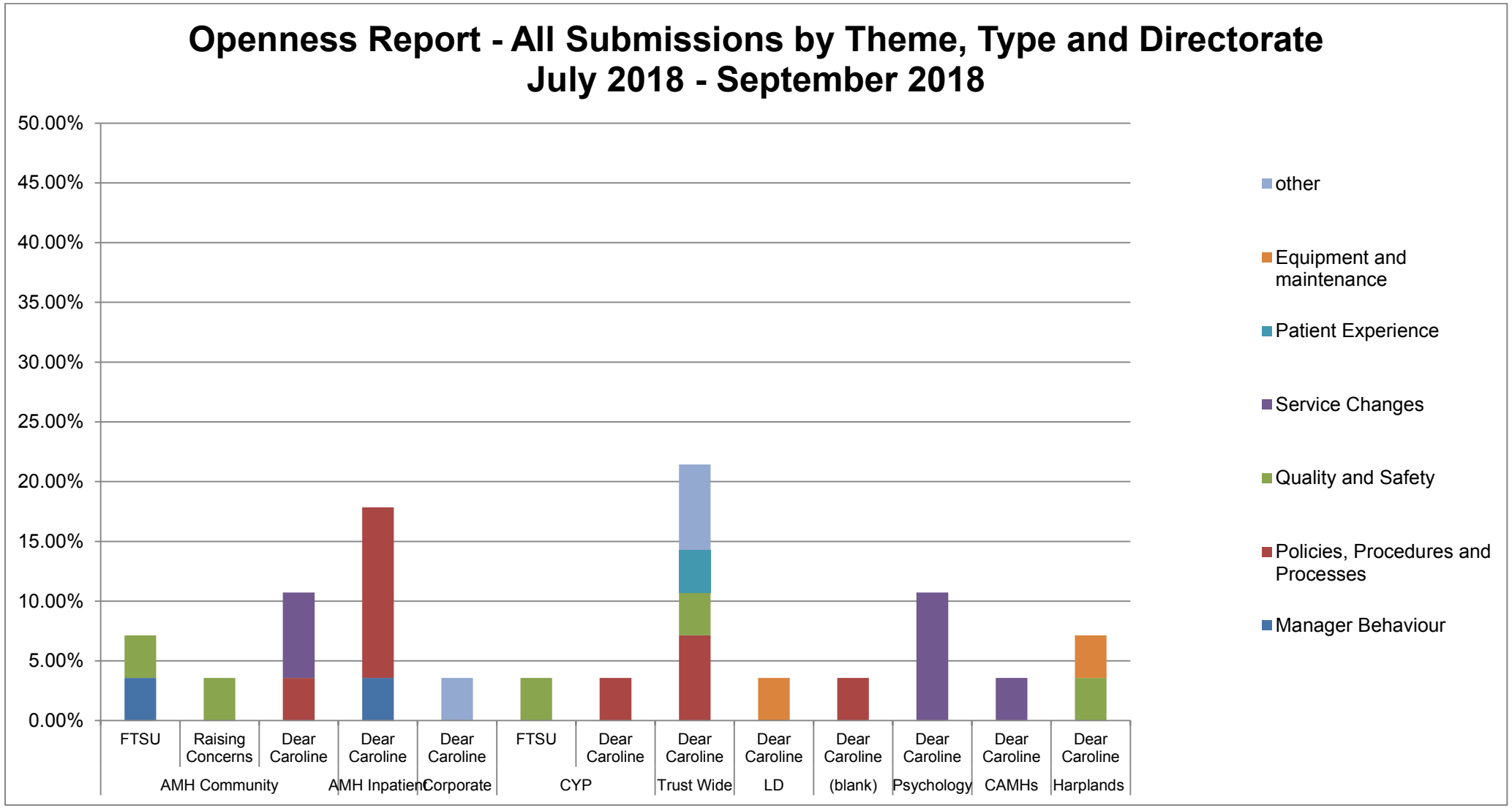
### 1.2.3. Service Changes (18.7%)

Submissions relate to service changes connected to the introduction of the Meridian tool in the AMH Community Directorate, concerns regarding the lack of Eating Disorder Service and the incorporation of the CAMHs service into the RAID/MHLT service. A number of submissions have been raised concerning the locality restructure relating to perceived changes to Psychology provision, the management of change process, Substance Misuse service and the section 75 TUPE.

### 1.2.4. Quality and Safety (15.6%)

Submissions relate to concerns with regards to AMH Community concerning Access and Home Treatment and Lymebrook. Concerns have also been raised with regards to CYP Directorate and AMH Inpatients.

For all Directorates/areas in receipt of submissions, graphs below demonstrate themes including Dear Caroline, FSUG, Raising Concerns and Grievance submissions. Due to the low submission and varied nature of submissions it is not possible to draw any significant themes.


Openness Report - All Submissions by Theme, Type and Directorate
July 2018 - September 2018
50.00%
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
FTSU
Raising Concerns
Dear Caroline
Dear Caroline
Dear Caroline
FTSU
Dear Caroline
Dear Caroline
Dear Caroline
Dear Caroline
Dear Caroline
Dear Caroline
Dear Caroline
Dear Caroline
AMH Community
AMH Inpatient
Corporate
CYP
Trust Wide
LD
(blank)
Psychology
CAMHs
Harplands
other
Equipment and maintenance
Patient Experience
Service Changes
Quality and Safety
Policies, Procedures and Processes
Manager Behaviour

## 2. Being Open Mechanisms – Impact review

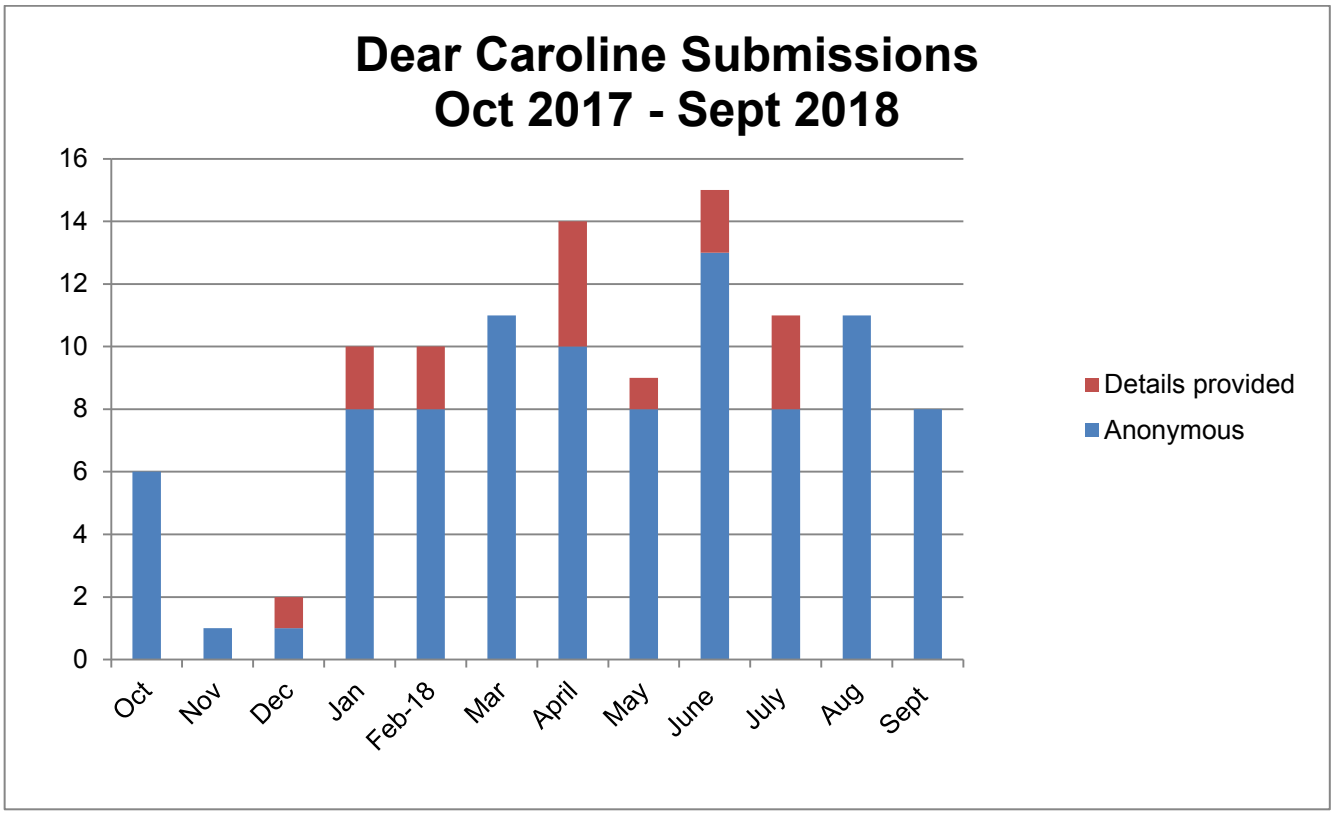
### 2.1. Dear Caroline Impact

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

May-August 2017 - http://sid/news/DC/Pages/May-to-August-2017.aspx
Sept – Dec 2017 - http://sid/news/DC/Pages/September-to-December-2017.aspx
Jan – June 2018 http://sid/news/DC/Pages/January-to-June-20180228-1636.aspx
July – Sept - http://sid/news/DC/Pages/July-to-December-2018.aspx

The Dear Caroline website provides staff with an anonymous channel to raise concerns. Between October 2017– September 2018, 92 submissions have been received against a position of 80 submissions for the same period in the previous 12 months (October 2016 – September 2017).

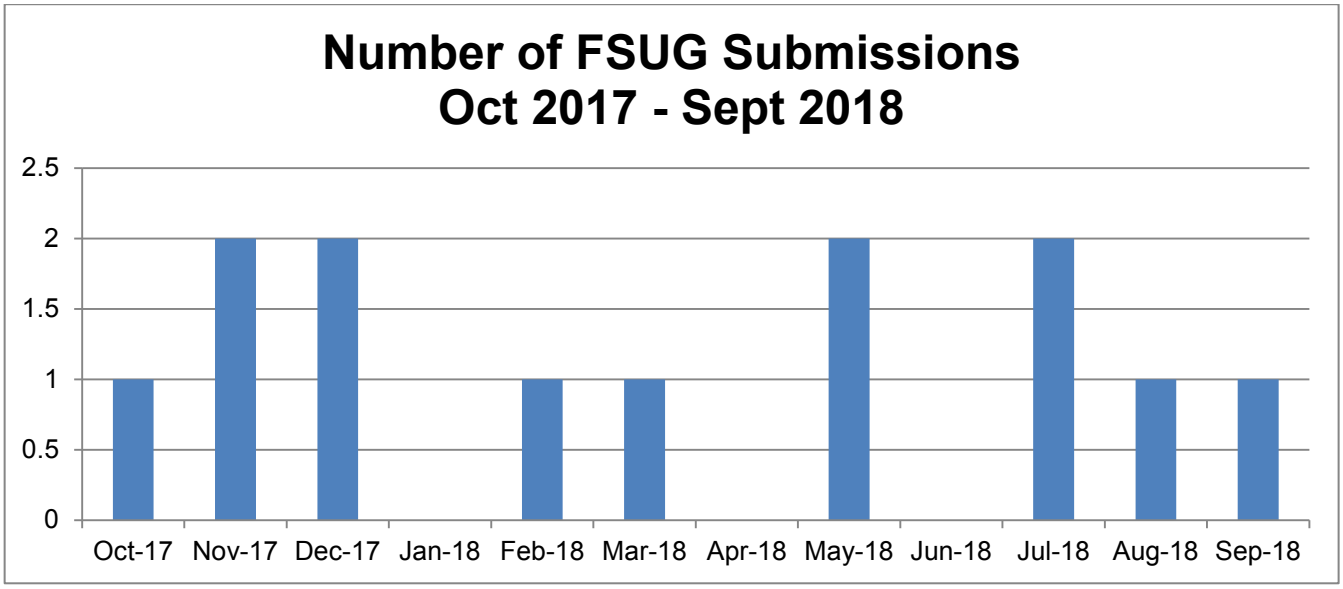
Feedback has been received from a range of areas and regular submissions are being made. The bar chart below shows the number of submissions made by month over a rolling 12 month period. The most recent quarter (July – September 2018) has maintained a consistent number in submissions of 27 in comparison from the previous two quarters (Jan – March 26 submissions and April-June 32 submissions). Moreover, this is significantly higher when also compared to the same time frame in 2017 (quarter July-Sept) during which 9 submissions were received.




The majority of submissions (84%) continue to be submitted anonymously; however some submissions have raised concerns with regards to whether the mechanism is entirely anonymous. That said it should be noted that 16% of the submissions received are choosing to leave their contact details which is encouraging. Where a submission has a named contact, feedback is directly provided.

### 2.2. Freedom to Speak Up Guardian Impact

13 concerns have been raised during October 2017 – September 2018 which is significantly less than the same period for 16/17 and 4 submissions in the last quarter.




It should be noted that a new Freedom to Speak Up Guardian has recently been appointed which may have led to an increase in submissions.

### 2.3. Raising Concerns Impact

One concern has been raised via this method in the last quarter which relates to the provision of ASD Services within the AMH Community Lymebrook team.

A total of four concerns have been raised via this method over the 12 month period and include an allegation of bullying and harassment, service changes and the introduction of the Meridian Tool. This is an overall reduction in submissions when compared to 5 submissions raised for the previous 12 months.

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

### 2.4. Grievances Impact

Four concerns have been raised via this method between October 2017 and September 2018 and none between July – September 2018. Grievances raised relate to a TUPE transfer, Management of Change outcome and job banding. This is a slight increase against three concerns which were raised between in the previous 12 months.

The Resolution of Grievance and Disputes procedure provides a clear informal and formal process for all Trust colleagues to raise serious concerns regarding their working arrangements. By the very nature that concerns relate in many cases to a matter which may not be able to be resolved informally it would be of great concern if many concerns were being raised via this method. It

should also be noted that the HR Advisory team support individuals to resolve grievance matters informally wherever possible, which this activity does not account for.

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

### 2.5. Summary of combined mechanisms impact

In summary, from October 2017 to September 2018 there has been a decrease in FSUG and Raising Concern submissions and an increase in submissions for DCs and Grievances when compared to the same period in 2016/17. All mechanisms will continue to be publicised internally using a variety of media.

### 2.6. Actions taken in response to submissions

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

- Car parking system at the Harplands site revised and additional communications published.
- Further recognition of long service event held and process amended based on suggestions received
- Team development sessions held for Access and Home Treatment and CYP Team
- Clarification of the Dear Caroline process and timely publication of responses
- Amending the Establishment Control Process
- Commissioning of a number of investigations
- Development of Values and Behaviours Framework
- Developments linked to the Trusts Digital approach
- Review of staffing in identified areas where raising concerns were raised
- Enhanced OD/Counselling support offered to teams raising concerns
- Changes made to Lorenzo processes/service developments
- Streamlining of recruitment and selection/Trac process and additional training sessions
- Developments to the REACH Awards ceremony and process
- Development of policies such as the Dress Code Policy.
- Development of the LMS
- Feedback led to changes being made as part of the Locality Restructure consultation

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

Detailed Staff Survey analysis based on the 2017 survey has been undertaken and a separate full report given and action plan developed which will continue to be monitored and reviewed at the Trust's People Culture and Development Committee along with the quarterly Towards Outstanding Engagement (F&F) survey results.

## 3. Conclusion

In conclusion, the Dear Caroline initiative continues to be used by our staff as an effective mechanism and means for staff to raise issues/concerns regarding the quality and effectiveness of our services, with 92 submissions received from October 2017 to September 2018. It continues to provide a mechanism for staff to raise concerns anonymously if they prefer. Whilst the majority of

submissions, 84% have been submitted anonymously, some staff are choosing to leave their contact details which is encouraging.

Furthermore, it continues to provide an additional direct source of information, enabling the Executive Team to be connected to current frontline issues and concerns from a staff perspective and provides a useful pointer for further investigation and/or action. The Dear Caroline process will therefore continue as a means of raising concerns. High level summary of each continues to be published on SID, along with each of the Dear Caroline submissions – published in a 'you said, we did' approach.

Although the FSUG role and initiative is relatively new in comparison, it is encouraging that staff are accessing the Guardian to raise issues or concerns. Further developments are expected with regards to this role as directed by the National FSUG office, the CQC advancements and the newly appointed FSUG.

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

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

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

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

## 4. Next Steps

It is proposed that the Trust will:

- Continue to utilise all four mechanisms to support staff to raise concerns and issues
- Support the ongoing development of an open and transparent culture through development and embedding of the Trust Values and supporting Behaviours Framework
- Continuation of the Freedom to Speak Up Guardian role including further strengthening of approach/ development of a range of Freedom to Speak Up Champions to further support the FSUG role.
- Continue and strengthen communication to the wider Trust to help promote speaking to managers, professional leads, trade union representatives as well as the more formal routes that are available.

## 5. Recommendations

It is recommended that the Trust Board

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

## Appendix One

Synopsis of Being Open Mechanisms

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

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

- **The Raising Concerns Policy**

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

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

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

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

  - Duties

- Conditions of Employment
- Working Conditions
- Working Procedures
- Working Practices

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

NHS
North Staffordshire
Combined Healthcare
NHS Trust

# REPORT TO Trust Board

Enclosure No:18

| | | | |
|---|---|---|---|
| Date of Meeting: | 22nd November 2018 | | |
| Title of Report: | Freedom to Speak Up Trust board Self-Assessment | | |
| Presented by: | Caroline Donovan | | |
| Author: | Zoe Grant (Freedom to Speak Up Guardian) | | |
| Executive Lead Name: | Caroline Donovan (CEO) | Approved by Exec | ☒ |

| Executive Summary: | Purpose of report | |
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| On 23rd October 2018 the Trust board completed the National Guardians office Freedom to Speak Up Self-Assessment.<br><br>The attached document offers a summery update of the findings; an action plan is currently being progressed. | Approval | ☒ |
| | Information | ☐ |
| | Discussion | ☐ |
| | Assurance | ☒ |

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| Seen at: | SLT ☐ Execs ☐<br>Date: | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☐<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☒<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Primary Care Integration Programme Board ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement .☐<br>2. To provide the highest quality services x ☐<br>3. Create a learning culture to continually improve .x☐<br>4. Encourage, inspire and implement research & innovation at all levels x.☐<br>5. Maximise and use our resources intelligently and efficiently. ☐<br>6. Attract and inspire the best people to work here .x ☐<br>7. Continually improve our partnership working x ☐ | | |
| Risk / legal implications:<br>Risk Register Reference | None | | |
| Resource Implications:<br><br>Funding Source: | None | | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | The areas for improvement within the self-assessment are representative of all Trust staff.<br>There is an acknowledgement of the focused work currently being progressed with BAME staff in particular, the self assessment recognises some of this work which will offer additional assurance, alongside the newly identified actions for 'Being Open' specifically. | | |
| STP Alignment / Implications: | | | |
| Recommendations: | Review recommendations for directorate lead implementation. | | |

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| | Review draft guidance to staff and confirm suitability for wider circulation. | |
| Version | Name/group | Date issued |
| | | |
| | | |

National Guardian
Freedom to Speak Up

NHS
Improvement

# Freedom to Speak Up self-review tool for NHS trusts and foundation trusts

May 2018

# How to use this tool

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust.

NHS Improvement and the National Guardian's Office have published a guide setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement.

This self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust's speaking up culture is.

| **Self review indicator**<br><br>**(Aligned to well-led KLOEs)** | **To what extent is this expectation being met?** | **What are the principal actions required for development?** | **How is the board assured it is meeting the expectation?**<br><br>Evidence |
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| **Our expectations** | | | |
| **Leaders are knowledgeable about FTSU** | | | |
| Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office. | NEDs overview in place. | National requirements to be incorporated into Being Open reports (Bi –monthly). | Dear Caroline & FTSU reported via Trust Board. |
| Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up. | Weekly CEO blogs offer feedback. | FTSU / Being Open to be integral to lessons learned.<br><br>'Being Open' vision (Dear Caroline & FTSU vision)<br><br>'You said, we did'. | CEO Blog & Being Open has dedicated space on CAT<br><br>Dear Caroline feedback via intranet / CAT |
| They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up. | Induction Programme – leadership framework<br><br>People and OD strategy. | Integral to Leadership development programmes and refreshed Leadership Academy due to be launched December 2018<br><br>Being Open into Leadership Competency framework. | Dear Caroline Published responses |

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| | | Strengthen induction at local level.<br><br>Strengthen lessons learned / you said, we did. | |
| Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy. | leadership academies<br><br>Board to team visits.<br><br>Board development focus. | More explicit in values and behaviours.<br><br>Strengthen alignment with 7 strategic priorities. | Board development focus<br><br>Leadership academies.<br><br>Board to team visits. |
| | **To what extent is this expectation being met?** | **What are the principal actions required for development?** | **How is the board assured it is meeting the expectation?**<br><br>Evidence |
| **Leaders have a structured approach to FTSU** | | | |
| There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement. | Champion's role at clinical interface. | More explicit link with SPAR<br><br>Champion training and 'readiness'<br><br>Regular Communications<br><br>FTSU policy under review to ensure clarity re FTSU, | Champions in place<br><br>Dedicated 'Being Open' section on CAT.<br><br>FTSU is seen as part of trust culture |

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| | | concerns and Whistleblowing | |
| There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement. | Being Open policy. | Needs refreshing | Policy in place and available. |
| The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian) and it aligns with existing guidance from the National Guardian. | National FTSU guardian. | Service user and carer council.<br><br>Self-assessment / action plan. | Guardian attends regional and national events.<br><br>Regular communications received from the National Guardian office<br><br>Regular contact with fellow FTSU leaders |
| Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures. | Bi – monthly Being Open report in open Trust Board. | Link between quality committee and people culture, committee Re Being Open.<br><br>Refreshing people/OD strategy to become more outcomes focused.<br><br>External collaboration to review strategy. | Being Open report to Trust board aligns all reporting to committees. |

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| | | Audit. | |
| | **To what extent is this expectation being met?** | **What are the principal actions required for development?** | **How is the board assured it is meeting the expectation?**<br><br>Evidence |
| **Leaders actively shape the speaking up culture** | | | |
| All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up. | Leadership academy.<br><br>Proactive involvement of senior leaders in Dear Caroline. | Strengthen awareness amongst frontline leaders.<br><br>Strengthen feedback mechanisms<br><br>'Being Open' specific meeting agenda item now included as a specific directorate agenda item<br><br>Engagement with professional leadership groups | Proactive involvement of senior leaders in Dear Caroline.<br><br>Being Open report to Board and SLT.<br><br>Directorate support of champion roles. |
| They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and | Directorate responses to Dear Caroline's.<br><br>Board development session. | Strengthen learning assurance.<br><br>Obtain feedback.<br><br>Strengthen assurance re: | Dear Caroline and published responses.<br><br>Board to team visits. |

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| honesty. | | directorate leadership<br><br>Each directorate to have 'Being Open and lessons learned' on governance meeting agenda's. | Announced and unannounced visits to teams.<br><br>CEO visits in response to concerns |
| Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers. | Dear Caroline<br><br>CAT intranet – FTSU<br><br>Board to team visits<br><br>Exec Visibility. | As above<br><br>Senior leaders at directorate level visibility & 'you said, we did'. | Dear Caroline and published responses.<br><br>Board to team visits.<br><br>Announced and unannounced visits to teams.<br><br>CEO visits in response to concerns |
| Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian. | FTSU guardian has direct access to execs.<br><br>Board development<br><br>Leadership academy x 2<br><br>FTSU Champions within directorates, working alongside senior leaders. | FTSU guardian actively engaging with ADs & CDs. | CAT (Intranet) – dedicated web page.<br><br>Relationships with FTSU already in place.<br><br>Leadership academy<br><br>FTSU Champions within directorates, working alongside senior leaders. |

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| Senior leaders model speaking up by acknowledging mistakes and making improvements. | Dear Caroline.<br><br>Lessons learnt bullet – in – Being Open Report<br><br>CEO Blog. | Strengthen learning assurance.<br><br>Obtain feedback.<br><br>Strengthen assurance re: directorate leadership | Dear Caroline.<br><br>Lessons learnt bullet – in – Being Open report.<br><br>CEO Blog. |
| The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly. | Dear Caroline and outcomes are open on Trust intranet.<br><br>FTSU<br><br>Information presented in open board.<br><br>Being Open policy.<br><br>Non exec FTSU lead. | Strengthen learning assurance.<br><br>Combine themes from FTSU & Dear Caroline.<br><br>FTSU Guardian to strengthen links with Staff side. | Dear Caroline and outcomes are open on Trust intranet.<br><br>FTSU<br><br>Information presented in open board.<br><br>Being Open policy.<br><br>Non exec FTSU lead. |
| | **To what extent is this expectation being met?** | **What are the principal actions required for development?** | **How is the board assured it is meeting the expectation?**<br><br>Evidence |
| **Leaders are clear about their role and responsibilities** | | | |

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| The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility. | NED and Exec lead in place. | | Board development focus. |
| They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support. | Open access from Board regarding FTSU | Regular meetings in place. | Meetings scheduled with FTSU Guardian & CEO<br><br>FTSU Guardian has direct line to CEO and Director of Nursing. |
| Other senior leaders support the FTSU Guardian as required. | Leadership academy Dear Caroline- senior leaders involved. | Being Open (Dear Caroline and FTSU) on agenda for directorate and team meetings. | Leadership academy Dear Caroline- senior leaders involved. |
| | **To what extent is this expectation being met?** | **What are the principal actions required for development?** | **How is the board assured it is meeting the expectation?**<br><br>Evidence |
| **Leaders are confident that wider concerns are identified and managed** | | | |
| Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate | Access to data – dear Caroline in detail. | Use of data to support and pre-empt.<br><br>Being Open report is | Boards development session and awareness.<br><br>Being Open report is reviewed by |

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| speaking up issues to proactively identify potential concerns. | SI's / complaints.<br><br>FTSU Guardian member of Senior Operational Meetings. | reviewed by SOT. | SLT. |
| The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate. | Being Open policy<br><br>FTSU guardian has established relationship and access to exec and senior leaders.<br><br>Recruited to FTSU champions | Champions and their freedom with clear escalation processes in place.<br><br>Opportunity for champions to establish links to senior leaders where appropriate. | Approved FTSU policy.<br><br>Responses to FTSU issues that have been raised demonstrate ability to escalate in a timely manner. |
| | **To what extent is this expectation being met?** | **What are the principal actions required for development?** | **How is the board assured it is meeting the expectation?**<br><br>Evidence |
| **Leaders receive assurance in a variety of forms** | | | |
| Workers in all areas know, understand and support the FTSU vision, are aware of the policy and | Dedicated page on CAT (intranet). | Being Open to be de a dedicated agenda item at | Dedicated page on CAT (intranet).<br><br>Policy available on Intranet. |

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| have confidence in the speaking up process. | Policy available on Intranet.<br><br>Communications via newsline and CEO Blog.<br><br>Dear Caroline and FTSU issues raised to date. | team level meetings, | Communications via newsline and CEO Blog.<br><br>Dear Caroline and FTSU issues raised to date. |
| Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers | FTSU Champions<br><br>5 priorities – inclusion sponsored by BAME staff member<br><br>2 x BAME leads & FTSU champions. | Champions equal to FTSU Guardian (in terms of knowledge and employment) visibility, conference.<br><br>Posters<br><br>FTSU at local induction<br><br>Agency worker / student nurse / medic inductions.<br><br>Inclusion Council established with CEO chair, Exec lead, Ops lead and BAME lead – 2 councils to date | Staff survey results are improved.<br><br>Inclusion Council established with CEO chair, Exec lead, Ops lead and BAME lead – 2 councils to date |

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| Speak up issues that raise immediate patient safety concerns are quickly escalated | Sponsored by CEO, every Dear Caroline is reviewed and addressed<br><br>FTSU direct line to CEO and director of nursing. | Strengthen links with patient safety team.<br><br>Strengthen policy to capture process. | WRES information shared with Board. |
| Action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority | Not aware of any evidence but have Being Open policy. | Feedback sessions (follow up/ closing loops) visits. (post speaking up).<br><br>Case reviews / audit. | Report (Being Open)<br><br>Staff survey |
| Lessons learnt are shared widely both within relevant service areas and across the trust. | Lessons learnt bulletin. (Dear Caroline / FTSU / External notifications report) | Board lessons learnt.<br><br>Being Open conference.<br><br>Staff stories at Board<br><br>Audit | Dear Caroline responses are published.<br><br>Open Board policy is to discuss as many agenda items in open Board |
| The handling of speaking up issues is routinely audited to ensure that the FTSU policy is | Need to establish process. | Identify audit indicators and embed. | Themes are reported via the 'Being Open' report. |

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| being implemented | | | |
| FTSU policies and procedures are reviewed and improved using feedback from workers. | Listening into action – recent LIA with BAME staff which has strengthened BAME speaking up. | Policy update required. | Listening into action – recent LIA with BAME staff which has strengthened BAME speaking up |
| The board receives a report, at least every six months, from the FTSU Guardian. | Board receive a report every 2 months. | Staffordshire forum – FTSU. | Being Open report – Qtly. |
| | **To what extent is this expectation being met?** | **What are the principal actions required for development?** | **How is the board assured it is meeting the expectation?**<br>Evidence |
| **Leaders engage with all relevant stakeholders** | | | |
| A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan. | Workforce improvement plan.<br>Staff Survey | Champions training,<br>Incorporated into 7 strategic quality priorities. | People and culture strategy. |

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| Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement. | CQRM-Being Open report.<br>CQC-engagement<br>NHSI- yes | | CQRM-Being Open report.<br>CQC-engagement<br>NHSI- yes |
| Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals). | Yes- Being Open | Patient story and staff story re: speak up issues. | Being Open report. |
| The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture. | Yes. | Speak section in report at front. | Being Open report. |
| Reviews and audits are shared externally to support improvement elsewhere. | Need to be embedded. | Audit indicators to be agreed and audit embedded. | Staff survey results.<br>BAME inclusion council. |
| Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture. | Workforce Improvement plan.<br>FTSU guardian attends regional and national meetings / | Standard approach needed. | FTSU guardian attends regional and national meetings / events |

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| | events | | |
| Senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians | Yes. | | FTSU meets with CQC and leads joint CCG and Health watch visits to services reporting back to Board as appropriate. |
| Senior leaders request external improvement support when required. | Yes.<br><br>AQUA workshops | Learning lessons concerns from staff perspective | AQUA workshops taken place and feedback offered to the board. Ongoing work with AQUA regarding learning from change and culture |
| | **To what extent is this expectation being met?** | **What are the principal actions required for development?** | **How is the board assured it is meeting the expectation?**<br><br>Evidence |
| **Leaders are focused on learning and continual improvement** | | | |
| Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience. | Dear Caroline routinely discussed with investigations lead within directorates where appropriate. | 6 monthly review of the process (define scope of review).<br><br>Strengthen positive acknowledgement of people who speak up. | Being Open report bi – monthly to the board and also SLT. |

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| Senior leaders and the FTSU Guardian engage with other trusts to identify best practice. | FTSU Guardian attends regional meetings with other Trusts. | Learning wider than NHS-NHS (LA / primary care) | Board development.<br>FTSU Guardian attendance at regional & national meetings |
| Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities. | Guidance is issued directly to FTSU Guardian and CEO. | FTSU- not HR<br>Guidance to be shared with senior directorate leaders. | Guidance is issued directly to FTSU Guardian and CEO. |
| Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation. | Lessons learnt bulletin.<br>SLT meetings | Internal audit could help with outcome of investigation process.<br>Being Open to be standardised item on meeting agenda's. | SLT meetings. |
| The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has | | More work around closing the loop on learning.<br>Strengthen loop to DON and MD RE pt. safety concerns | Board development focus. Dedicated session held to undertake self assessment review with agreement on actions to be taken forward |

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| been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success. | | Scope what qualitative measures are used in other Trusts | |
| The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them. | Policy in date however under review. | Schedule 'Open Space' event to capture views / opinions.<br><br>Refresh policy | Being Open policy. |
| A sample of cases is quality assured to ensure:<br><br>• the investigation process is of high quality; that outcomes and recommendations are reasonable and that the impact of change is being measured<br><br>• workers are thanked for speaking up, are kept up to date though out the | Direct response to concerns raised via Dear Caroline published on Trust Intranet. | Share responses of FTSU via CAT.<br><br>Link with the OD teams work re values – ' talking responsibly'<br><br>Publicly thank people who speak up (where confidentiality is not of concern).<br><br>Animation of Being Open – | "Being Open into supervision policy."<br><br>EIA undertaken for any major change programme |

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| investigation and are told of the outcome<br><br>• Investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored | | linking to values. | |
| Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up. | Dear Caroline responses openly published.<br><br>Dedicated Being Open and FTSU page on CAT (Intranet). | Staff stories to be shared.<br><br>Case reviews to be conducted and published,<br><br>You said, we did, in all teams.<br><br>Being Open to be standing agenda item on team meetings. | Dear Caroline responses openly published.<br><br>Dedicated Being Open and FTSU page on CAT (Intranet). |
| **Individual responsibilities** | | | |

| Chief Executive **and Chair** | | | |
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| The Chief Executive is responsible for appointing the FTSU Guardian. | Yes. | Complete self-assessment | Being Open report to Board.<br><br>Structure/Policy/Activity. |
| The Chief Executive is accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust. | Yes. | System and processes for everyone to voice concerns.<br><br>DC, WB, FTSU, Team meetings- LL | PCD.<br><br>FTSU report to board.<br><br>DC and on website FTSU. |
| The chief executive and chair are responsible for ensuring the annual report contains information about FTSU. | Yes. | Complete ????. | AR to board.<br><br>FTSU to go into Quality Account. |
| The chief executive and chair are responsible for ensuring the trust is engaged with both the regional Guardian network and the National Guardian's Office. | Yes. | FTSUG attends regional and national events. | # on social media.<br><br>CEO blog.<br><br>CEO Report to board. |
| Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly. | Yes. | Regular 1:1 | Tracking system.<br><br>Exception reporting. |

| **Executive lead for FTSU** | | | |
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| Ensuring they are aware of latest guidance from National Guardian's Office. | Yes. | Populate FTSU section on intranet.<br><br>Clarify ACEO+DWF roles. | National guidance summary to open board. |
| Overseeing the creation of the FTSU vision and strategy. | partial | FTSU vision.<br><br>People and OD strategy.<br><br>Align to strategic priorities | PCD oversight of people and OD strategy. |
| Ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian. | Yes. | Via internal advert as per recruitment policy. | FTSU in post. |
| Ensuring that the FTSU Guardian has a suitable amount of ring fenced time and other resources and there is cover for planned and unplanned absence. | partial | Champions in post end October will help resource. | |

| | | | |
|---|---|---|---|
| Ensuring that a sample of speaking up cases have been quality assured. | No. | Need to embed Quality Assurance process. | To include in Being Open report. |
| Conducting an annual review of the strategy, policy and process. | Planned. | Board self-assessment action plan. | Action plan to PCD and 'Board for regular oversight. |
| Operationalising the learning derived from speaking up issues. | Planned. | Build process into MOOD tool e.g. LIA, FTSU , DC value makers etc. | Board report and topics via Board Developement ongoing work. |
| Ensuring allegations of detriment are promptly and fairly investigated and acted on. | Need to strengthen. | You said, we did.<br>The number of staff openly reporting. | |
| Providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process. | | MooOOD reporting by team directorate and trust wide. | Being Open report. |
| **Non-executive lead for FTSU** | | | |
| Ensuring they are aware of latest guidance from National Guardian's Office. | See 1. | | |
| Holding the chief executive, executive FTSU lead and the board | Partially | Clear that policy and procedures are in place to | Chair PCD. |

| | | | |
|---|---|---|---|
| to account for implementing the speaking up strategy. | | deal with concerns. | Chair QC. |
| Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement. | | Annual FTSU assessment. | Board Development session.<br>Self-Assessment annually. |
| Role-modelling high standards of conduct around FTSU. | Chair of PCD – standing agenda item.<br>Participates in Unannounced and service visits. | Annual FTSU assessment. | Chair of PCD – standing agenda item.<br>Participates in Unannounced and service visits. |
| Acting as an alternative source of advice and support for the FTSU Guardian. | FTSU guardian has working rapport with non-exec lead. | | FTSU guardian has working rapport with non-exec lead. |
| Overseeing speaking up concerns regarding board members. | Yes | As part of new NED recruitment this is strengthened into job descrition and role purpose | NED as part of Board open discusssion |
| **Human resource and organisational development directors** | | | |

| | | | |
|---|---|---|---|
| Ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up. | See exec lead detail. | | |
| Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust. | Needs strengthening. | Campaign re being<br>Open- culture change.<br>D&T<br>Staff survey results<br>Reach award for openness. | Staff survey action plan .<br>People and OD strategy. |
| Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively. | Needs strengthening. | Further training for staff and managers.<br>Improved intranet. | |

| **Medical director and director of nursing** | | | |
|---|---|---|---|
| Ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues. | Yes. | Open door policy.<br><br>SI/complaints oversight. | Chair of QC is vice chair of PCD thus ensuring read across. |
| Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up. | Needs strengthening | Policy needs updating<br><br>Implement flagging system e.g. pt. safety issue.<br><br>Triangulating safety data e.g. FTSU, IPSM,CSM S/S, COMPLAINTS, FOIS ETC. | |
| Ensuring learning is operationalised within the teams and departments that they oversee. | Needs strengthening. | Strengthen links with post/LL<br><br>Link LL<br><br>Link LL with DC<br><br>Develop B/U<br><br>Link in with NHS choices. | Lessons learned. |

NHS
North Staffordshire
Combined Healthcare
NHS Trust

# REPORT TO Trust Board

Enclosure No:19

| | | | |
|---|---|---|---|
| Date of Meeting: | 22/11/2018 | | |
| Title of Report: | Finance Position Month 6 | | |
| Presented by: | Suzanne Robinson – Executive Director of Finance, Performance and Digital | | |
| Author: | L Dodds - Assistant Director of Finance | | |
| Executive Lead Name: | Suzanne Robinson – Executive Director of Finance, Performance and Digital | Approved by Exec | ☒ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| The report summarises the finance position at month 6 (September 2018) | Approval | ☒ |
| | Information | ☐ |
| | Discussion | ☐ |
| | Assurance | ☒ |

| | | | |
|---|---|---|---|
| Seen at: | SLT ☐ Execs ☒<br>Date: | Document Version No. | |

| | |
|---|---|
| Committee Approval / Review | • Quality Committee ☐<br>• Finance & Performance Committee ☒<br>• Audit Committee ☐<br>• People & Culture Development Committee ☐<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Primary Care Integration Programme Board ☐ |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement.☐<br>2. To provide the highest quality services ☐<br>3. Create a learning culture to continually improve.☐<br>4. Encourage, inspire and implement research & innovation at all levels.☐<br>5. Maximise and use our resources intelligently and efficiently.☒<br>6. Attract and inspire the best people to work here.☐<br>7. Continually improve our partnership working. ☐ |
| Risk / legal implications:<br>Risk Register Reference | Ref 1035: Trust top 3 risks around delivery of cost improvement target. |
| Resource Implications:<br><br>Funding Source: | None applicable |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | There is no direct impact on the protected characteristics as part of the completion of this report. |
| STP Alignment / Implications: | This report forms part of the aggregate STP reported financial position |
| Recommendations: | The Trust Board are asked to:<br>Note:<br><br>The reported YTD surplus of £359k against a planned surplus of £264k. This |

| | |
|---|---|
| | is a favourable variance to plan of £95k.<br><br>The M6 CIP achievement:<br>• YTD achievement of £538k (52%); an adverse variance of £499k;<br>• 2018/19 forecast CIP delivery of £1,492k (53%) based on schemes identified; an adverse variance of £1,303k to plan;<br>• The recurrent value of schemes transacted at £1,053k, 38% of target.<br>• The recurrent risk adjusted forecast of £1,813k; 65% of target.<br><br>The cash position of the Trust as at 30th September 2018 with a balance of £9,894k; £1,327k better than plan;<br><br>Month 6 capital expenditure at £192k compared to planned capital expenditure of £455k;<br><br>Use of resource rating of 2 against a plan of 2.<br><br>Approve:<br><br>The month 6 position reported to NHSI. |

| Version | Name/group | Date issued |
|---|---|---|
| 1 | FPD | 08/11/2018 |
| | | |

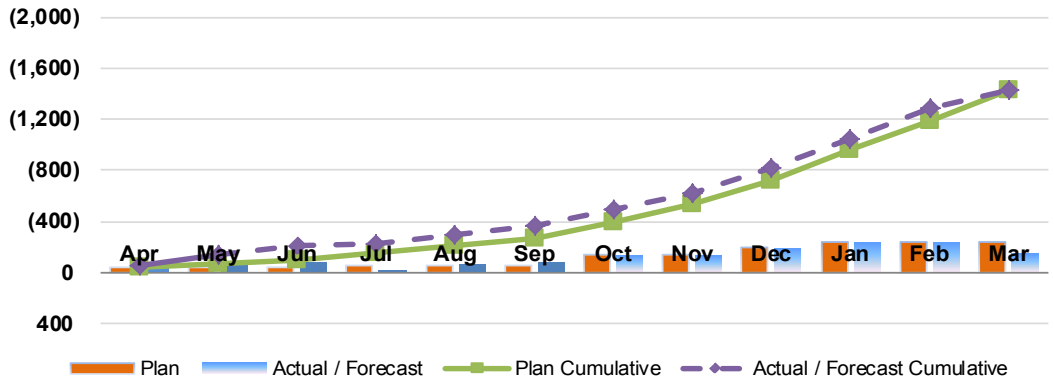
NHS
North Staffordshire
Combined Healthcare
NHS Trust

# Financial Overview as at 30th September 2018

## Income & Expenditure - Control Total (Surplus) / Deficit

| £000 | Plan | Actual | Var | % | RAG |
|---|---|---|---|---|---|
| YTD | (264) | (359) | (95) | (36) | G |
| FOT | (1,423) | (1,423) | 0 | 0 | G |

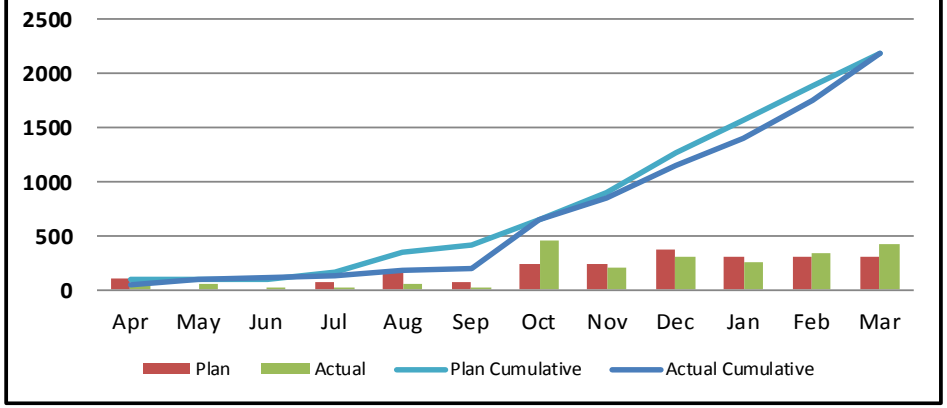
### Retained (Surplus) / Deficit Run Rate 2018/19




## Charge to CRL

| £000 | Plan | Actual | Var | % | RAG |
|---|---|---|---|---|---|
| YTD | 342 | 192 | (150) | (44) | G |
| FOT | 2,185 | 2,185 | 0 | 0 | G |

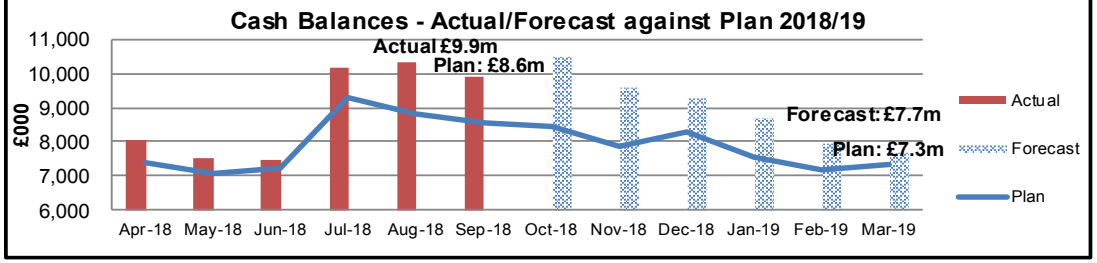
### Net Capital Expenditure - Plan / Forecast 2018/19




## Cash Balances

| £000 | Plan | Actual | Var | % | RAG |
|---|---|---|---|---|---|
| YTD | 8,568 | 9,896 | 1,328 | 15 | G |
| FOT | 7,339 | 7,682 | 343 | 5 | G |

### Cash Balances - Actual/Forecast against Plan 2018/19




## Cost Improvement

| £000 | Plan | Actual | Var | % | Rec Var | RAG |
|---|---|---|---|---|---|---|
| Clinical | 805 | 364 | (441) | (55) | (771) | R |
| Corporate | 232 | 173 | (59) | (25) | (211) | R |
| Total | 1,037 | 537 | (500) | (48) | (982) | R |

| Use of Resource | Plan | Actual |
|---|---|---|
| **Overall Risk Rating** | **2** | **2** |
| Liquidity Ratio | 1 | 1 |
| Capital Servicing Capacity | 3 | 3 |
| I& E Margin | 2 | 2 |
| I&E Margin Variance to Plan | 1 | 1 |
| Agency Spend | 1 | 2 |

**Introduction:**

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

## 1. Income & Expenditure (I&E) Performance

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

- During month 6, the trust had an in month trading position of £21k surplus against a plan of £7k surplus; **giving a favourable variance of £15k**. Provider Sustainability Funding (PSF) has been assumed at £47k for month 6, bringing the overall trust control total to a £68k surplus against plan of £54k; **giving a favourable variance of £15k**.

- Year to date, the trust has a trading position of £113k surplus against a plan of £18k surplus, **giving a favourable variance of £95k**. Provider Sustainability Funding (PSF) is assumed at £246k, bringing the overall year to date trust control total to £359k surplus, **giving a favourable variance of £95k.**

- The Trust's forecast outturn for the year is expected to deliver in line with plan to give a trading surplus of £0.720m. Provider Sustainability Funding (PSF) is expected to be £0.703m in line with plan giving an overall Control Surplus of £1.423m.

| | | Month 6 | | | Year to Date | | | Forecast | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Table 1: Summary Performance** | **Annual Budget £'000** | **Budget £'000** | **Actual £'000** | **Variance £'000** | **Budget £'000** | **Actual £'000** | **Variance £'000** | **Budget £'000** | **Actual £'000** | **Variance £'000** |
| Income | (83,459) | (6,990) | (6,997) | (7) | (41,847) | (41,990) | (143) | (84,116) | (84,286) | (171) |
| Pay | 62,025 | 5,242 | 5,076 | (166) | 31,535 | 30,127 | (1,408) | 61,898 | 60,620 | (1,279) |
| Non Pay | 17,981 | 1,513 | 1,648 | 135 | 8,928 | 10,356 | 1,428 | 18,764 | 20,200 | 1,436 |
| **EBITDA** | **(3,453)** | **(235)** | **(273)** | **(38)** | **(1,384)** | **(1,507)** | **(122)** | **(3,453)** | **(3,467)** | **(14)** |
| Other Non-Op Costs | 2,733 | 228 | 251 | 23 | 1,367 | 1,394 | 28 | 2,733 | 2,747 | 14 |
| **Trading Surplus** | **(720)** | **(7)** | **(21)** | **(15)** | **(18)** | **(113)** | **(95)** | **(720)** | **(720)** | **0** |
| Provider Sustainability Funding | (703) | (47) | (47) | 0 | (246) | (246) | 0 | (703) | (703) | 0 |
| **(Surplus)/Deficit for the year** | **(1,423)** | **(54)** | **(68)** | **(15)** | **(264)** | **(359)** | **(95)** | **(1,423)** | **(1,423)** | **0** |

## 2. Income

Table 2 below shows the Trust income position by contract:

- The NHS Stoke-on-Trent CCG and NHS North Staffordshire CCG contracts are set on a block basis. Under performance relates to 2017/18 quarter 4 under performance of CQUIN, which was not confirmed until June 2018 and further CQUIN under performance in quarter 1 of 2018/19.
- Specialised Services are under performing year to date by £115k due to a reduction in activity at the Darwin Centre.
- OATs income is over performing year to date by £221k due to out of area patients in A&T.
- Other income is over performing on Estates maintenance charges, pay recharges to other organisations and training income.

| | | Month 6 | | | Year to Date | | | Forecast | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Table 2: Income** | **Annual Budget £'000** | **Budget £'000** | **Actual £'000** | **Variance £'000** | **Budget £'000** | **Actual £'000** | **Variance £'000** | **Budget £'000** | **Actual £'000** | **Variance £'000** |
| NHS Stoke-on-Trent CCG | (37,331) | (3,051) | (3,053) | (3) | (18,350) | (18,341) | 9 | (37,244) | (37,228) | 16 |
| NHS North Staffordshire CCG | (25,525) | (2,081) | (2,082) | (2) | (12,533) | (12,527) | 6 | (25,467) | (25,456) | 11 |
| Specialised Services | (3,189) | (266) | (201) | 65 | (1,595) | (1,480) | 115 | (3,189) | (2,960) | 230 |
| Stoke-on-Trent CC s75 | (3,999) | (333) | (333) | 0 | (2,000) | (2,000) | (0) | (3,999) | (3,999) | (0) |
| Staffordshire CC s75 | (527) | (88) | (88) | (0) | (527) | (528) | (1) | (527) | (528) | (1) |
| Stoke-on-Trent Public Health | (1,190) | (123) | (111) | 12 | (739) | (663) | 77 | (1,655) | (1,507) | 148 |
| Staffordshire Public Health | (613) | (51) | (51) | (0) | (307) | (307) | 0 | (613) | (613) | 0 |
| ADS/One Recovery | (1,467) | (122) | (122) | 0 | (733) | (733) | 0 | (1,467) | (1,467) | 0 |
| Associates | (837) | (55) | (54) | 2 | (333) | (332) | 0 | (666) | (665) | 1 |
| OATS | (600) | (64) | (142) | (78) | (385) | (606) | (221) | (771) | (1,181) | (410) |
| Department of Health | (810) | (68) | (68) | 0 | (408) | (408) | 0 | (810) | (810) | 0 |
| Private Patients | 0 | 0 | 0 | 0 | 0 | (5) | (5) | 0 | (5) | (5) |
| **Total Clinical Income** | **(76,088)** | **(6,302)** | **(6,306)** | **(4)** | **(37,910)** | **(37,930)** | **(20)** | **(76,408)** | **(76,419)** | **(11)** |
| Other Income | (7,371) | (687) | (691) | (3) | (3,938) | (4,060) | (123) | (7,708) | (7,867) | (160) |
| **Total Income** | **(83,459)** | **(6,990)** | **(6,997)** | **(7)** | **(41,847)** | **(41,990)** | **(143)** | **(84,116)** | **(84,286)** | **(171)** |
| Provider Sustainability Funding | (703) | (47) | (47) | 0 | (246) | (246) | 0 | (703) | (703) | 0 |
| **Total Income Incl. PSF** | **(84,162)** | **(7,037)** | **(7,044)** | **(7)** | **(42,093)** | **(42,236)** | **(143)** | **(84,819)** | **(84,989)** | **(171)** |

## 3. Expenditure

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

- Underspend of £1,408k at month 6 on pay is due to vacancies across the trust, partially covered by temporary staffing (bank and agency).
- Agency costs at month 6 are £1,003k, **£24k above the M6 agency ceiling of £979k.** A detailed review of agency spend is being undertaken across all categories.
- Non-Pay over spend at month 6 of £1,428k mainly due to residential payments and unachieved CIP.

| | | Month 6 | | | Year to Date | | | Forecast | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Table 3: Expenditure** | **Annual Budget £'000** | **Budget £'000** | **Actual £'000** | **Variance £'000** | **Budget £'000** | **Actual £'000** | **Variance £'000** | **Budget £'000** | **Actual £'000** | **Variance £'000** |
| Medical | 7,412 | 624 | 551 | (73) | 3,742 | 3,072 | (669) | 7,519 | 6,667 | (851) |
| Nursing | 29,521 | 2,500 | 2,385 | (115) | 14,992 | 14,306 | (686) | 29,357 | 28,645 | (711) |
| Other Clinical | 14,673 | 1,256 | 1,085 | (172) | 7,601 | 6,546 | (1,056) | 14,602 | 12,968 | (1,634) |
| Non-Clinical | 10,205 | 848 | 861 | 13 | 5,093 | 5,091 | (3) | 10,207 | 10,289 | 82 |
| Apprenticeship Levy | 214 | 18 | 18 | 1 | 107 | 110 | 3 | 214 | 220 | 6 |
| Agency | 0 | (4) | 176 | 180 | 0 | 1,003 | 1,003 | 0 | 1,830 | 1,830 |
| Cost Improvement | | | | | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Pay** | **62,025** | **5,242** | **5,076** | **(166)** | **31,535** | **30,127** | **(1,408)** | **61,898** | **60,620** | **(1,279)** |
| Drugs & Clinical Supplies | 2,169 | 182 | 200 | 18 | 1,090 | 1,210 | 121 | 2,363 | 2,534 | 172 |
| Establishment Costs | 1,586 | 136 | 112 | (25) | 827 | 687 | (140) | 1,812 | 1,381 | (431) |
| Information Technology | 683 | 62 | 53 | (9) | 346 | 355 | 9 | 687 | 717 | 30 |
| Premises Costs | 2,152 | 187 | 268 | 81 | 1,096 | 1,231 | 135 | 2,188 | 2,472 | 283 |
| Private Finance Initiative | 4,372 | 364 | 360 | (5) | 2,186 | 2,173 | (12) | 4,372 | 4,366 | (5) |
| Services Received | 3,396 | 284 | 296 | 12 | 1,701 | 1,781 | 80 | 3,407 | 3,595 | 188 |
| Residential Payments | 1,760 | 147 | 170 | 23 | 880 | 1,288 | 408 | 1,760 | 2,479 | 719 |
| Consultancy & Prof Fees | 133 | 9 | 78 | 69 | 80 | 200 | 119 | 133 | 357 | 224 |
| External Audit Fees | 65 | 5 | 5 | (0) | 32 | 31 | (1) | 65 | 62 | (3) |
| Legal Fees | 65 | 5 | 4 | (1) | 32 | 35 | 2 | 65 | 65 | 0 |
| Unacheived CIP | (1,745) | (83) | 0 | 83 | (499) | 0 | 499 | (1,303) | 509 | 1,812 |
| Other | 3,346 | 215 | 103 | (112) | 1,156 | 1,365 | 209 | 3,216 | 1,662 | (1,553) |
| **Total Non-Pay** | **17,981** | **1,513** | **1,648** | **135** | **8,928** | **10,356** | **1,428** | **18,764** | **20,200** | **1,436** |
| Finance Costs | 1,293 | 108 | 103 | (5) | 647 | 629 | (18) | 1,293 | 1,239 | (54) |
| Local Government Pension Scheme | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Unwinding of Discounts | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Dividends Payable on PDC | 561 | 47 | 74 | 28 | 281 | 308 | 28 | 561 | 599 | 38 |
| Investment Revenue | (14) | (1) | (6) | (5) | (7) | (21) | (14) | (14) | (48) | (34) |
| Fixed Asset Impairment | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Depreciation (excludes IFRIC 12) | 893 | 74 | 80 | 5 | 447 | 478 | 32 | 893 | 957 | 64 |
| **Total Non-op. Costs** | **2,733** | **228** | **251** | **23** | **1,367** | **1,394** | **28** | **2,733** | **2,747** | **14** |
| **Total Expenditure** | **82,739** | **6,983** | **6,975** | **(8)** | **41,830** | **41,877** | **48** | **83,396** | **83,566** | **171** |

**Agency Breakdown**

| Agency Type | YTD (£'000) | % |
|---|---|---|
| Medical | 654 | 65% |
| Nursing | 260 | 26% |
| Other Clinical | 1 | 0% |
| Non Clinical | 88 | 9% |
| **Total** | **1,003** | **100%** |

## Directorate Summary

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

| Table 4: YTD Expenditure | Pay | | | Non Pay | | | Income | | | Total | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Budget £'000 | Actual £'000 | Variance £'000 | Budget £'000 | Actual £'000 | Variance £'000 | Budget £'000 | Actual £'000 | Variance £'000 | Budget £'000 | Actual £'000 | Variance £'000 |
| AMH Community | 9,110 | 8,479 | (631) | 2,128 | 2,653 | 525 | (1,125) | (1,175) | (50) | 10,113 | 9,957 | (156) |
| AMH Inpatients | 3,147 | 3,180 | 32 | 158 | 174 | 16 | (1) | (1) | (0) | 3,304 | 3,353 | 48 |
| Children's Services | 3,098 | 3,002 | (96) | 303 | 394 | 91 | (305) | (325) | (21) | 3,096 | 3,070 | (26) |
| Substance Misuse | 1,559 | 1,467 | (92) | 452 | 480 | 28 | (247) | (179) | 68 | 1,764 | 1,767 | 3 |
| Learning Disabilities | 2,726 | 2,454 | (272) | 106 | 184 | 78 | (245) | (241) | 4 | 2,587 | 2,397 | (190) |
| Neuro & Old Age Psychiatry | 6,292 | 6,004 | (288) | 265 | 385 | 119 | (617) | (625) | (8) | 5,940 | 5,763 | (177) |
| Corporate | 5,603 | 5,541 | (62) | 6,882 | 7,481 | 599 | (39,554) | (39,689) | (135) | (27,069) | (26,666) | 402 |
| **Total** | **31,535** | **30,127** | **(1,408)** | **10,294** | **11,750** | **1,456** | **(42,093)** | **(42,236)** | **(143)** | **(264)** | **(359)** | **(95)** |

## Material Variances

- AMH Community
  - The underspent on pay is due to vacancies partially offset with bank and agency.
  - The adverse variance on non-pay is due to an under delivery of cost improvement against the target
  - The directorate is reporting a significant overspend on residential payments for the section 75 agreement.
- Corporate
  - Non-delivery of cost improvement is driving the adverse variance partially offset by an over recovery on income.

## 4. Cost Improvement Programme

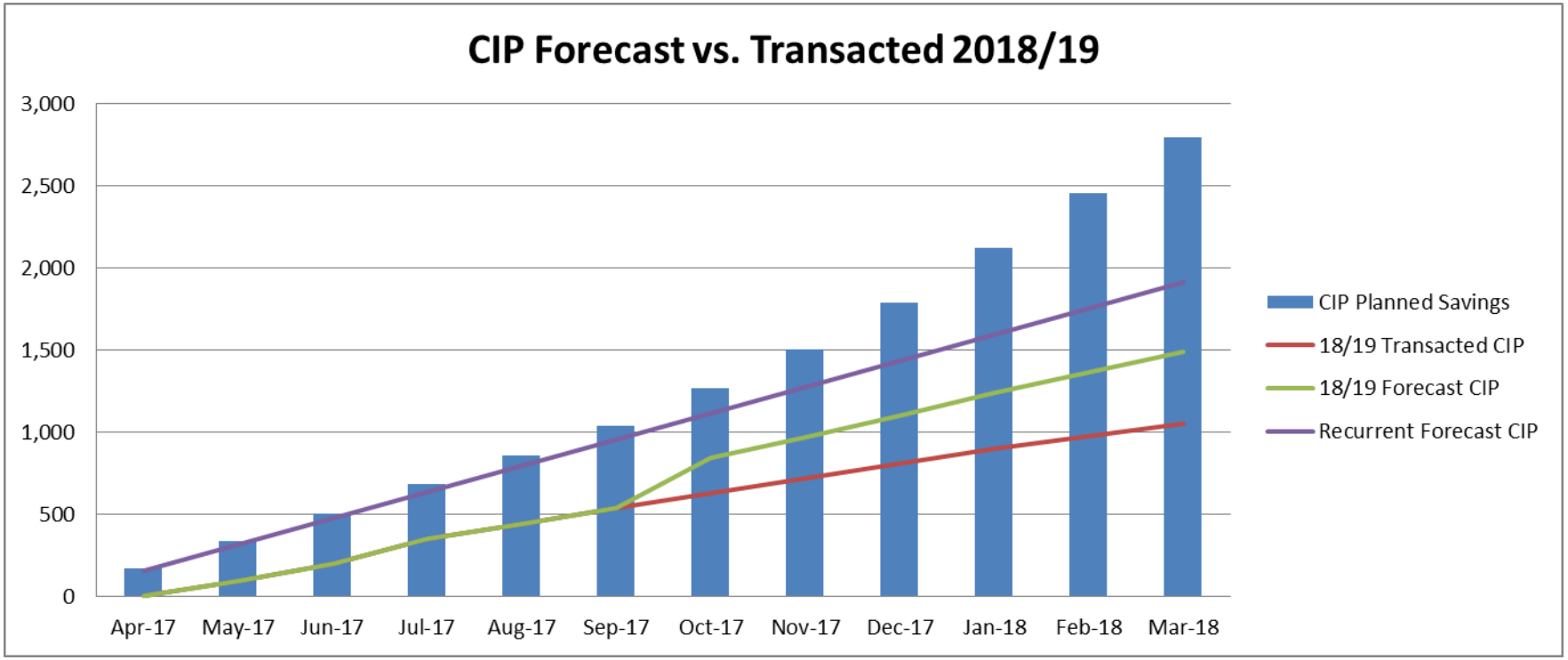
The Trust target for the year is £2,795k, as reported to NHSI. This takes into account the requirement to deliver a £1,423k control surplus for 2018/19. The table below shows the achievement by Directorate towards individual targets at M6.

| | | YTD M6 | | | Forecast | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| CIP Delivery | Annual CIP Target 2018/19 | Plan | Transacted | (Under)/Over Achievement | Plan | Total Schemes | (Under)/Over Achievement | RAG | Recurrent Transacted | Recurrent Forecast |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | | £'000 | £'000 |
| **Clinical** | | | | | | | | | | |
| AMH Community | 973 | 315 | 54 | (262) | 973 | 371 | (603) | 38% | 142 | 637 |
| AMH Inpatients | 160 | 60 | 42 | (19) | 160 | 106 | (53) | 66% | 129 | 129 |
| Children's Services | 296 | 126 | 103 | (22) | 296 | 257 | (39) | 87% | 236 | 297 |
| Learning Disabilities | 234 | 131 | 88 | (42) | 234 | 135 | (99) | 58% | 64 | 94 |
| NOAP | 551 | 173 | 77 | (95) | 551 | 283 | (268) | 51% | 161 | 286 |
| **Total Clinical** | **2,214** | **805** | **364** | **(441)** | **2,214** | **1,152** | **(1,062)** | **52%** | **733** | **1,443** |
| **Corporate** | | | | | | | | | | |
| CEO | 15 | 7 | 7 | 0 | 15 | 15 | 0 | 100% | 15 | 15 |
| Finance, Performance & Digital | 43 | 22 | 30 | 9 | 43 | 60 | 17 | 140% | 60 | 60 |
| MACE | 9 | 5 | 7 | 2 | 9 | 14 | 4 | 144% | 14 | 14 |
| Operations | 6 | 3 | 3 | (0) | 6 | 6 | 0 | 100% | 6 | 6 |
| Quality & Nursing | 41 | 20 | 11 | (9) | 41 | 34 | (6) | 84% | 22 | 42 |
| Strategy | 11 | 6 | 6 | (0) | 11 | 11 | 0 | 100% | 11 | 11 |
| Trustwide | 384 | 134 | 80 | (54) | 384 | 141 | (243) | 37% | 133 | 163 |
| Workforce & OD | 72 | 36 | 30 | (6) | 72 | 60 | (13) | 82% | 60 | 60 |
| **Total Corporate** | **581** | **232** | **173** | **(59)** | **581** | **340** | **(241)** | **58%** | **320** | **370** |
| **Total** | **2,795** | **1,037** | **538** | **(499)** | **2,795** | **1,492** | **(1,303)** | **53%** | **1,053** | **1,813** |

| | | | |
|---|---|---|---|
| Below 75% | | Target | 2,795 |
| Below 90% | | Variance | (982) |

- The forecast position as at M6 for 2018/19 is £1,492 (53%), which represents an in year shortfall against the annual target of £1,303k.
- The recurrent transacted cost improvement stands at £1,053k (37.6%), recurrent (risk adjusted) forecast is reported to be £1,813k (65%)

### 4.1 Cost Improvement Programme Forecast & Transacted 2018/19



## 5. Statement of Financial Position

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

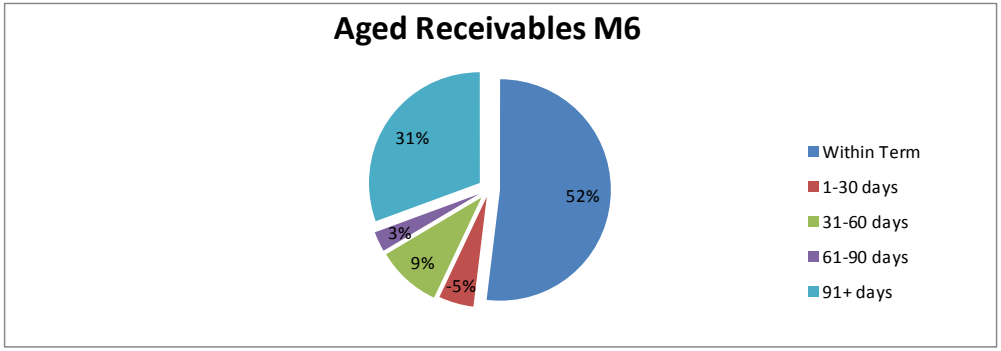
| *Table 6: SOFP* | 31/03/2018 £'000 | 31/07/2018 £'000 | 31/08/2018 £'000 | 30/09/2018 £'000 |
|---|---|---|---|---|
| **Non-Current Assets** | | | | |
| Property, Plant and Equipment - PFI | 16,185 | 16,175 | 16,177 | 16,170 |
| Property, Plant and Equipment | 14,841 | 14,681 | 14,663 | 14,609 |
| Intangible Assets | 277 | 252 | 246 | 239 |
| NCA Trade and Other Receivables | 608 | 0 | 0 | 0 |
| Other Financial Assets | 1,089 | 1,089 | 1,089 | 1,089 |
| **Total Non-Current Assets** | **33,000** | **32,197** | **32,174** | **32,108** |
| **Current Assets** | | | | |
| Inventories | 79 | 80 | 70 | 85 |
| Trade and Other Receivables | 7,347 | 5,722 | 5,647 | 5,322 |
| Cash and Cash Equivalents | 6,633 | 10,159 | 10,309 | 9,894 |
| Non-Current Assets Held For Sale | 0 | 0 | 0 | 0 |
| **Total Current Assets** | **14,058** | **15,961** | **16,025** | **15,301** |
| **Current Liabilities** | | | | |
| Trade and Other Payables | (7,166) | (8,298) | (8,342) | (7,534) |
| Provisions | (621) | (540) | (531) | (532) |
| Borrowings | (633) | (635) | (635) | (635) |
| **Total Current Liabilities** | **(8,420)** | **(9,473)** | **(9,508)** | **(8,701)** |
| **Net Current Assets / (Liabilities)** | **5,639** | **6,487** | **6,518** | **6,600** |
| **Total Assets less Current Liabilities** | **38,639** | **38,684** | **38,692** | **38,708** |
| **Non Current Liabilities** | | | | |
| Provisions | (458) | (458) | (458) | (458) |
| Borrowings | (11,557) | (11,373) | (11,320) | (11,267) |
| **Total Non-Current Liabilities** | **(12,015)** | **(11,831)** | **(11,778)** | **(11,725)** |
| **Total Assets Employed** | **26,624** | **26,853** | **26,914** | **26,983** |
| **Financed by Taxpayers' Equity** | | | | |
| Public Dividend Capital | 7,648 | 7,648 | 7,648 | 7,648 |
| Retained Earnings reserve | 7,943 | 8,172 | 8,234 | 8,302 |
| Other Reserves (LGPS) | 1,089 | 1,089 | 1,089 | 1,089 |
| Revaluation Reserve | 9,944 | 9,944 | 9,944 | 9,944 |
| **Total Taxpayers' Equity** | **26,624** | **26,853** | **26,914** | **26,983** |

Current receivables are £5,322k, of which:

- £2,712k is based on accruals (not yet invoiced) and relates to income accruals for services invoiced retrospectively at the end of every quarter.
- £2,610k is awaiting payment of invoice. (£1,509k within terms)

£1,249k is overdue by 31 days or more and therefore subject to routine credit control processes. This excludes a credit note for £152k.

| | | Days Overdue | | | | |
|---|---|---|---|---|---|---|
| *Table 6.1 Aged Receivables/Payables* | Within Term £'000 | 1-30 Days £'000 | 31-60 Days £'000 | 61-90 Days £'000 | 91+ Days £'000 | Total £'000 |
| Receivables Non NHS | 544 | 4 | 107 | 48 | 682 | 1,385 |
| Receivables NHS | 965 | (152) | 167 | 37 | 208 | 1,225 |
| Payables Non NHS | 473 | 92 | 39 | 0 | 4 | 608 |
| Payables NHS | 321 | 42 | 35 | 17 | 22 | 437 |

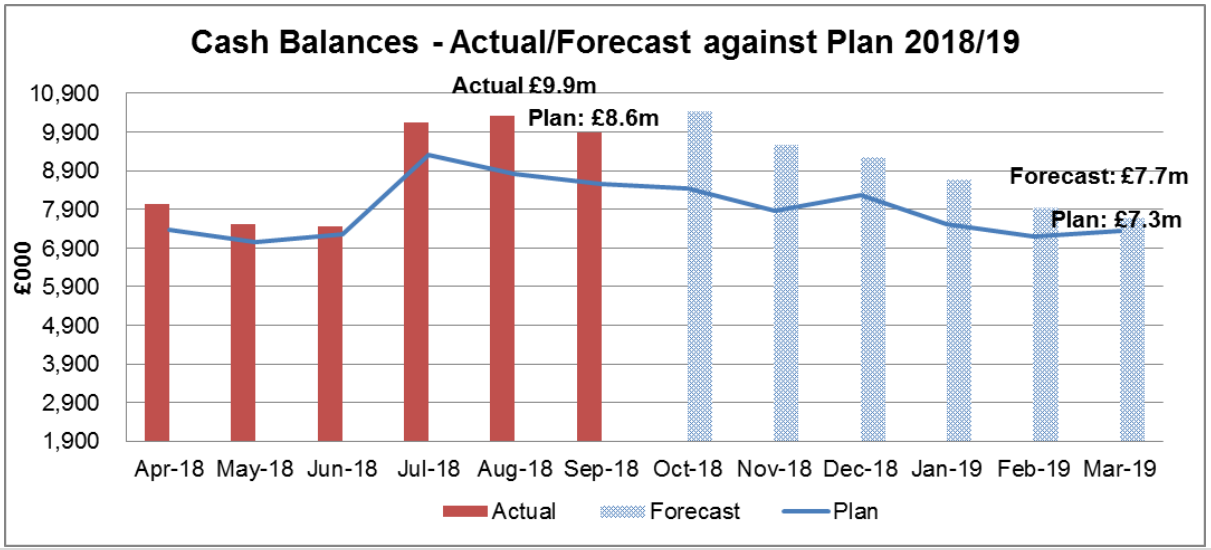


## 6. Cash Flow Statement

The Trust cash position at 30th September 2018 is £9.894m, **£1.327m higher than planned.** The variance is mainly due to lower monthly payroll payments, additional CCG income (OATs over performance) and Staffordshire County Council (SCC) Section 75 income (not planned to continue into 2018/19). The cash forecast is being closely monitored and the Trust anticipates being slightly ahead of plan by March 2019.

Table 7 below shows the Trust's cash flow for the financial year:

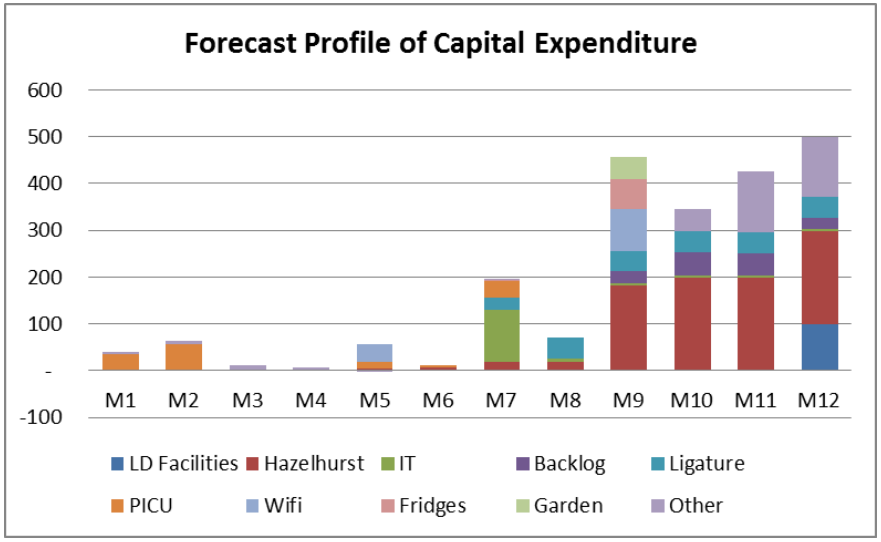
| *Table 7: Statement of Cash Flows* | Apr-18 £'000 | May-18 £'000 | Jun-18 £'000 | Jul-18 £'000 | Aug-18 £'000 | Sep-18 £'000 | Oct-18 £'000 | Nov-18 £'000 | Dec-18 £'000 | Jan-19 £'000 | Feb-19 £'000 | Mar-19 £'000 | Annual £'000 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Net Inflows/(Outflow) from Operating Activities | 927 | (281) | 159 | 2,908 | 408 | (178) | 1,044 | (439) | 12 | (55) | (206) | 536 | **4,836** |
| Net Inflows/(Outflow) from Investing Activities | 676 | (60) | (8) | (6) | (54) | (6) | (293) | (238) | (238) | (305) | (306) | (598) | **(1,437)** |
| Net Inflows/(Outflow) from Financing Activities | (193) | (193) | (202) | (202) | (203) | (230) | (194) | (197) | (111) | (208) | (209) | (209) | **(2,351)** |
| **Net Increase/(Decrease)** | **1,410** | **(534)** | **(51)** | **2,701** | **151** | **(414)** | **557** | **(874)** | **(337)** | **(568)** | **(721)** | **(271)** | **1,049** |
| | | | | | | | | | | | | | |
| **Opening Cash & Cash Equivalents** | **6,633** | **8,043** | **7,509** | **7,458** | **10,159** | **10,310** | **9,896** | **10,452** | **9,578** | **9,241** | **8,673** | **7,952** | **6,633** |
| **Closing Cash & Cash Equivalents** | **8,043** | **7,509** | **7,458** | **10,159** | **10,310** | **9,896** | **10,452** | **9,578** | **9,241** | **8,673** | **7,952** | **7,682** | **7,682** |
| | | | | | | | | | | | | | |
| Plan | 7,366 | 7,055 | 7,255 | 9,307 | 8,825 | 8,568 | 8,445 | 7,873 | 8,263 | 7,523 | 7,204 | 7,339 | 7,339 |
| **Variance** | **(677)** | **(454)** | **(203)** | **(852)** | **(1,485)** | **(1,328)** | **(2,007)** | **(1,705)** | **(978)** | **(1,150)** | **(748)** | **(343)** | **(343)** |



## 7. Capital Expenditure

The Trust's permitted capital expenditure agreed within the 2017/18 plan is £2,058k. Further PDC funding has been granted for £127k for 2020 Wifi – Secondary care implementation. Table 7 below shows the planned capital expenditure for 2018/19 as submitted to NHSI.

| | | | Year to Date | | | Forecast | | |
|---|---|---|---|---|---|---|---|---|
| *Capital Expenditure* | Original Plan £'000 | Revised Plan £'000 | Revised Plan £'000 | Actual £'000 | Variance £'000 | Revised Plan £'000 | Actual £'000 | Variance £'000 |
| Learning Disability Facilities | 400 | 100 | 0 | 0 | 0 | 100 | 100 | 0 |
| Hazelhurst incl Second Place of Safety | 1,000 | 827 | 0 | 11 | 11 | 827 | 827 | 0 |
| Information Technology Replacement Programme | 137 | 137 | 137 | 1 | (136) | 137 | 137 | 0 |
| Backlog Maintenance | 150 | 150 | 50 | 2 | (48) | 150 | 150 | 0 |
| Reduced Ligature Risks | 250 | 250 | 84 | 0 | (84) | 250 | 250 | 0 |
| Equipment Replacement Programme | 50 | 50 | 0 | 0 | 0 | 50 | 50 | 0 |
| Psychiatric Intensive Care Unit | 0 | 150 | 150 | 114 | (36) | 150 | 150 | 0 |
| Generator | 34 | 34 | 34 | 33 | (1) | 34 | 34 | 0 |
| Garden Redesign CYP Short Breaks | 48 | 48 | 0 | 0 | 0 | 48 | 48 | 0 |
| Pharmacy Temperature Monitoring System | 65 | 65 | 0 | 0 | 0 | 65 | 65 | 0 |
| Contingency | 100 | 247 | 0 | (5) | (5) | 247 | 247 | (0) |
| **Sub Total Gross Capital Expenditure** | **2,234** | **2,058** | **455** | **154** | **(301)** | **2,058** | **2,058** | **(0)** |
| Wifi | 127 | 127 | 0 | 38 | 38 | 127 | 127 | 0 |
| **Total Gross Capital Expenditure** | **2,361** | **2,185** | **455** | **192** | **(263)** | **2,185** | **2,185** | **(0)** |




**This graph excludes the contingency.*

- Actual YTD Capital Expenditure as at month 6 is **£192k** mainly relating to PICU, Wifi and the Estates generator; a shortfall of £263k.
- Following the latest Operational Project Oversight group for the Urgent Care Centre, a full review of the programme costs and time lines are being reviewed. This is anticipated to impact on the forecast capital spend for 2018/19 and will need to be reflected in the Month 7 return to NHS Improvement.
- The Capital Investment Group will review all spend against contingency funds at its meeting in November.
- A realistic capital forecast for 2018/19 is required in Month 7.

## 8. Use of Resource Metrics

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

| *Table 9: Use of Resource* | Year to Date Plan | Year to Date Actual | RAG Rating |
|---|---|---|---|
| **Liquidity Ratio (days)** | | | |
| Working Capital Balance (£000) | | 6,515 | |
| Annual Operating Expenses (£000) | | 40,483 | |
| Liquidity Ratio days | | 29 | |
| **Liquidity Ratio Metric** | 1 | 1 | |
| **Capital Servicing Capacity (times)** | | | |
| Revenue Available for Debt Service (£000) | | 1,773 | |
| Annual Debt Service (£000) | | 1,224 | |
| Capital Servicing Capacity (times) | | 1.4 | |
| **Capital Servicing Capacity Metric** | 3 | 3 | |
| **I&E Margin** | | | |
| Normalised Surplus/(Deficit) (£000) | | 359 | |
| Total Income (£000) | | 42,236 | |
| I&E Margin | | 0.8% | |
| **I&E Margin Rating** | 2 | 2 | |
| **I&E Margin Variance from Plan** | | | |
| I&E Margin Variance | | 0.2% | |
| **I&E Margin Variance From Plan** | 1 | 1 | |
| **Agency Spend** | | | |
| Providers Cap (£000) | | 979 | |
| Agency Spend (£000) | | 1,003 | |
| Agency % | | 2% | |
| **Agency Spend Metric** | 1 | 2 | |
| **Use of Resource** | 2 | 2 | |

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

- A full review of all agency spend invoicing will take place in month 7.

## 9. Better Payment Practice Code

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

At month 6, the Trust has achieved above the 95% target in terms of the value of invoices paid, but has under-performed against this target for the number of invoices, having paid 89% of the total number within target. Table 10 below shows the Trust's BPPC performance split between NHS and non-NHS suppliers.

| | 2017/18 | | | 2018/19 Month 6 | | | 2018/19 YTD | | |
|---|---|---|---|---|---|---|---|---|---|
| ***Table 10: Better Payment Practice Code*** | **NHS** | **Non-NHS** | **Total** | **NHS** | **Non-NHS** | **Total** | **NHS** | **Non-NHS** | **Total** |
| **Number of Invoices** | | | | | | | | | |
| Total Paid | 659 | 10,933 | 11,592 | 56 | 914 | 970 | 337 | 5,468 | 5,805 |
| Total Paid within Target | 575 | 9,527 | 10,102 | 52 | 819 | 871 | 316 | 4,856 | 5,172 |
| % Number of Invoices Paid | 87% | 87% | 87% | 93% | 90% | 90% | 94% | 89% | 89% |
| % Target | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |
| **RAG Rating (Variance to Target)** | **-8%** | **-8%** | **-8%** | **-2%** | **-5%** | **-5%** | **-1%** | **-6%** | **-6%** |
| **Value of Invoices** | | | | | | | | | |
| Total Value Paid (£000s) | 7,164 | 33,211 | 40,375 | 905 | 2,809 | 3,714 | 3,442 | 16,575 | 20,017 |
| Total Value Paid within Target (£000s) | 6,258 | 31,653 | 37,911 | 904 | 2,706 | 3,610 | 3,279 | 15,920 | 19,199 |
| % Value of Invoices Paid | 87% | 95% | 94% | 100% | 96% | 97% | 95% | 96% | 96% |
| % Target | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |
| **RAG Rating (Variance to Target)** | **-8%** | **0%** | **-1%** | **5%** | **1%** | **2%** | **0%** | **1%** | **1%** |

The majority of breaches in number of invoices relates to the retrospective raising of purchase orders, or late authorisation.

## 10. Recommendations

The Trust Board are asked to:

**Note:**

- The reported YTD surplus of £359k against a planned surplus of £264k. **This is a favourable variance to plan of £95k.**

- The M6 CIP achievement:
  - YTD achievement of £538k (52%); **an adverse variance of £499k**;
  - 2018/19 forecast CIP delivery of £1,492k (53%) based on schemes identified; **an adverse variance of £1,303k to plan**;
  - The recurrent value of schemes transacted at £1,053k; **38% of target**.
  - The recurrent risk adjusted forecast of £1,813k; **65% of target.**

- The cash position of the Trust as at 30th September 2018 with a **balance of £9,894k**; £1,327k better than plan

- Month 6 capital expenditure at £192k compared to planned capital expenditure of £455k;

- Use of resource rating of **2** against a plan of 2.

**Approve:**

- The month 6 position reported to NHSI.

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# REPORT TO OPEN TRUST BOARD

Enclosure No:20

| | | | |
|---|---|---|---|
| Date of Meeting: | 22nd November 2018 | | |
| Title of Report: | Finance, Performance and Digital Committee Assurance Report | | |
| Presented by: | Tony Gadsby<br>Chair/Non-Executive Director | | |
| Author: | Mike Newton - Deputy Director of Finance | | |
| Executive Lead Name: | Suzanne Robinson – Executive Director of Finance, Performance and Digital | Approved by Exec | ☒ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| This paper details the issues discussed at the Finance, Performance and Digital Committee meeting on the 8th November 2018. The meeting was quorate with minutes approved from the previous meeting on the 11th October 2018. Progress was reviewed and actions confirmed from previous meetings. | Approval | ☐ |
| | Information | ☒ |
| | Discussion | ☐ |
| | Assurance | ☒ |

| | | | |
|---|---|---|---|
| Seen at: | SLT ☐ Execs X<br>Date: | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☐<br>• Finance & Performance Committee X<br>• Audit Committee ☐<br>• People & Culture Development Committee ☐<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Digital by Choice Board ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement.☐<br>2. To provide the highest quality services X☐<br>3. Create a learning culture to continually improve.☐<br>4. Encourage, inspire and implement research & innovation at all levels.☐<br>5. Maximise and use our resources intelligently and efficiently. X<br>6. Attract and inspire the best people to work here.☐<br>7. Continually improve our partnership working. ☐ | | |
| Risk / legal implications:<br>Risk Register Ref | Oversees the risk relevant to the Finance & Performance Committee | | |
| Resource Implications:<br>Funding Source: | None applicable directly from this report | | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups) | There are no direct impact of this report on the 10 protected characteristic of the Equality Act | | |
| STP Alignment / Implications | The Trust Financial performance feed into the overall STP Financial Position. The Digital priorities include support in delivery of STP Digital Programme; Integrated Care Record. | | |
| Recommendations: | The Trust Board is asked to note the contents of this report and take assurance from the review and challenge evidenced in the Committee. | | |

# Assurance Report to the Trust Board
# 22nd November 2018

## Finance, Performance and Digital Committee Report to the Trust Board – 22nd November 2018.

This paper details the issues discussed at the Finance, Performance and Digital Committee meeting on the 8th November 2018. The meeting was quorate with minutes approved from the previous meeting on the 11th October 2018. Progress was reviewed and actions confirmed from previous meetings.

## Executive Director of Finance, Performance and Digital Update

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

- **November 2018 UK Budget Announcement –** An update on the November 2018 budget announcement from NHS Providers. The Government has committed to extend Mental Health Crisis services at a cost of £250m per year, including 24/7 support via NHS 111, All Age Crisis, Mental Health input in Schools, Mental Health input into every major A&E / ED, more specialist Ambulances and more community services such as Crisis Cafes.

- **2019/20 Planning Guidance –** An update on the planning guidance issued on 16th October 2018; outlining the planning timetable for 2019/20 operational plans.

- **National Tariff Proposals 2019/20 –** An update on the policies and pricing proposals for the national tariff payment system in 2019/20. This considers a blended payment approach for mental health services, consisting of a fixed element for forecast activity and variable element linked to local quality and outcome metrics.

- **L.E.D Lighting National Funding** – The Direct of Finance invited the Deputy Finance Director to update on the £46m funding for energy efficient lighting, which has been managed through the STP Energy Efficiency Group. The Trust will submit a bid for the lighting, predominantly in the PFI site.

- **Q2 Deep Dive –** A presentation providing a deep dive analysis into the 2018/19 financial position, which outlined the current forecast and sensitivity analysis to consider best and worst case forecast scenarios. Key risks to the financial position were presented, as well as mitigations, with a particular focus around the shortfall in identified schemes for Cost Improvement.

  The committee are assured around the delivery of control in 2018/19, but were concerned proportion of the surplus which is non recurrent. The recurrent financial risk surrounding Section 75 Residential Placements and delivery of Cost Improvement was also noted. The committee discussed a proposal for setting a realistic plan in 2019/20, which fully considers the availability of resources and balancing with the requirement to deliver Control and efficiency.

## Finance

- **Monthly Finance Report – M6**

The Finance position was presented, showing £95k favourable variance to plan. Notable forecast underperformance against the Darwin contract was highlighted, due to a reduction in length of stay and was being investigated by the Finance Team with Operations.

The committee noted the improvement in performance around the Better Payment Practice Code compared to previous years.

Use of resource rating is 2 against a plan of 2.

- **Agency**

The Year to Date Agency position breached the ceiling at M6, by £24k (2.3%) against a target of £1m. As a result, the Agency Metric within the Use of Resources is a 2 compared to a plan of 1.

Whist the majority of expenditure on Agency is Medical Locum spend, the Trust has incurred unplanned, non-clinical spend of £58k as a direct result of the decision to support the System with the STP Director of Finance appointment.

The committee are assured that the Agency expenditure will be in line with the ceiling by the end of the year and were reassured that a deep dive into the Agency expenditure will be undertaken as part of preparing the M7 management accounts.

- **Cost Improvement Programme (CIP)**

The Committee received an update for Cost Improvement for M5 and were concerned that the total identified was significantly short of the target. CIP achievement in M5 was £538k, giving an adverse variance of £499k. The recurrent shortfall is forecast to be £982k, which has been 'risk adjusted' down to reflect an element of uncertainty for schemes not yet worked up fully.

The Committee were assured that there was sufficient focus being placed on Cost Improvement but are unable to give assurance around the ability to deliver the target for 2018/19, particularly given the level of unidentified schemes.

The Committee also sought further assurance around deliverability of a 2019/20 programme, having not had sight of a plan. The committee requested a high level plan of proposed schemes for 2019/20 at the next committee.

- **2018/19 Capital Programme and Q2 Affordability profile**

The committee received an update on the actual capital expenditure against plan for 2018/19, which is £263k (57%) underspent at Q2, mainly due to slippage in Ligature programme, Urgent Care Centre and Backlog Maintenance.

The Urgent Care Centre conclusion date is now expected slip into 2019/20. This, in addition

to anticipated slippage on other schemes, means the Trust is expecting to undershoot its Capital Resource Limit in 2018/19. A restated forecast position would be submitted to NHSI in M7.

The committee noted concern around the deliverability of schemes which spanned financial years, as the funding is not guaranteed and expect to receive an updated profile in December Committee. The committee were assured that the 5 year Capital programme is affordable within the minimum cash limit.

## Performance

- **Q2 Enhanced Performance Report**

The committee received a Q2 performance report outlining PQMF, Single Oversight Framework Metrics and 5YFV for Mental Health. The committee were assured with performance, noting that the Trust has achieved the Delayed Transfer of Care target in M6.

The Committee welcomed the proposed reports under development which look to automate Directorate reporting through 'vital signs' dashboards, but also streamline committee reporting, reducing duplication and improving the visibility of Key Performance Metrics across all committees.

- **CAMHs Waiting Times Report Q2**

The committee received a Q2 report on Waiting Times which demonstrated the improvement against both the 18 week target, now being delivered, and 4 week target.

The committee noted that the 4 week referral to assessment is not yet being delivered, but acknowledged the improvement of nearly 12% to 67.5% between April and September. The committee noted that performance against this measure is a national challenge and the potential opportunity for faster improvement, should the STP be successful in the CAMHs Trailblazer bid.

- **PBR Care Cluster Activity Report**

The committee received the Q2 update on PBR Care Clustering Compliance. Whilst the proportion of the suspense "Cluster 99" codes was reducing, progress appears to be starting to flat line after drastic improvements in Q1. The committee challenged that a new approach might be needed to ensure continued improvement. This is of particular importance due to the likelihood of Clusters featuring in Blended Tariff approach, should this be implemented.

## Other:

- **Policies for Review**

The following policies were received and approved by the committee, requesting ratification from Trust Board:

- Lease Car Policy
- Petty Cash Procedure
- Official Orders Procedure
- Security of Assets Procedure
- Information Governance Policy
- Mobile Information Handling Policy
- Disposal of Items Surplus to Requirements.

- **Awards**

The Committee congratulated Suzanne Robinson and Mike Newton (DDoF) for their two successful shortlists for Finance Director of the Year and Deputy Finance Director of the year in the National HFMA Awards.

- **Additional Assurance Reports:**

The Committee received additional assurance reports as follows:

- Long Term Financial Model Framework
- Digital Update (Verbal)
- Finance, Performance and Digital Risk Register
- Draft Q2 BAF
- Cycle of Business 2018/19 *(For Information)*
- Finance, Performance and Digital Monitoring Schedule *(For Information)*
- Q2 Cash and Treasury Report *(For Information)*
- Q2 Partnerships and Contracting *(For Information)*

## Recommendation

The Board is asked to receive the contents of this report and take assurance from the review and challenge evidenced in the Committee.

On Behalf of Tony Gadsby
Chair of Finance, Performance and Digital Committee

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# REPORT TO TRUST BOARD

Enclosure No:21

| | | | |
|---|---|---|---|
| Date of Meeting: | 22nd November 2018 | | |
| Title of Report: | EPRR Core Standards Compliance | | |
| Presented by: | Jonathan O'Brien, Executive Director of Operations | | |
| Author: | Jonathan O'Brien, Executive Director of Operations | | |
| Executive Lead Name: | Jonathan O'Brien, Executive Director of Operations | Approved by Exec | ☐ |

| Executive Summary: | | Purpose of report | |
|---|---|---|---|
| The paper contains the annual declaration of Emergency Planning Resilience & Response (EPRR) Core Standards. The Executive Lead is required to present the annual declaration and outcome regarding EPRR to the Trust Board.<br><br>The Trust has been rated as 'green' which is fully/substantially compliant. | | Approval | ☐ |
| | | Information | ☐ |
| | | Discussion | ☐ |
| | | Assurance | ☒ |
| Seen at: | SLT ☐ Execs ☐<br>Date: | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☐<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☒<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Primary Care Integration Programme Board ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement. ☐<br>2. To provide the highest quality services ☒<br>3. Create a learning culture to continually improve. ☒<br>4. Encourage, inspire and implement research & innovation at all levels. ☐<br>5. Maximise and use our resources intelligently and efficiently. ☐<br>6. Attract and inspire the best people to work here. ☐<br>7. Continually improve our partnership working. ☐ | | |
| Risk / legal implications:<br>Risk Register Reference | There is a risk of non-compliance with EPRR standards if the self-assessment submitted is not validated and supported by the external review on 17th September 2018. | | |
| Resource Implications:<br>Funding Source: | N/A<br>N/A | | |
| Diversity & Inclusion Implications | N/A | | |
| STP Alignment / Implications: | N/A | | |
| Recommendations: | To Approve | | |

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# Emergency Planning, Resilience & Response (EPRR) Annual Declaration

## Executive Summary

Every NHS organisation must assess itself against the national core standards for EPRR on an annual basis. In 2016/17, the Trust achieved substantial compliance rating. In 2017/18 the Trust self-assessed as substantially compliant and however during the external validation, this was upgraded to full compliance.

In the current year of 2018/19, there are 62 standards (54 Core & 8 Deep Dive). The Trust submitted the self-assessment declaration and evidence on 6th September 2018 as 'substantially compliant' (green) with full compliance against 61 of 62 standards and partial compliance against one standard. A confirm and challenge session was held with commissioners and NHS England on 17th September 2018 where evidence was presented by the Executive Director of Operations and received an in depth challenge.

The Trust has now received written confirmation that the self-assessment declaration was accurate and has had a substantial compliance (green rating) status confirmed.

The Executive lead is required to present the annual declaration and outcome regarding EPRR to the Trust Board.

**Table 1 - EPRR Compliance Matrix**

| Compliance Level | Definition | |
|---|---|---|
| **FULL / SUBSTANTIAL** | Fully compliant with core standards. | X |
| **PARTIAL** | Not compliant with core standards.<br>The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months. | |
| **NON-COMPLIANT** | Not compliant with core standards.<br>In line with the organisation's EPRR work programme, compliance will not be achieved within 12 months. | |

The appended documents provide a detailed assessment of each standard, the Trust's response and the evidence base submitted by the Trust.

## Recommendation

The Board is asked to **note** and **approve** the annual declaration.

Please select type of organisation: **Mental Health Providers**

| Core Standards | Total standards applicable | Fully compliant | Partially compliant | Non compliant |
|---|---|---|---|---|
| Governance | 6 | 6 | 0 | 0 |
| Duty to risk assess | 2 | 2 | 0 | 0 |
| Duty to maintain plans | 13 | 13 | 0 | 0 |
| Command and control | 2 | 2 | 0 | 0 |
| Training and exercising | 3 | 3 | 0 | 0 |
| Response | 5 | 5 | 0 | 0 |
| Warning and informing | 3 | 3 | 0 | 0 |
| Cooperation | 4 | 4 | 0 | 0 |
| Business Continuity | 9 | 9 | 0 | 0 |
| CBRN | 7 | 6 | 1 | 0 |
| Total | 54 | 53 | 1 | 0 |

| Deep Dive | Total standards applicable | Fully compliant | Partially compliant | Non compliant |
|---|---|---|---|---|
| Incident Coordination Centres | 4 | 4 | 0 | 0 |
| Command structures | 4 | 4 | 0 | 0 |
| Total | 8 | 8 | 0 | 0 |

| **Overall assessment:** | Substantially compliant |
|---|---|

Instructions:
Step 1: Select the type of organisation from the drop-down at the top of this page
Step 2: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 3: Complete the Self-Assessment RAG in the 'Deep dive' tab
Step 4: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 5: Click the 'Produce Action Plan' button below

| Ref | Domain | Standard | Detail | Mental Health Providers | Evidence - examples listed below | Self assessment RAG<br><br>Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.<br><br>Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months.<br><br>Green = Fully compliant with core standard. | Action to be taken | Lead | Timescale | Comments (including organisational evidence) |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Governance | Appointed AEO | The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio.<br><br>A non-executive board member, or suitable alternative, should be identified to support them in this role. | Y | • Name and role of appointed individual | Fully compliant | | | | Jonathan O'Brien - Director of Operations |
| 2 | Governance | EPRR Policy Statement | The organisation has an overarching EPRR policy statement.<br><br>This should take into account the organisation's:<br>• Business objectives and processes<br>• Key suppliers and contractual arrangements<br>• Risk assessment(s)<br>• Functions and / or organisation, structural and staff changes.<br><br>The policy should:<br>• Have a review schedule and version control<br>• Use unambiguous terminology<br>• Identify those responsible for making sure the policies and arrangements are updated, distributed and regularly tested<br>• Include references to other sources of information and supporting documentation. | Y | Evidence of an up to date EPRR policy statement that includes:<br>• Resourcing commitment<br>• Access to funds<br>• Commitment to Emergency Planning, Business Continuity, Training, Exercising etc. | Fully compliant | | | | EPRR Policy (Evidence 1.1) |
| 3 | Governance | EPRR board reports | The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually.<br><br>These reports should be taken to a public board, and as a minimum, include an overview on:<br>• training and exercises undertaken by the organisation<br>• business continuity, critical incidents and major incidents<br>• the organisation's position in relation to the NHS England EPRR assurance process. | Y | • Public Board meeting minutes<br>• Evidence of presenting the results of the annual EPRR assurance process to the Public Board | Fully compliant | | | | EPRR Policy (Evidence 1.1) |
| 4 | Governance | EPRR work programme | The organisation has an annual EPRR work programme, informed by lessons identified from:<br>• incidents and exercises<br>• identified risks<br>• outcomes from assurance processes. | Y | • Process explicitly described within the EPRR policy statement<br>• Annual work plan | Fully compliant | | | | Draft Workplan (Evidence 1.2) |
| 5 | Governance | EPRR Resource | The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties. | Y | • EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board<br>• Assessment of role / resources<br>• Role description of EPRR Staff<br>• Organisation structure chart<br>• Internal Governance process chart including EPRR group | Fully compliant | | | | EPRR Policy (Evidence 1.1) |
| 6 | Governance | Continuous improvement process | The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements. | Y | • Process explicitly described within the EPRR policy statement | Fully compliant | | | | Cyber Attack lessons learnt and debrief reports (Evidence 1.1, 1.3, 1.4, 1.5) |
| 7 | Duty to risk assess | Risk assessment | The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers. | Y | • Evidence that EPRR risks are regularly considered and recorded<br>• Evidence that EPRR risks are represented and recorded on the organisations corporate risk register | Fully compliant | | | | Trust Risk Strategy & Policy<br>RAWG Statement. Show how Trust considers community based risks and their impact on the Trust's ability to deliver services in the event of a risk being realised. (Evidence 1.6, 1.35) |
| 8 | Duty to risk assess | Risk Management | The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks. | Y | • EPRR risks are considered in the organisation's risk management policy<br>• Reference to EPRR risk management in the organisation's EPRR policy document | Fully compliant | | | | Risk manager in role and corporate risk register and strategy/policy. Input from RAWG, LHRP & HEPOG. (Evidence 1.1, 1.6, 1.35) |
| 9 | Duty to maintain plans | Collaborative planning | Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered. | Y | Partners consulted with as part of the planning process are demonstrable in planning arrangements | Fully compliant | | | | Consulted with North Staffs on wider plans. Severe Weather plan has been written in conjunction with NHSE & Met Office guidance and use of CCU information. Infection Control Policy adopted from Infection Prevention Control Group.(Evidence 1.10) |
| 11 | Duty to maintain plans | Critical incident | In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as per the EPRR Framework). | Y | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Fully compliant | | | | Incident response plan & Business continuity plans. These plans refer to nature of incidents (Evidence 1.7, 1.8, 1.9) |
| 12 | Duty to maintain plans | Major incident | In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as per the EPRR Framework). | Y | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Fully compliant | | | | Incident response plan & Business continuity plans. These plans refer to nature of incidents (Evidence 1.7, 1.8, 1.9) |
| 13 | Duty to maintain plans | Heatwave | In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heat wave on the population the organisation serves and its staff. | Y | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Fully compliant | | | | Severe Weather Plan (Evidence 1.10) |
| 14 | Duty to maintain plans | Cold weather | In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves. | Y | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Fully compliant | | | | Severe Weather Plan (Evidence 1.10) - needs local review but will be informed by LRF cold weather plan |
| 15 | Duty to maintain plans | Pandemic influenza | In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza as described in the National Risk Register. | Y | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Fully compliant | | | | Pandemic Flu Plan (Evidence 1.11) |
| 16 | Duty to maintain plans | Infectious disease | In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3. | Y | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Fully compliant | | | | infectious disease group will deliver plan (Evidence 1.36, 1.37, 1.38) |

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| **17** | **Duty to maintain plans** | **Mass Countermeasures** | In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution, eg mass prophylaxis or mass vaccination.<br><br>There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop Mass Countermeasure distribution arrangements. These will be dependant on the incident, and as such requested at the time.<br><br>CCGs may be required to commission new services dependant on the incident. | Y | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Fully compliant | | | | | Infection and prevention control policy<br>Outbreak break management SOP<br>Always hold stock of tamiflu<br>(Evidence 1.36, 1.37, 1.38) |
| **18** | **Duty to maintain plans** | **Mass Casualty - surge** | In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to increase capacity by 10% in 6 hours and 20% in 12 hours. | Y | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Fully compliant | | | | | mass casulaty working group to be setup by local health authority to look at mass cas arrangements |
| **20** | **Duty to maintain plans** | **Shelter and evacuation** | In line with current guidance and legislation, the organisation has effective arrangements in place to place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation. | Y | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Fully compliant | | | | | Fire & Evac Plan (evidence 1.12) |
| **21** | **Duty to maintain plans** | **Lockdown** | In line with current guidance and legislation, the organisation has effective arrangements in place safely manage site access and egress of patients, staff and visitors to and from the organisation's facilities. This may be a progressive restriction of access / egress that focuses on the 'protection' of critical areas. | Y | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Fully compliant | | | | | Action card (Evidence 1.13)<br>SOP - Reception Lockdown (Evidence 1.14) |
| **22** | **Duty to maintain plans** | **Protected individuals** | In line with current guidance and legislation, the organisation has effective arrangements in place to respond to manage "protected individuals"; including VIPs, high profile patients and visitors to the site. | Y | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Fully compliant | | | | | There is a VIP plan in place |
| **23** | **Duty to maintain plans** | **Excess death planning** | Organisation has contributed to and understands its role in the multiagency planning arrangements for excess deaths, including mortuary arrangements. | Y | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Fully compliant | | | | | part of LRF excess death plan/process |
| **24** | **Command and control** | **On call mechanism** | A resilient and dedicated EPRR on call mechanism in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents.<br><br>This should provide the facility to respond or escalate notifications to an executive level. | Y | • Process explicitly described within the EPRR policy statement<br>• On call Standards and expectations are set out<br>• Include 24 hour arrangements for alerting managers and other key staff. | Fully compliant | | | | | Pocket Gold On call card (Evidence 1.15) |
| **25** | **Command and control** | **Trained on call staff** | On call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf on the Chief Executive Officer / Clinical Commissioning Group Accountable Officer.<br><br>The identified individual:<br>• Should be trained according to the NHS England EPRR competencies (National Occupational Standards)<br>• Can determine whether a critical, major or business continuity incident has occurred<br>• Has a specific process to adopt during the decision making<br>• Is aware who should be consulted and informed during decision making<br>• Should ensure appropriate records are maintained throughout. | Y | • Process explicitly described within the EPRR policy statement | Fully compliant | | | | | TNA of on-call gold/silver staff |
| **26** | **Training and exercising** | **EPRR Training** | The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this. | Y | • Process explicitly described within the EPRR policy statement<br>• Evidence of a training needs analysis<br>• Training records for all staff on call and those performing a role within the ICC<br>• Training materials<br>• Evidence of personal training and exercising portfolios for key staff | Fully compliant | | | | | TNA |
| **27** | **Training and exercising** | **EPRR exercising and testing programme** | The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements.<br><br>Organisations should meet the following exercising and testing requirements:<br>• a six-monthly communications test<br>• annual table top exercise<br>• live exercise at least once every three years<br>• command post exercise every three years.<br><br>The exercising programme must:<br>• identify exercises relevant to local risks<br>• meet the needs of the organisation type and stakeholders<br>• ensure warning and informing arrangements are effective.<br><br>Lessons identified must be captured, recorded and acted upon as part of continuous improvement. | Y | • Exercising Schedule<br>• Evidence of post exercise reports and embedding learning | Fully compliant | | | | | Carillion Exerice (Evidence (1.16)<br>Business continuity exercise & report (Evidence 1.17, 1.18)<br>Exercise Hermes (1.19) |
| **28** | **Training and exercising** | **Strategic and tactical responder training** | Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation | Y | • Training records<br>• Evidence of personal training and exercising portfolios for key staff | Fully compliant | | | | | TNA |
| **30** | **Response** | **Incident Co-ordination Centre (ICC)** | The organisation has a preidentified an Incident Co-ordination Centre (ICC) and alternative fall-back location.<br><br>Both locations should be tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation. | Y | • Documented processes for establishing an ICC<br>• Maps and diagrams<br>• A testing schedule<br>• A training schedule<br>• Pre identified roles and responsibilities, with action cards<br>• Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards | Fully compliant | | | | | Incident response plan & Business continuity plans. These plans refer to nature of incidents (Evidence 1.7, 1.8, 1.9) |
| **31** | **Response** | **Access to planning arrangements** | Version controlled, hard copies of all response arrangements are available to staff at all times. Staff should be aware of where they are stored; they should be easily accessible. | Y | Planning arrangements are easily accessible - both electronically and hard copies | Fully compliant | | | | | Incident response plan & Business continuity plans. These plans refer to nature of incidents (Evidence 1.7, 1.8, 1.9) |
| **32** | **Response** | **Management of business continuity incidents** | The organisations incident response arrangements encompass the management of business continuity incidents. | Y | • Business Continuity Response plans | Fully compliant | | | | | Incident response plan & Business continuity plans. These plans refer to nature of incidents (Evidence 1.7, 1.8, 1.9) |
| **33** | **Response** | **Loggist** | The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents. | Y | • Documented processes for accessing and utilising loggists<br>• Training records | Fully compliant | | | | | Loggist Contact List (Evidence 1.32) and SRF Loggist Handbook (Evidence 1.33) |
| **34** | **Response** | **Situation Reports** | The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents. | Y | • Documented processes for completing, signing off and submitting SitReps<br>• Evidence of testing and exercising | Fully compliant | | | | | Sit reps are completed in line with SRF training when required. Recent incidents have not required them to be completed |

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|---|---|---|---|---|---|---|---|---|---|---|
| **37** | **Warning and informing** | **Communication with partners and stakeholders** | The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident. | Y | • Have emergency communications response arrangements in place<br>• Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response<br>• Using lessons identified from previous major incidents to inform the development of future incident response communications<br>• Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes<br>• Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work | Fully compliant | | | | Comms Plan (Evidence 1.20) |
| **38** | **Warning and informing** | **Warning and informing** | The organisation has processes for warning and informing the public and staff during major incidents, critical incidents or business continuity incidents. | Y | • Have emergency communications response arrangements in place<br>• Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies)<br>• Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders<br>• Using lessons identified from previous major incidents to inform the development of future incident response communications<br>• Setting up protocols with the media for warning and informing | Fully compliant | | | | Comms Plan (Evidence 1.20) |
| **39** | **Warning and informing** | **Media strategy** | The organisation has a media strategy to enable communication with the public. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times. | Y | • Have emergency communications response arrangements in place<br>• Using lessons identified from previous major incidents to inform the development of future incident response communications<br>• Setting up protocols with the media for warning and informing<br>• Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads' | Fully compliant | | | | Comms Plan (Evidence 1.20) |
| **40** | **Cooperation** | **LRHP attendance** | The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum. | Y | • Minutes of meetings | Fully compliant | | | | Not 75% past attendance by AEO, however some attendence by Delegated officers. Future meetings are diarised for AEO to attend with agenda item |
| **41** | **Cooperation** | **LRF / BRF attendance** | The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with other responders. | Y | • Minutes of meetings<br>• Governance agreement if the organisation is represented | Fully compliant | | | | Attendence by Marcel Comer on behalf of NHS trusts (Evidence 1.30) |
| **42** | **Cooperation** | **Mutual aid arrangements** | The organisation has agreed mutual aid arrangements in place outlining the process for requesting, co-ordinating and maintaining resource eg staff, equipment, services and supplies.<br><br>These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA). | Y | • Detailed documentation on the process for requesting, receiving and managing mutual aid requests<br>• Signed mutual aid agreements where appropriate | Fully compliant | | | | informal with UHNM for countermeasures, OPEL, new mass cas working group, part of LHRP, HEPOG, LRF. (Evidence 1.29, 1.34) |
| **46** | **Cooperation** | **Information sharing** | The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders. | Y | • Documented and signed information sharing protocol<br>• Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'. | Fully compliant | | | | LRF Information Sharing Forum (Evidence 1.29, 1.34) |
| **47** | **Business Continuity** | **BC policy statement** | The organisation has in place a policy statement of intent to undertake Business Continuity Management System (BCMS). | Y | Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement | Fully compliant | | | | Business Continuity Policy (Evidence 1.9) |
| **48** | **Business Continuity** | **BCMS scope and objectives** | The organisation has established the scope and objectives of the BCMS, specifying the risk management process and how this will be documented. | Y | BCMS should detail:<br>• Scope e.g. key products and services within the scope and exclusions from the scope<br>• Objectives of the system<br>• The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties<br>• Specific roles within the BCMS including responsibilities, competencies and authorities.<br>• The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process<br>• Resource requirements<br>• Communications strategy with all staff to ensure they are aware of their roles<br>• Stakeholders | Fully compliant | | | | Business Continutiy Plan (Evidence 1.8)<br>Business Continuity Policy (Evidence 1.9) |
| **49** | **Business Continuity** | **Business Impact Assessment** | The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s). | Y | Documented process on how BIA will be conducted, including:<br>• the method to be used<br>• the frequency of review<br>• how the information will be used to inform planning<br>• how RA is used to support. | Fully compliant | | | | Business Continutiy Plan (Evidence 1.8)<br>Business Continuity Policy (Evidence 1.9) |
| **50** | **Business Continuity** | **Data Protection and Security Toolkit** | Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis. | Y | Statement of compliance | Fully compliant | | | | HISS disater recvovery plan (evidence 1.21) |
| **51** | **Business Continuity** | **Business Continuity Plans** | The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to:<br>• people<br>• information and data<br>• premises<br>• suppliers and contractors<br>• IT and infrastructure<br><br>These plans will be updated regularly (at a minimum annually), or following organisational change. | Y | • Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation | Fully compliant | | | | Business Continutiy Plan (Evidence 1.8)<br>Business Continuity Policy (Evidence 1.9, 1.31) |
| **52** | **Business Continuity** | **BCMS monitoring and evaluation** | The organisation's BCMS is monitored, measured and evaluated against the Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board. | Y | • EPRR policy document or stand alone Business continuity policy<br>• Board papers | Fully compliant | | | | EPRR Policy (Evidence 1.1)<br>Business Continuity Policy (Evidence 1.9) |
| **53** | **Business Continuity** | **BC audit** | The organisation has a process for internal audit, and outcomes are included in the report to the board. | Y | • EPRR policy document or stand alone Business continuity policy<br>• Board papers<br>• Audit reports | Fully compliant | | | | EPRR Policy (Evidence 1.1)<br>Business Continuity Policy (Evidence 1.9, 1.31) |
| **54** | **Business Continuity** | **BCMS continuous improvement process** | There is a process in place to assess and take corrective action to ensure continual improvement to the BCMS. | Y | • EPRR policy document or stand alone Business continuity policy<br>• Board papers<br>• Action plans | Fully compliant | | | | EPRR Policy (Evidence 1.1)<br>Business Continuity Policy (Evidence 1.9, 1.31) |
| **55** | **Business Continuity** | **Assurance of commissioned providers / suppliers BCPs** | The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own. | Y | • EPRR policy document or stand alone Business continuity policy<br>• Provider/supplier assurance framework<br>• Provider/supplier business continuity arrangements | Fully compliant | | | | PFI Contract recovery plan & Impact Assessment (Evidence 1.22 & 1.23) |

| Ref | Domain | Standard | Detail | Mental Health Providers | Evidence - examples listed below | Self assessment RAG<br><br>Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.<br><br>Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months.<br><br>Green = Fully compliant with core standard. | Action to be taken | Lead | Timescale | Comments |
|---|---|---|---|---|---|---|---|---|---|---|
| **Deep Dive - Command and control** | | | | | | | | | | |
| **Domain: Incident Coordination Centres** | | | | | | | | | | |
| **1** | **Incident Coordination Centres** | **Communication and IT equipment** | The organisation has equipped their ICC with suitable and resilient communications and IT equipment in line with NHS England Resilient Telecommunications Guidance. | Y | | Fully compliant | | | | yes |
| **2** | **Incident Coordination Centres** | **Resilience** | The organisation has the ability to establish an ICC (24/7) and maintains a state of organisational readiness at all times. | Y | Up to date training records of staff able to resource an ICC | Fully compliant | | | | yes ex hermes/mercury (Evidence 1.19) |
| **3** | **Incident Coordination Centres** | **Equipment testing** | ICC equipment has been tested every three months as a minimum to ensure functionality, and corrective action taken where necessary. | Y | Post test reports<br>Lessons identified<br>EPRR programme | Fully compliant | | | | regular incidents to test usage (Evidence 1.19) |
| **4** | **Incident Coordination Centres** | **Functions** | The organisation has arrangements in place outlining how it's ICC will coordinate it's functions as defined in the EPRR Framework. | Y | Arrangements outline the following functions:<br>Coordination<br>Policy making<br>Operations<br>Information gathering<br>Dispersing public information. | Fully compliant | | | | EPRR Policy (Evidence 1.1) |
| **Domain: Command structures** | | | | | | | | | | |
| **5** | **Command structures** | **Resilience** | The organisation has a documented command structure which establishes strategic, tactical and operational roles and responsibilities 24 / 7. | Y | Training records of staff able to perform commander roles<br>EPRR policy statement - command structure<br>Exercise reports | Fully compliant | | | | Incident response plan & Business continuity plans & EPRR Policy (Evidence 1.1, 1.7, 1.8, 1.9) |
| **6** | **Command structures** | **Stakeholder interaction** | The organisation has documented how its command structure interacts with the wider NHS and multi-agency response structures. | Y | EPRR policy statement and response structure | Fully compliant | | | | Incident response plan & Business continuity plans & EPRR Policy (Evidence 1.1, 1.7, 1.8, 1.9) |
| **7** | **Command structures** | **Decision making processes** | The organisation has in place processes to ensure defensible decision making; this could be aligned to the JESIP joint decision making model. | Y | EPRR policy statement inclusive of a decision making model<br>Training records of those competent in the process | Fully compliant | | | | Incident response plan & Business continuity plans & EPRR Policy (Evidence 1.1, 1.7, 1.8, 1.9) |
| **8** | **Command structures** | **Recovery planning** | The organisation has a documented process to formally hand over responsibility from response to recovery. | Y | Recovery planning arrangements involving a coordinated approach from the affected organisation(s) and multi-agency partners | Fully compliant | | | | Incident response plan & Business continuity plans & EPRR Policy (Evidence 1.1, 1.7, 1.8, 1.9) |

| Overall assessment: | | | Substantially compliant | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Ref** | **Domain** | **Standard** | **Detail** | Evidence - examples listed below | **Self assessment RAG**<br><br>Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.<br><br>Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates an action plan to achieve full compliance within the next 12 months.<br><br>Green = Fully compliant with core standard. | **Action to be taken** | **Lead** | **Timescale** | **Comments** |
| **60** | **CBRN** | **Equipment and supplies** | The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients.<br><br>• Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/<br>• Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londoncn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf)<br>• Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ | Completed equipment inventories; including completion date | Partially compliant | | | | Procedure for handing IOR if self presenter is documented in CBRN SOP (Evidence 1.24, 1.25) without grab box usage. |

NHS
North Staffordshire
Combined Healthcare
NHS Trust

# REPORT TO TRUST BOARD

Enclosure No:22

| | | | |
|---|---|---|---|
| Date of Meeting: | 22nd November 2018 | | |
| Title of Report: | Annual Fire Safety Report | | |
| Presented by: | Jonathan O'Brien, Director of Operations | | |
| Author: | Mick Daniels, Fire Safety & Security Advisor | | |
| Executive Lead Name: | Jonathan O'Brien, Director of Operations | Approved by Exec | ☒ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| The Annual Fire Safety report for 2017/18 is presented to Trust Board for approval. The report reflects compliance with mandatory training standards, an analysis of incidents during the 2017/18 year and confirmation of fire safety processes and procedures in place. | Approval | ☒ |
| | Information | ☐ |
| | Discussion | ☐ |
| | Assurance | ☐ |

| | | | |
|---|---|---|---|
| Seen at: | SLT X Execs X<br>Date: 8th October 2018 & 16th October 2018 | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☐<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☐<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Digital by Choice Board ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement.☐<br>2. To provide the highest quality services X<br>3. Create a learning culture to continually improve.☐<br>4. Encourage, inspire and implement research & innovation at all levels.☐<br>5. Maximise and use our resources intelligently and efficiently.☐<br>6. Attract and inspire the best people to work here.☐<br>7. Continually improve our partnership working. ☐ | | |
| Risk / legal implications:<br>Risk Register Reference | | | |
| Resource Implications:<br><br>Funding Source: | N/A<br><br>N/A | | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | N/A | | |
| STP Alignment / Implications: | N/A | | |
| Recommendations: | Approve the Annual Report and Statement of Compliance. | | |

| Version | Name/Group | Date |
|---|---|---|
| | | |
| | | |

North Staffordshire Combined Healthcare NHS Trust

# Fire Safety Report 2017/18


Towards Outstanding

We're on a journey...

CQC Organisational Rating - GOOD

Our main website: www.combined.nhs.uk
Our jobs website: www.discoveryourfuture.co.uk

@CombinedNHS
@CombinedNHSJobs

safe • personalised • accessible • recovery focused

spar

COMPASSIONATE
APPROACHABLE
RESPONSIBLE
EXCELLENT
PROUD TO CARE

Mick Daniels Dip Mgt MICM MIFireE ASMS
Fire Safety and Security Advisor
North Staffordshire Combined Healthcare NHS Trust

**Index**

## 1. Executive Summary

**Period 01/04/17 – 31/3/18**

North Staffordshire Combined Healthcare NHS Trust (NSCHT) remains committed to providing and maintaining exemplary standards of fire safety in all premises for which it is responsible.

This report is presented with the intention of demonstrating such a commitment and bringing to attention the fire safety activity and arrangements within the Trust.

The Fire Safety arrangements are the responsibility of the Chief Executive. This is delegated at board level to the Executive Director of Operations. The head of estates and senior estates manager are responsible for the day to day management of the fire safety arrangements. The fire and security advisor is accountable to the head of estates for all matters of fire safety.

Fire safety advice, assessments, training, audits, and investigations are carried out by the fire and security advisor.

The Trust operates from approximately 16 different sites and during the period there have been **49** reported fire and smoking related incidents. There were no serious injuries or deaths reported and no loss of service or re-location of services as a result of these incidents.

Completion of mandatory fire training was slightly above the Trusts own target and should be a priority to demonstrate the continued commitment to a strong fire safety culture. This is particularly important for staff that have direct patient contact. A training needs analysis based on risk has been completed so that training is relevant and timely; a new e-learning package has been developed in house in liaison with the training department and was rolled out as part of the new learning Management System in July 2017. Cascade trainers are in place across the Harplands Wards and have assisted in developing a relevant walk / talk / show training checklist session as opposed to an on-line / presentation package. Specialist training for NSCHT premises Fire Wardens, Duty Senior Nurses and potential Incident Controllers was completed.

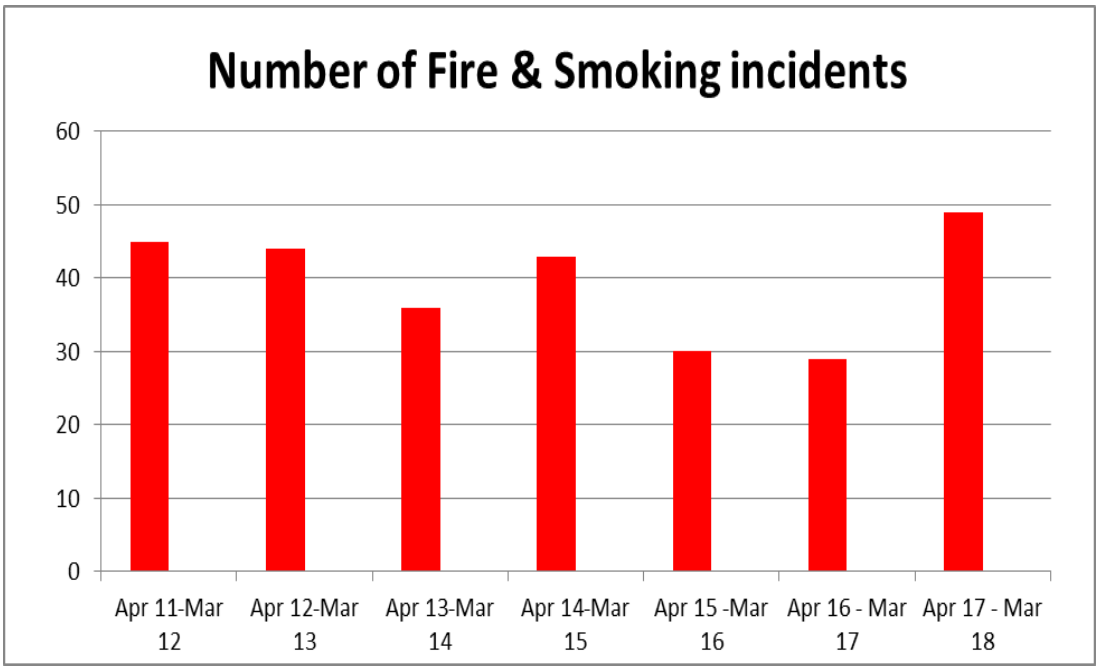
For smaller sites continuation of the approach to ensure all staff are aware of their responsibilities under the Regulatory Reform (Fire Safety) Order 2005 is emphasised at training sessions. Local procedures are assessed and audited to ensure they reflect those requirements. It is for the responsible persons of all owned/leased NSCHT premises to ensure that fire evacuation exercises take place to test staff knowledge and prove procedures. On wards where full evacuations are difficult a table top / theoretical evacuation is carried out on a more frequent basis.

The Trust is required to ensure a safe and healthy environment (fire), to meet its responsibilities under the Care Quality Commission (CQC) essential standards of quality and safety Outcome 10: Safety and suitability of premises. This includes maintaining documented evidence to support Outcome 10. The Trust had a CQC inspection and some fire related information was requested and provided via the Quality group. Following the Grenfell fire, there were many requests for information which were provided throughout the reporting period. Communications and learning lessons have been provided to groups and staff on specific areas of fire safety either following incidents or as part of prevention activity.

Staffordshire Fire and rescue Service also have attended a Learning lessons session to deliver learning on a fatal house fire in which a Trust patient sadly died. Details of the Fire Services offer of free hazard spotting training – ‘Olive Branch’ training and their Free ‘Safe and secure ‘checks are provided in the Trust mandatory fire training sessions.

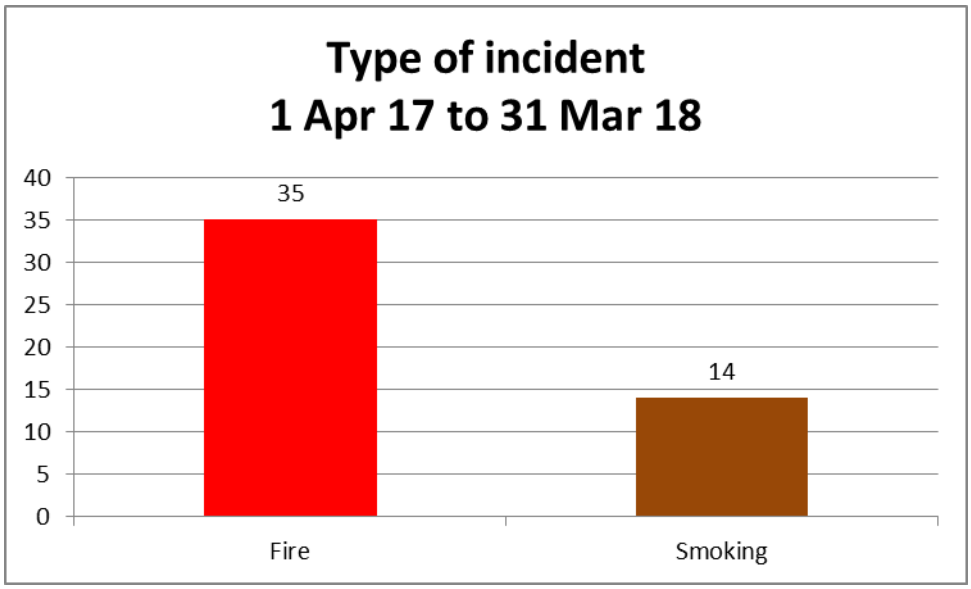
## 2. Fire and Smoking related incidents 2017 - 2018

There were **49** reported incidents on the Trusts safeguard system

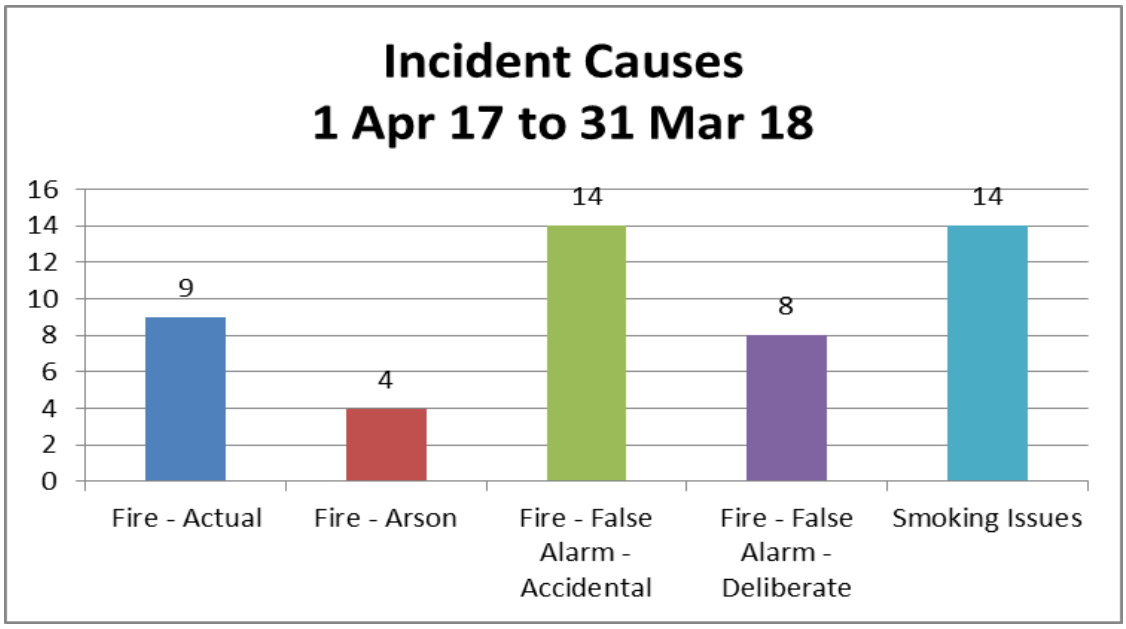



The average number of incidents over the last 7 years is **38** per year – This year has seen an increase in reported incidents from the previous year (16/17) of **29.**
(*2013 / 14 – new reporting system implemented)

### 2.1 Main causes




The **2** main incident groups are initially identified as **Fire** or **Smoking**.




From this they are then placed into **5** cause groups. (As above) Further details of all incidents are analysed and a severity rating is applied.

### 2.2 Sub Cause – Root

A large majority of incidents were false alarms – **22** in total (deliberate and accidental). The greatest risk of fire can be attributed to patient involvement with the access around the control of ignition sources and smoking materials.

### 2.3 Fire – Actual and Arson

There was a total of **13** reported fires – Actual and Arson.

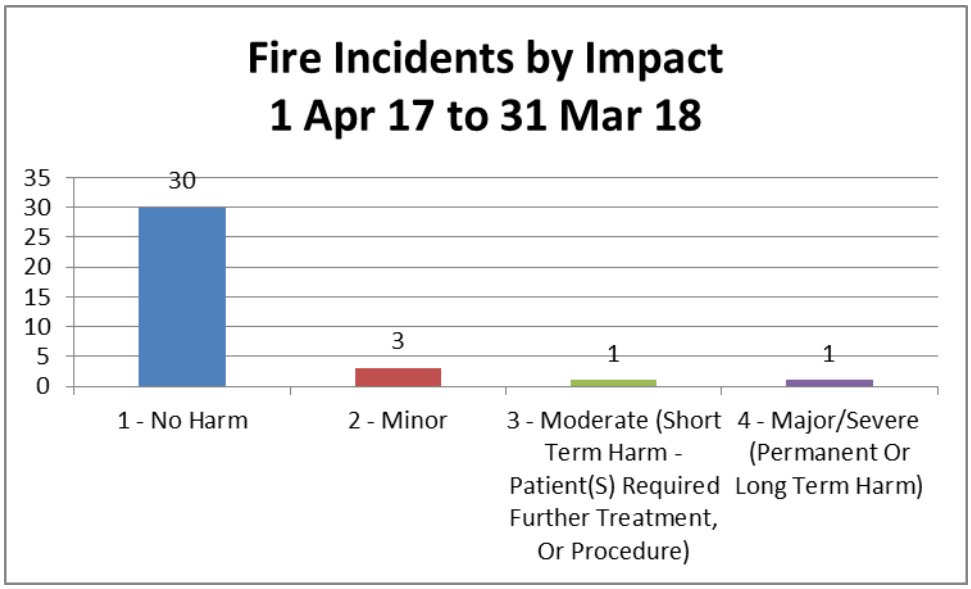
Where required and appropriate further investigations have been completed and feedback communicated to teams and staff to try and learn and prevent further fires occurring.

Of the **4 arson** incidents, 2 occurred at patient's own dwellings, where individuals were arrested and charged by the police, the other 2 occurred on Trust premises. 1 at the Darwin Centre was caused by a patient setting fire to towels in a communal bathroom and there was 1 at the Harplands caused by a discharged Ward 3 patient with an ignition source who was arrested by police but not charged.

The **9 actual** fires were accidental with two taking place at patient's homes. Two were caused by NSCHT staff on Trust premises. One occurred at the Harplands (Ward 2) when staff left toast unattended. One incident occurred at Dragon Square children's respite unit when a paper bag was placed on top of cooker. The other three fires involved patients on Trust premises with the main cause attributed to the careless use of smoking materials.

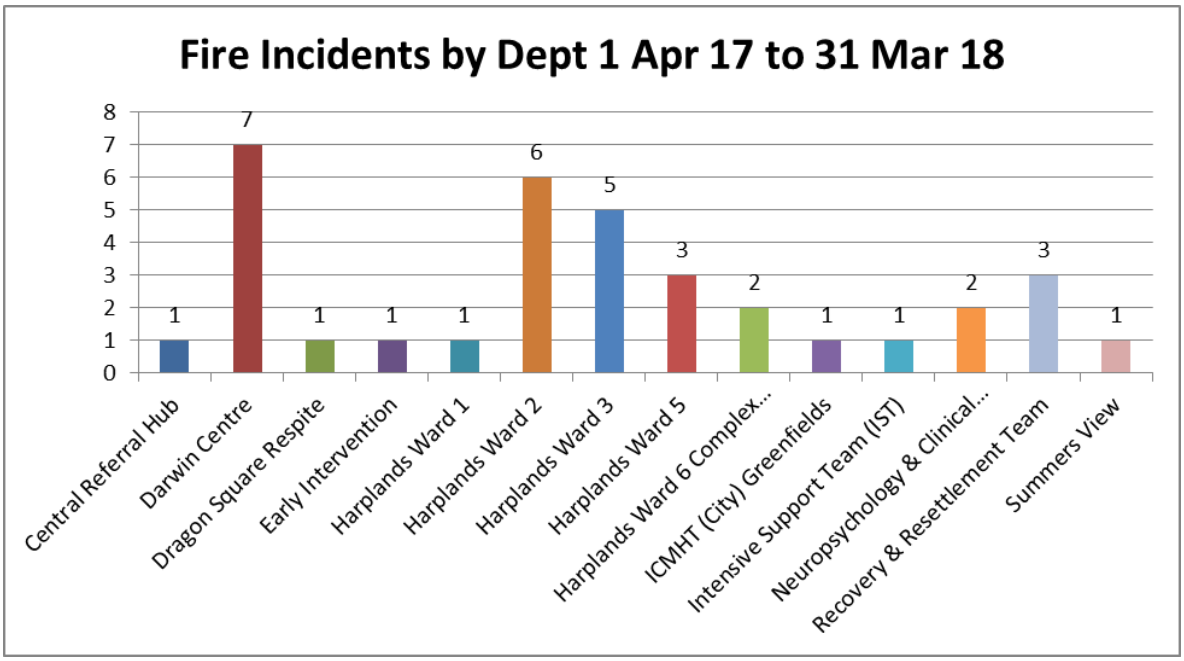
On some occasions ignition sources have been passed to patients from visiting relatives or friends or been brought back onto the Ward following a period of leave. Vigilance, Risk Assessments and knowledge of the patient are essential to prevent such incidents. Ozi-lite external cigarette lighters are provided on all the acute Wards (1 – 3) where the highest risk of a fire starting exists. This means patients should not be in possession of ignition sources. Where incidents of smoking indoors have occurred patients have been reminded of the law that smoking inside public buildings is not permitted and also of the Trust smoking policy as to where smoking is permitted. The incidents of patients smoking indoors at the Edward Myers Unit may be down to a number of factors, including the location and distance of the Unit to the external garden area.

### 2.4 Fire Incidents by Impact




No fires led to the loss of service or re-location of services at any Trust premises or resulted in serious injury or death. The 1 major / severe long term harm (4) was to a patient's home where an accidental fire resulted in them being re-located due to the severity of the fire. The 1 moderate short term harm (3) was to a patient's health following a deliberate fire at the patient's home where they were charged by the Police with arson.

### 2.5 Fire type incidents – by Departments



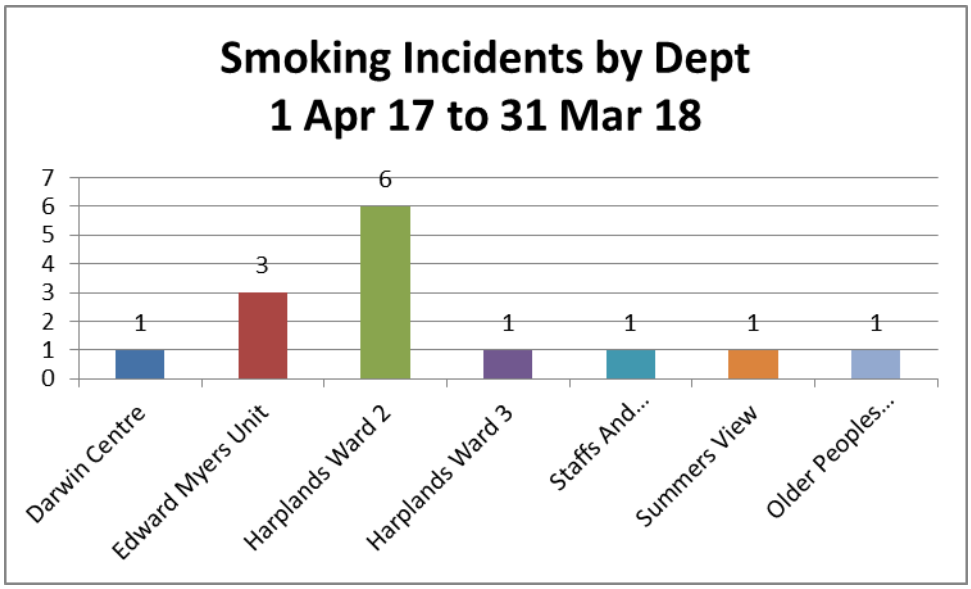

The Departments with the highest number of recorded incidents were the Darwin Centre (7) and Harplands Hospital Wards 2 (6) and 3 (5).

The seven incidents at the Darwin Centre included five deliberate and one accidental false alarm and one arson incident. Following the deliberate breakages of alarm points by a patient a decision was made to replace them with key operated alarms, following this change there has been no further false alarms.

Ward 2 incidents included three accidental false alarms, two deliberate false alarms and one accidental fire caused by staff leaving toast unattended.

Ward 3 incidents included two accidental and one deliberate false alarm, one accidental fire in the garden area and one arson fire caused by a discharged patient.

### 2.6 Smoking Incidents




Reported smoking incidents have increased compared to the previous 12 months. These have occurred inside Trust properties and are breaches of legislation as smoking inside are prohibited. There was a trial on ward 2 in March 2018 prior to the main launch of the Trust 'Smoke free' sites policy and a number of breaches occurred during this period. Looking forward over the next 12 months the greatest risk of fire is likely to be from smoking breaches and the concealment of ignition sources by patients on in-patient units. This has been informed to staff on training so they are fully aware of likely scenarios.

## 3. Unwanted Fire Signals - False Alarms (accidental and deliberate)

The **14** accidental false alarms could have been prevented, however on a positive note the Trust deals and manages with all the false alarms and it is rare that the Fire Service attend under their policy arrangements. False alarms also act as a drill / evacuation and test of local procedures.

There were a range of causes of the **6** accidental false alarms: steam from a kettle and shower, aerosols sprayed, the fire alarm accidentally operated, an electrical fault and; smoke from burnt toast. Learning has taken place via forms of communication with staff to try and prevent repeat alarms.

The **8** deliberate false alarms were all caused by patients. Five break glass alarm points were broken at the Darwin Centre and resulted in the break glass alarm points being changed in the patient areas to staff operated key alarms. Two were caused by patients smoking blowing smoke into detectors and one was caused by a patient spraying an aerosol.

## 4. Staff Training and Fire Drills

Fire safety training has been delivered as part of the Trusts Mandatory and Corporate Induction training sessions. The Trust launched a new Learning Management System (LMS) in June 2017 and in line with this the Fire Safety advisor undertook and analysis of training needs and a new Matrix was produced based on job role and risk. It means that those that work on Wards with patients must complete face to face training every year, those that work out in the community every two years and all other staff every three years. A bespoke fire safety on – line presentation was produced and these are completed by staff in the in-between years.

At 31st March 2018 mandatory fire training compliance across the Trust was at **88%** (excluding bank staff) against a Trust target **85%.** Training compliance is monitored by the Training department and each directorate / team managers / individual. Directorates and Heads of Departments are aware of the non-attendance or over-due personnel for mandatory fire sessions.

**Bank Staff** were showing **87%** compliance on the LMS system at 31st March 2018.

Other fire related training during the period was delivered to Cascade Fire Trainers, Premises Fire Wardens and Duty Senior Nurses at Harplands hospital. Sessions have been delivered to the premises responsible person who may be required to undertake the role of 'Incident Controller'.

Fire drills are carried a minimum of once per year across all Trust sites. These comprise of a full evacuation of the premises, drills were completed across all Trust sites. The only exception is Wards 1 to 7 at Harplands, the A & T / Telford unit and bungalows 4 & 5 at Dragon Square (Childrens) where it is not a requirement to do a full evacuation drill. This is because the mode of evacuation is based on staged (phased) horizontal movements from compartment to compartment based on a minimum of 2 x 30 minute fire doors away from the incident, so to practice this table top and walk through exercises are conducted with staff twice per year. Fire drills at sites that we multi–occupy are completed via the responsible landlord for the premises.

In addition, Harplands Hospital had to carry out a full evacuation on 6th October 2017 following a call to reception stating there was a bomb in the premises. This was completed successfully and staff worked hard and in difficult circumstances well to keep patients secure and comfortable. There were no injuries as a result and the premises were re-occupied once Police had checked the building out. A full de-brief was carried out in conjunction with the Trust and Staffordshire Civil Contingencies Unit. There were lessons learned and shared. The Harplands fire procedure and policy was amended to include contingency information around non – fire situations and further evacuation guidance and recovery.

## 5. Trust Fire Safety Policy

The Trust fire policy was reviewed and updated by the Trust's Fire Safety Advisor and was approved by the Quality committee on 31st August 2017 and by the Trust Board on 7th September 2017. It is subject to review on 31st August 2020 (or sooner if deemed necessary).

## 6. Risk Assessments

The 'Regulatory Reform (Fire Safety) Order 2005 'introduced in October 2006 is legislation which consolidates previous fire safety legislation. It covers all aspects of fire safety management in the workplace. The legislation changes the emphasis of compliance from that previously involving fire certification to a risk based assessment undertaken by or on behalf of the owner/occupier.

Fire risk assessments and annual reviews have been carried out at all Trust sites and are subject to a risk based programmed inspection regime, with the highest risk premises: the main hospital and all in- patient sleeping risks having the most frequent inspections, i.e. at least once annually and as required if any circumstances change or following any incidents. All other Trust premises such as Day Centre's / office accommodation / joint partnerships etc. have a less frequent inspection based on the risk and these can be between 18 months to 3 years. Where non-compliance has been found then these are recorded in the premises Fire Risk Assessment 'Action Plan'. Action Plans have a priority rating – high, medium, low and timescales for completion with the responsible person listed. These are updated when actions are completed.

**Fire Risk assessment methodology - frequency of reviews of Fire Risk Assessments for Trust settings:**

- **12 Monthly** - Harplands Hospital - whole site including Edward Myers Unit and A/T and Telford Unit
- **12 Monthly** - All other Trust in-patient units
- **18 Monthly** - All community based units and resource centres
- **24 + monthly** - All other Trust buildings and premises not falling into the above.

Risk assessments are also carried out as required following an incident or change in use, layout, extension or re-location etc.

There are some sites that Trust staff are occupying as part of a multi-occupied site e.g. Hope Centre, Hanley. In these circumstances the Fire Risk Assessment is carried out for the area which the Trust staff occupy and have responsibility for. These are shared with the responsible landlord or landlords agent as required by the Fire Safety Order. In the same way we request information to be shared by the Landlord or Landlords agent about the Fire Risk Assessments for the common areas and their areas of responsibility such as fire alarms.

### 6.1 Key Issues From Risk Assessments

Where an area of fire safety in a building or premises is found to be non-compliant or defective then these are recorded in each individual premises Fire Risk Assessment within the 'Action Plan' with a priority rating, and responsible person assigned. A copy is held on the premises and a copy in the Estates Department. Progress on the Action plan is monitored by the fire safety advisor, estates and the premises responsible person.

Alterations or changes to buildings which involve any fire safety equipment or protection are agreed prior to the works starting and are monitored to the conclusion with certificates and documents to confirm that the work meets the required standards.

## 7. Fire Safety Monitoring

The monitoring of fire safety compliance is the responsibility of the Head of Estates. The Senior Estates Manager and Fire Safety Advisor meet six monthly with a representative of the Fire Protection department at Staffordshire Fire and Rescue Service to discuss and review all relevant Fire Safety matters. There is also a good relationship with the Fire Services Prevent department with the promotion of their 'Olive branch' training following fatal fires in clients homes and the sharing of lessons learned. The Safety Advisor also meets on a monthly basis as part of security role with the Executive Director – Director of Operations who has responsibility for Fire at NSCHT.

In addition a Harplands Fire Safety Group has been formed with representatives from all stakeholders meeting on a quarterly basis to review Harplands Fire Safety matters. Both these groups are reported via the fire safety advisor to the Trust Health, Safety and Wellbeing (HSW) group which meets Bi-monthly and is chaired by the Director of Nursing.

## 8. Annual Statement of Fire Safety

Each year Chief Executives are required by NHS to confirm compliance with the Department of Health fire safety policy, by applying Firecode standards or some other suitable method in satisfying these arrangements. This endorsement applies to all aspects of fire safety in buildings within their control and I can confirm that the Trust is in compliance.

The Annual Statement indicates at 2 where significant risks have been identified in the premises fire risk assessment that action plans are put in place to reduce or eliminate the risk – these are site specific.

The requirement to send NHS Estates the annual statement has been withdrawn, however it is recommended the practice remains and records kept locally as an indicator of compliance with legislation and codes of practice, alternatively improvement programmes are in place.

## 9. Conclusion

There has been an increase in reported fire and smoking related incidents in 2017 / 18. A large proportion were false alarms and the impact of the majority of incidents was no harm. No incidents resulted in injury, death or loss of an area of operation or Trust premises. Where there have been fires on Trust premises these have been dealt with promptly by staff responding and with the attendance of the Fire and Rescue Service. Trust staff demonstrate a positive and responsible attitude to Fire Safety and are pro-active to try and prevent incidents occurring or to learn when incidents have. Pre-planned Maintenance Checks (PPM's), assessments and drills are in place to ensure a good standard of Fire Safety is maintained by staff.

Training compliance has improved over the last 12 months following the introduction of the new Learning Management System (LMS). The Trust meet with fire service officers from Staffordshire Fire and Rescue Service twice per year and have a specific fire safety group for the Harplands Hospital.

For 2018/19, the greatest challenge around fire safety will be the introduction of the Trusts 'smoke free' sites specifically at the Harplands Hospital and the likely concealment of ignition sources by patients with breaches of smoking inside Trust premises. This will require monitoring and control by staff and understanding around specific needs and circumstances so that incidents do not escalate into more serious matters.

## 10. Recommendations

The paper is presented to the Board as **assurance** that the Trust has adequate policies, procedures training and systems in place to manage fire safety and to both prevent and respond to fire safety across the organisation.

The Board is asked to **approve** the Annual Statement of Compliance.

## Appendix 1 – Annual Statement of Fire Safety

**Annual Statement of Fire Safety 2017 - 18**

| | | |
|---|---|---|
| NHS Organisation Code: RLY | NHS Organisation Name: North Staffs Combined Healthcare NHS Trust | |
| I confirm that for the period **1st April 2017 to 31st March 2018**, all premises which the organisation owns, occupies or manages, have fire risk assessments that comply with the Regulatory Reform (Fire Safety) Order 2005, and (*please tick the appropriate boxes*): | | |
| 1 | There are no significant risks arising from the fire risk assessments. | N/A |
| OR 2 | The organisation has developed a programme of work (This is contained in each premises fire risk assessment- 'Action Plans') to eliminate or reduce as low as reasonably practicable the significant fire risks identified by the fire risk assessment. | Yes |
| OR 3 | The organisation has identified significant fire risks, but does **NOT** have a programme of work to mitigate those significant fire risks.* | N/A |
| *Where a programme to mitigate significant risks **HAS NOT** been developed, please insert the date by which such a programme will be available, taking account of the degree of risk. Date: N/A | | |
| 4 | During the period covered by this statement, has the organisation been subject to any enforcement action by the Fire & Rescue Authority? **(Delete as appropriate)** If Yes - Please outline details of the enforcement action in Annex A – **Part 1**. | No |
| 5 | Does the organisation have any unresolved enforcement action pre-dating this Statement? **(Delete as appropriate)** If Yes Please outline details of unresolved enforcement action in Annex A – **Part 2.** | No |
| AND 6 | The organisation achieves compliance with the Department of Health Fire Safety Policy, contained within HTM 05-01, by the application of Firecode or some other suitable method. | Yes |
| Fire Safety Officer | Name: Mick Daniels | |
| | E-mail: Mick.Daniels@combined.nhs.uk | |
| Contact details: | Telephone: 01782 275083 | |
| | Mobile: 07720337403 | |
| Chief Executive Name: | Caroline Donovan | |
| Signature of Chief Executive: | | |
| Date: | 18/5/18 | |

**ANNEX A**

| Part 1 – Outline details of any enforcement action during the past 12 months and the action taken or intended by the organisation. Include, where possible, an indication of the cost to comply. |
| --- |
| None - N/A |
| Part 2 – Outline details of any enforcement action unresolved from previous years, including the original date, and the action the organisation has taken so far. Include any outstanding proposed action needed. Include an indication of the cost incurred so far and, where possible, an indication of costs to fully comply. |
| None - N/A |

NHS Organisation Code: RLY
NHS Organisation Name: North Staffs Combined Healthcare NHS Trust
Date: 1/4/2018

*Completed statement to be kept on file as evidence of good practice and included in any annual report.

NHS
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Combined Healthcare
NHS Trust

# REPORT TO OPEN TRUST BOARD

Enclosure No: 23

| | | | |
|---|---|---|---|
| Date of Meeting: | 22 November 2018 | | |
| Title of Report: | Assurance Report from the People and Culture Development Committee | | |
| Presented by: | Lorien Barber, Non-Executive Director | | |
| Author: | Jonathan O'Brien, Director of Operations/Interim Director of Workforce, OD and Communications | | |
| Executive Lead Name: | Jonathan O'Brien, Director of Operations/Interim Director of Workforce, OD and Communications | Approved by Exec | ☒ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| This report is a summary of the People & Culture Development Committee meeting held on 12 November 2018 and chaired by Mrs Lorien Barber. | Approval | ☒ |
| | Information | ☒ |
| | Discussion | ☐ |
| | Assurance | ☒ |

| | | | |
|---|---|---|---|
| Seen at: | SLT ☐ Execs ☐<br>Date: N/A | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☐<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☒<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Digital by Choice Board ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement. ☒<br>2. To provide the highest quality services ☒<br>3. Create a learning culture to continually improve. ☒<br>4. Encourage, inspire and implement research & innovation at all levels. ☐<br>5. Maximise and use our resources intelligently and efficiently ☒<br>6. Attract and inspire the best people to work here ☒<br>7. Continually improve our partnership working. ☐ | | |
| Risk / legal implications:<br>Risk Register Ref | N/A | | |
| Resource Implications:<br><br>Funding Source: | N/A<br><br>N/A | | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups) | The Committee plays a significant role in actions and assurance related to Diversity and Inclusion and the oversight of the Public Sector Equality Duty under the Equalities Act. This duty requires the Trust to<br>• Eliminate unlawful discrimination<br>• Advance equality of opportunity<br>• Foster good relations | | |
| STP Alignment / Implications | None | | |
| Recommendations: | The Board are asked to approve the policy extension for ratification and receive the summary for assurance purposes. | | |

**Summary to Trust Board**
**People & Culture Development Committee**
**Monday, 12 November 2018, 9.30 – 12.40am**

The meeting was chaired by Mrs Lorien Barber.

## 1. Director of Workforce, OD and Communications Update

The Committee received the following updates:

- Linda Holland, Director of Workforce, OD and Inclusion, is due to commence on 19 November 2018.
- Suzanne Robinson is moving on from her post as Director of Finance, Performance and digital and it is anticipated she will leave in March 2019.
- Andrew Hughes, Director of Strategy, Development and Estates is finishing his fixed term contract at the end of December 2018, the Trust has interviewed and appointed to this post. An announcement will be made shortly.
- NHSi whistleblowing campaign is due to be launched. This is a programme to support individuals back into NHS employment. The Trust is reviewing how we might want to support this.
- TUPE Section 75 -TUPE transfer of staff has been completed on 1 October 2018 and this was a smooth transaction.

## 2. Locality Working

The Committee was informed that the new structure has now been implemented and commenced on 1st October 2018.

## 3. Board Assurance Framework – Q2 2018/19

This report was deferred and will be circulated to members virtually.

## 4. Workforce & OD Risks

The Workforce and OD Risks were reviewed and will continue to be monitored.

## 5. Performance Report

The Committee was updated on the highlights from M6 data:

- Sickness absence days lost remains within 4.95% target (2.5%).
- Staff Turnover remains at 1.6% for M6.
- 90.5% of staff have completed their statutory and mandatory training.

## 6. Workforce Metrics

The Committee were updated by exception. Sickness absence rate remains low at 2.79%.
It was noted that Trust appraisal rates require improvement. Statutory and mandatory training rate is 91%, which is extremely positive.
**Agency -** 2.0% over cap at M6 from -2.0% at M5.

## 7. Toward Outstanding Engagement

The response rate for the Q1 pulse check report was 16.14%, so caution needs to be applied when reviewing the results as the recommended response rate is 30%

The Trust overall engagement score is 3.94 out of 5 (moderate to positive level)

Highest scoring enablers;

1. Work relationships (significant increase) 4.21 out of 5
2. Trust 4.08 out of 5

Other strengths for the Trust (scoring 4-5) also include;

- Dedication
- Focus
- Persistence
- Discretionary effort

Lowest scoring enablers

1. Recognition 3.5 out of 5
2. Perceived fairness 3.52 out of 5
3. Mindset 3.69 out of 5

Towards Outstanding Engagement quarter 3 was paused in view of the Locality restructure.

**8. Workforce Race Equality Standard (WRES) full report and Equality and Diversity Update**

The Committee received the Workforce Race Equality Standard (WRES) which is based on the principle NHS employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. This included an update from the recent Inclusion Council.

**9. Being Open Report**

The Committee received the Being Open report which provides a combined report of Dear Caroline, FSUG, Raising Concerns and Grievances submissions, reporting on their collective activity providing details regarding the themes, trends and patterns for assurance at Trust Board. It provides a full summary of activity covering a 12 month period for October 2017 – September 2018 and a detailed quarterly review for the period of July 2018 –September 2018. During the 12 month period there have been 92 DC submissions.

**10. Retention and Exit Interviews**

The Committee received this report which provides an update on the Trust's Exit Interview Process and supporting leavers' questionnaire during the period September 2017 to October 2018.

Responses indicate the majority of staff report communication is good and are satisfied with staff benefits. Staff are reporting an awareness of the Trust values and generally believe the Trust is a good place to receive clinical treatment.

The majority of concerns raised by leavers relate to resources, staffing levels, caseloads and opportunities for career progression. Concerns were also raised to a lesser extent with regards to leadership and colleague dynamics. Also there appears to be a need to improve work-life balance options (where possible) which also appears to be a repeat theme.

**11. Communications Highlight report**

The Committee received a verbal updates in terms of work around our Communications Team. In particular, the new intranet 'CAT' has been launched.

**12. Guardian of Safe Working report**

The Committee received this report. From August 2017 rotation all junior doctors including higher trainees have been employed on the new contract. The Guardian of Safe Working role has been established and all junior doctors on the rotations since the time have been made aware of the need to use the exception reporting system. The report covers Q2 July to September 2018.

**13. Mid-Year review of effectiveness**

The Committee received this report and are required to produce an annual assessment of effectiveness. This will be feedback at the January Committee.

**14. Person Centeredness Framework**

The Committee received this framework and approved in principle to be defined.

**15. Staff Survey**

The Committee were updated in respect of the Staff Survey which is currently live. The survey is due to close at the end of November 2018 and the committee will receive further updates.

**16. Policies**

The policies below were recommended for approval by the Board.
3.01 Disciplinary Policy
1.75 Domestic Abuse Policy
3.15 Personal Relationships at work policy
3.19 Retirement policy
3.12 Inclusion Policy

**17. Non-Executive Chair - PCD**

The meeting ended with Patrick Sullivan and Jonathan O'Brien thanking Lorien for her time as Chair of PCD, this being her last meeting, and wishing her the best for the future.

NHS
North Staffordshire
Combined Healthcare
NHS Trust

# REPORT TO OPEN TRUST BOARD

Enclosure No:24

| | | | |
|---|---|---|---|
| Date of Meeting: | 22 November 2018 | | |
| Title of Report: | Assurance Report from Quality Committee | | |
| Presented by: | Patrick Sullivan, Non-Executive Director and Chair of Quality Committee | | |
| Author: | Sandra Storey, Associate Director of MACE | | |
| Executive Lead Name: | Maria Nelligan, Executive Director of Nursing and Quality | Approved by Exec | ☒ |

| Executive Summary: | | Purpose of report | |
|---|---|---|---|
| This report provides a high level summary of the work of the Committee during October 2018 and request for the Trust Board to ratifiy policies and endorse recommendations in the report. | | Approval | ☐ |
| | | Information | ☒ |
| | | Discussion | ☐ |
| | | Assurance | ☒ |
| Seen at: | SLT ☐ Execs ☐<br>Date: | Document Version No. | |
| Committee Approval / Review | • Quality Committee ☒<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☐<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Primary Care Integration Programme Board ☐ | | |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement.☒<br>2. To provide the highest quality services ☒<br>3. Create a learning culture to continually improve.☒<br>4. Encourage, inspire and implement research & innovation at all levels.☒<br>5. Maximise and use our resources intelligently and efficiently.☒<br>6. Attract and inspire the best people to work here.☒<br>7. Continually improve our partnership working. ☒ | | |
| Risk / legal implications:<br>Risk Register Reference | None identified | | |
| Resource Implications:<br><br>Funding Source: | N/A<br><br>N/A | | |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | None identified. | | |
| STP Alignment / Implications: | N/A | | |
| Recommendations: | To note the contents and ratify policies. | | |

| Version | Name/group | Date issued |
|---|---|---|
| | | |
| | | |

North Staffordshire Combined Healthcare NHS
NHS Trust

**Outputs from the Quality Committee**
**for the Trust Board meeting on 22 November 2018**

## 1. Introduction

During the month of November 2018, members of the Quality Committee were asked to consider a number of reports and policies. This was undertaken by virtual review in the absence of meeting. The purpose of this report is to notify the Trust Board of the outcome of this work and to recommend ratification and removal of policies as noted.

## 2. Policy report – the recommendations were supported by the Committee for ratification of policies by the Trust Board for 3 years or otherwise stated as follows:

### 2a Policies:

- ✓ 3.43 Serious placement issues Policy – extend to 28.2.19
- ✓ 5.32 Serious Incident Policy
- ✓ 5.01 Incident Reporting Policy
- ✓ R05 Management of locked doors, access and egress Policy
- ✓ 5.19 Management of Violence and Aggression with Police Partnership Protocol
- ✓ Water Systems Management Policy – remove 5.31 Legionella Policy as this is now incorporated into new Policy.
- ✓ 5.40 Non Urgent Patient Transport Policy
- ✓ 5.06 Waste Policy – extend to 31.01.19
- ✓ 5.25 New & Expectant Working Mothers – remove as now part of 3.16 Maternity, Paternity, adoption and Special Leave Policy.
- ✓ 5.37 Pinpoints (PITS) – extend to 31.01.19
- ✓ An Organisation Wide Document for Undertaking and Learning from Clinical Audit – replace 4.39 Clinical Audit Policy
- ✓ 4.41 Responding to Patient Opinion – remove as part of 4.26 Listening and responding PALS and Complaints
- ✓ 1.04 Complimentary Therapies – extend to 31.01.19
- ✓ 1.55 Advanced Statements – extend to 31.01.19
- ✓ 1.78 Palliative Care – extend to 31.01.19
- ✓ 4.20 Volunteer Policy – extend to 31.01.19
- ✓ 4.40 Duty of Candour – extend to 31.01.19
- ✓ MHA01 – Community Treatment Order
- ✓ 4.34 Intellectual Property

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

### 3a Reports:

- ✓ Board Assurance Framework Q2 2018/19
- ✓ Patient Story – Ward 4
- ✓ Mental Health Act Compliance - themes and actions Q1 & Q2 2018/19

- ✓ Smoke free update
- ✓ Serious incidents Q2 2018/19
- ✓ Mortality Surveillance Q2 2018/19
- ✓ Safer Staffing monthly report – September 2018
- ✓ Safe Staffing mid-year review
- ✓ Person Centredness Framework
- ✓ Director of Infection Prevention and Control (DIPC) Quarter 2
- ✓ OFSTED Action Plan

**4. Next meeting:**
**Thursday 6 December 2018 2pm**

On behalf of the Committee Chair, Mr Patrick Sullivan, Non-Executive Director
Sandra Storey Associate Director Medical and Clinical Effectiveness

12 November 2018

NHS
North Staffordshire
Combined Healthcare
NHS Trust

# REPORT TO OPEN TRUST BOARD

Enclosure No:25

| | | | |
|---|---|---|---|
| Date of Meeting: | 22 November 18 | | |
| Title of Report: | The state of health care and adult social care in England 2017/18 – NHS Providers Briefing | | |
| Presented by: | Laurie Wrench | | |
| Author: | N/A | | |
| Executive Lead Name: | Caroline Donovan | Approved by Exec | ☒ |

| Executive Summary: | Purpose of report | |
|---|---|---|
| The NHS Providers briefing summarises the CQC publication 'The state of health care and adult social care in England 2017/18,' its annual assessment of quality performance, trends and themes from the year's regulatory activity. | Approval | ☐ |
| | Information | ☒ |
| | Discussion | ☐ |
| | Assurance | ☐ |

| | | | |
|---|---|---|---|
| Seen at: | SLT ☐ Execs ☐<br>Date: N/A | Document Version No. | 1 |

| | |
|---|---|
| Committee Approval / Review | • Quality Committee ☐<br>• Finance & Performance Committee ☐<br>• Audit Committee ☐<br>• People & Culture Development Committee ☒<br>• Charitable Funds Committee ☐<br>• Business Development Committee ☐<br>• Primary Care Integration Programme Board ☐ |
| Strategic Objectives<br>(please indicate) | 1. To enhance service user and carer involvement.☐<br>2. To provide the highest quality services ☒<br>3. Create a learning culture to continually improve.☐<br>4. Encourage, inspire and implement research & innovation at all levels.☐<br>5. Maximise and use our resources intelligently and efficiently.☐<br>6. Attract and inspire the best people to work here.☐<br>7. Continually improve our partnership working. ☐ |
| Risk / legal implications:<br>Risk Register Reference | N/A |
| Resource Implications:<br><br>Funding Source: | None |
| Diversity & Inclusion Implications:<br>(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance | The paper describes the challenges for different groups of patients when accessing services including learning disabilities, mental health and those with long term conditions |
| STP Alignment / Implications: | The briefing describes the challenges of funding and commissioning across a number of services. |
| Recommendations: | To note the briefing for information purposes |

| Version | Name/group | Date issued |
|---|---|---|
| 1 | Laurie Wrench | 14.11.18 |

11 October 2018

on the day BRIEFING

NHS Providers

# The state of health care and adult social care in England 2017/18

# Care Quality Commission

This briefing summarises today's publication of the Care Quality Commission's (CQC) State of Health and Adult Social Care in England 2017/18, its annual assessment of quality performance, trends, and themes from the year's regulatory activity in social care; acute hospitals; community health and ambulance services; mental health; and primary medical services. Our briefing follows State of Care's structure, highlighting the points most relevant to our members and our media statement is included at the end of the briefing. Part 1 of the document presents the state of care in England, and part 2 offers sector-specific reviews as well as reviews of equalities outcomes and use of the Deprivation of Liberty Safeguards. We have summarised the main points but encourage you to read the full report for a thorough overview. Unless specified, the term 'providers' encompasses all sectors. We would welcome feedback on this briefing - please contact Cassandra.Cameron@nhsproviders.org.

## Summary

Overall, the quality of health and social care has been maintained or improved. The CQC emphasises the fact that NHS staff, carers and leaders should be commended for achieving this despite the continuing pressures around demand, funding and workforce vacancies. However, variation in quality and access persists and this is increasingly determined by how well different parts of local health and care systems are working together. Ineffective collaboration is undermining early intervention and care provision in the community, with struggling local hospitals and the inaccessibility of mental health services the symptoms of a struggling local system. The CQC has identified five factors that affect the sustainability of good care for people: access to care and support; the quality of care services; the workforce available to deliver that care; the capacity of providers to meet demand; and the funding and commissioning of services. CQC recommends that government reforms funding to incentivise stronger local collaboration and partnership working.

## Key messages

- This year's State of Care builds on the CQC's July 2018 report about care in 20 local areas based on reviews of older people's experience of moving between the different health and care services they need. Overall, the CQC found that the quality of health and social care has been largely maintained and in some cases improved, despite continued demand and funding pressures and significant workforce shortages. However, there is a growing 'integration lottery', with quality and timely access increasingly dependent on how well local systems work together.

- The continued fragility of the adult social care market is impeding effective collaboration between community-based health and social care services in many local areas. With rising unmet need for older people's care, the government's longer-term funding settlement for the NHS risks being undermined by the lack of a long-term funding solution for social care. The CQC recommends that government explore funding-based solutions to incentivise stronger collaboration, such as pooled resources to fund improvements in technology for more joined-up care and to help prevent people from needing hospital admission.
- The proportion of acute hospitals and mental heath services rated good or outstanding has improved slightly compared with 2016-17; the proportion rated requires improvement has declined and the proportion rated inadequate remains unchanged. NHS community services remain good, and the quality of care delivered by NHS ambulance services, which is heavily shaped by the system pressures, remains unchanged. However, not all providers are responding to the demand pressures in a way that effectively protects care quality, and safety remains a significant concern in most services.
- A complex commissioning environment makes coordinating local care systems difficult. Sustainable funding reform that addresses social care and the NHS together is needed, to remove the barriers that prevent social care and NHS commissioners from pooling their resources and using their budgets flexibly to best meet the needs of their local populations.

# Part 1: The State of Care in England

## 1. How people experience care today

- Most people receive good quality care from health and social care services, and there has been more improvement than deterioration in quality despite the pressures on services.
- Inconsistency and variation in quality are persistent challenges and access is a growing problem, which is related to the effectiveness of partnership working across a local system. People get good care from services; problems occur when people move between services along the care pathway.
- Quotes from 'Experts by Experience' interviewed by CQC about their involvement with the NHS and social care services are mostly very complimentary about the quality of people and services, despite the challenges. However they recognised that funding, poor communication and lack of consultation with patients and carers about people's needs was undermining quality and accessibility.
- Recent NHS surveys showed that, among adults who receive NHS mental health services, 75% felt that they had seen services often enough for their needs, and 72% said that in the previous 12 months they had met with someone from NHS mental health services to discuss the effectiveness of their care.
- The latest GP patient survey found that 79% of people with long-term conditions said that they received enough support from local services to manage their conditions. But 21% do not get the right support and 10% had an unexpected stay in hospital in the last 12 months due to their condition.

## 2. The challenges for local areas in ensuring high quality care

There is wide variation in the access to and availability of services, depending on where people lived and was a result of disjointed organisation, funding and delivery of health and care services. The CQC has

considered outcomes across the following five factors that affect the sustainability of good care: access; quality; workforce capacity; the capacity to meet demand; and funding and commissioning for services.

## Access to care and support:

- Age UK estimates that the number of older people living with an unmet care need has risen by almost 20% since 2016 to 1.4 million and about 150,000 - one in seven - older people without access to needed care and support for essential daily tasks.
- Financial thresholds for accessing publicly funded adult social care have declined by 12% in real terms since 2010/11 and fewer people are eligible to access it.
- There is wide variation in uptake of personal budgets and direct payments for social care and health. In 2016/17, 17.6% of older people received direct payments for long-term social care and 9,127 adults received a personal health budget (of which 4,784 received direct payments) for their care.
- Local authority spending rose by 1% on short-term support and 4% on long-term support, and the ONS Family Resources Survey 2016/17 found that 8% of people provide some type of informal care.
- The GP workforce is stretched, with a larger workload and the number of GP full-time equivalents falling. These pressures may be affecting people's access to their GP practice, as despite longer opening hours, public satisfaction with GP services has fallen to its lowest level for 35 years.
- In community health services, from 2009 to 2017 there was a 40% fall in the number of full-time equivalent community matrons and a 44% drop in the number of district nurses. At the same time, the number of nurses caring for adults in hospitals increased by 8%.
- From 2010/11 to 2016/17, the rate of emergency hospital admissions for older people (numbers of people with the condition per 100,000 older people in the population) has steadily increased for conditions (for example kidney and urinary tract infections, flu, pneumonia, upper respiratory tract infections and angina) that would not usually require hospital admission. Each age group over 65 years showed at least a 24% increase over this period, and the number of patients waiting 18 weeks to start treatment rose by 55% from 2011 to 2018.
- Inappropriately high eligibility thresholds are sometimes preventing access to mental health services for children and young people– particularly if alternative sources of help are not available. Because eligibility criteria are often applied after a child or young person has been referred, long delays may pass before they are told their needs cannot be met by the service they have been referred to.
- Mental health crisis resolution home treatment teams (CRHTTs) maintained gate-keeping of emergency admissions to hospital at above 98% overall, but with significant geographic variation on performance and consequent out of area placements.
- The percentage of beds occupied in acute hospitals is higher than it has ever been. In April 2018, only 16 of 152 local authority areas had bed occupancy rates below the 85% level.
- Performance against the four-hour target in emergency departments has continued a long-term trend of deterioration and a year-on-year decrease in performance.
- Effective local strategies to reduce avoidable admissions included community-based rapid response services such as hospital-at-home, streaming ED services, links for hospital admission staff with local

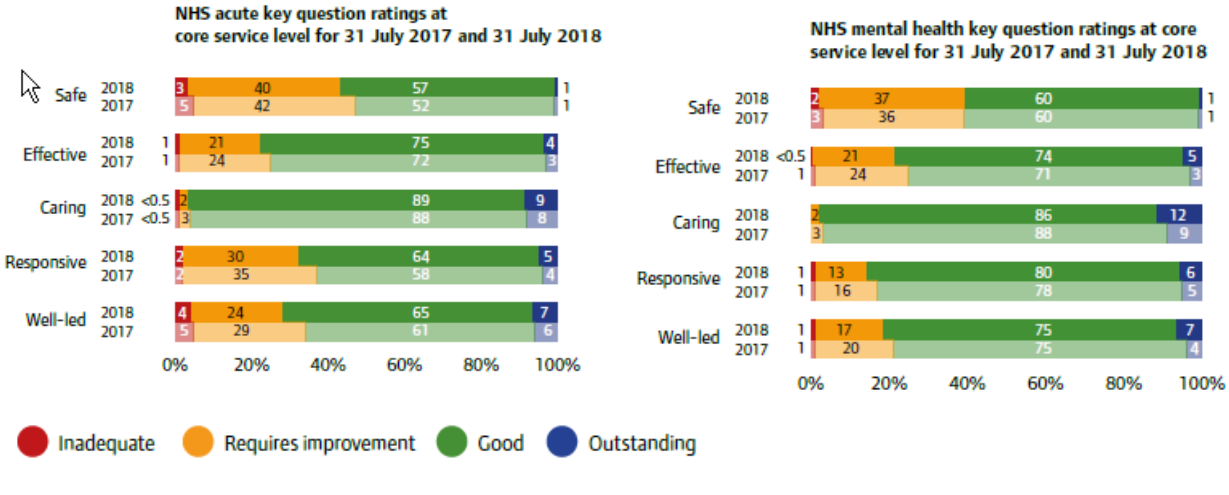
voluntary and community services; 'care navigators' in EDs to help links with social services for non-medical presentations at hospital.

- Though performance on delayed transfers of care had improved, pressure on local systems to reduce delays in hospital discharge has almost overwhelmed other health and social care priorities and in some areas responses had compromised safety to meet pressures. Effective strategies to improve timely discharge included better information sharing and communication with patients about their ongoing care needs, trialling a trusted assessment model, reablement and rehabilitation services, and more proactive medical and social support for unpaid carers

## Quality of care services

- The overall quality of care in the major health and care sectors has improved slightly though the most common result of re-inspection was an unchanged rating (figure 1).
- At 31 July 2018:
  - 60% of NHS hospital core services and 70% of NHS mental health core services were rated as good
  - 25% of NHS mental health core services were rated as RI and 1% was rated inadequate.
  - Almost a third of NHS acute core services were rated as RI and 3% rated as inadequate.
- Safety remains the CQC's biggest concern. Despite small safety improvements, at 31 July 2018:
  - 40% of NHS acute hospitals core services were rated as RI and 3% rated as inadequate.
  - 37% of core NHS mental health services were rated as RI and 2% as inadequate.
- The hallmark of high-quality care is good leadership and governance, a strong organisational culture that embraces learning, and good partnership working. The CQC found that leaders who demonstrate a willingness to learn from and engage with others are more likely to improve the quality of services.
- There is an association between good and outstanding services, and a focus on person-centred care, and equality and inclusion for both people using services and for staff. Equality and inclusion is often embedded into the culture of organisations where good practice is found.

Figure 1: Acute and mental health services key question 2017-18




Source: CQC ratings data, 31 July 2017 and 2018.

## Workforce planning

In 2017/18 there were about 1.47 million people working in adult social care and about 1.2 million working in the NHS in England. All sectors are struggling to recruit, retain and develop enough staff:

- Adult social care: the vacancy rate was 8%; for domiciliary care staff it was 10%. Skills for Care estimates that there are 110,000 job vacancies at any one time, mostly for the regulated professions that include registered nurses, allied health professionals and social workers.
- Acute medical care: Shortages across staffing groups and particularly urgent and emergency care.
- General practice: An ageing workforce along with recruitment and retention challenges is creating service instability and access gaps in many local areas.
- Community health: nursing shortages are affecting the responsive seven-day care, and shortages of allied health professionals are impacting on timely discharge from hospital and step-down care.
- Mental Health: low staffing levels were the most common reason for delays in the access and responsiveness of NHS children and young people's mental health services.
- Social services: a lack of social workers means more are carrying high caseloads of people with complex needs, and having an impact on the timeliness of support for older people.
- Ambulance services: a shortage of paramedics is impacting on timely responses to emergencies.
- The Brexit vote has appeared to impact on EEA staffing:
  - the number of first registrations with the Nursery and Midwifery Council from nurses and midwives from EEA countries (9,389 in the year to March 2016 compared with 805 in the year to March 2018).
  - the number of EEA nurses and midwives leaving the register (1,981 in the year to March 2016, compared with 3,962 in the year to March 2018).
  - There was a small rise in the total number of nurses and midwives from outside the EEA.
- Staff shortages are driving continued high use of bank and agency staff in ED and mental health inpatient escalation areas, although often still not ensuring enough suitably qualified and skilled staff.
- Many hospital emergency departments were failing to meet 16 hours a day consultant cover, and the skills of permanent staff are starting to stagnate as they cannot be released from duties to undertake training. Many staff are increasingly absent with sickness, experiencing burnout and morale is low.
- Safe high quality staffing is a key driver of quality and also of a provider's ratings. Modelling tools such as the 'safer nursing care tool' had been used to improve safety in EDs and led to more recruitment, but this is in the face of overall declines in nurses.

## Capacity of providers to meet demand

- Demand continues to rise from an ageing population and an increasing number of people living with complex, chronic or multiple conditions, such as diabetes, cancer, heart disease and dementia.
- NHS had the highest attendances on record at emergency departments in January 2018.
- The number of adult social care beds dropped slightly, with wide differences from April 2016 to 2018 relating to proportion of self-payers; a 44% rise in one local authority to a 58% reduction in another.

- A third (32%) of adult social care directors had seen home care providers close or cease trading in the previous six months; the number of nursing homes decreased by 1.4% and the number of residential homes by 2.4% in the year to April 2018. The number of domiciliary care agencies rose by 4.3%.
- CQC recognised that a number of external factors outside a provider's control, such as geography, socioeconomics, other services performing poorly and escalating demand combined with more complex and changing care needs is placing pressures on capacity and performance.

### Funding and commissioning of services

- From 2009/10 to 2016/17, the average social care spend per adult fell 14%, from £439 to £379, and since 2008/09 tightened eligibility criteria has reduced accessibility to support for 400,000 older people. The amount of LA-provided home care fell by more than three million hours since 2015.
- The area of greatest concern to councils is the increasing cost of care packages for growing numbers of people, both older and younger adults with complex needs, and their families.
- Services across adult social care, primary care, acute health care and mental health care operate within a complex commissioning environment and in some specialist areas, uneven distribution of budgets.
- Sustainable funding reform that addresses social care and the NHS together is needed, to remove the barriers that prevent social care and NHS commissioners from pooling their resources and using their budgets flexibly to best meet the needs of their local populations.

## 3. Working together to meet people's needs

### Challenges for different groups

People with a learning disability: continued inequalities from services, reflected in:

- premature and avoidable mortality (23 years younger for men and 29 years younger for women compared with the general population);
- on average four times more symptoms that are unexplained compared with others;
- lack of understanding about how to communicate with people with a learning disability;
- poor application of the Mental Capacity Act;
- secondary acute care services lacking reasonable adjustments for people with learning disabilities.

People with mental health conditions: mental health care is highly fragmented, which results in:

- navigating and accessing services becoming particularly challenging;
- variation in quality of local system prioritisation and planning for mental health services;
- capacity issues related to a lack of specialist staff and services, leading to out of area placements;
- children's mental health services being particularly problematic;
- mental and physical illnesses not being treated together or in a coordinated way.

People with long term conditions: relationships and partnership working are particularly important in creating effective pathways to prevent health problems from escalating to avoid admission to hospital. This needs to be underpinned by adequate support for unpaid carers.

### Challenges in accessing high-quality care

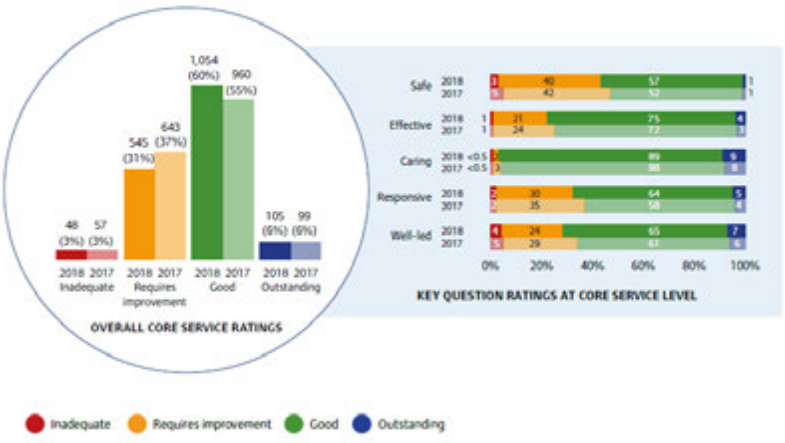
Good care is not evenly spread across the country. Local health and care systems need to look at how they meet the needs of all their local people, and ensure that people are able to access the services they need. Some local areas are starting to do this. Some services are using technology well to resolve geographic issues and help patients with access to care, and to improve availability of real time information.

## 2. Overview of regulated sectors

The following sections have been summarised for brevity to headline points only; more detail is available in the report, with specific reference also made to relevant CQC thematic reviews published in 2017-18.

### Hospitals, community health services and ambulance services

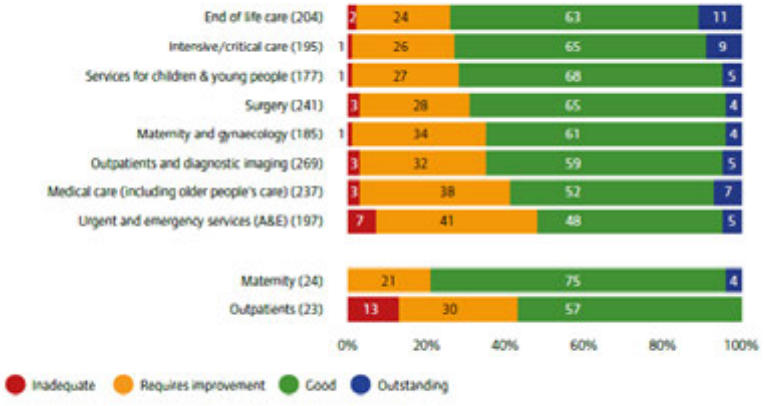
**Figure 2.5 NHS acute hospitals, overall core service and key question ratings, 2017 and 2018**




Source: CQC ratings data, 31 July 2017 and 2018.

- NHS acute hospitals: during 2017/18, there was improvement in the quality of care, with 60% of core services rated as good, compared with 55% in 2016-17 (figures 2.5 and 2.6), particularly in medical care services, surgery and end of life care and small improvements in maternity services.
- The quality of leadership is a key factor. In 68% of NHS hospitals, the ratings are the same for both the well-led and the safe key questions.
- CQC has found some improvement in the leadership of acute hospital core services, with 24% rated for well-led as RI (29% in 2016-17) and 4% rated inadequate (5% in 2016-17).

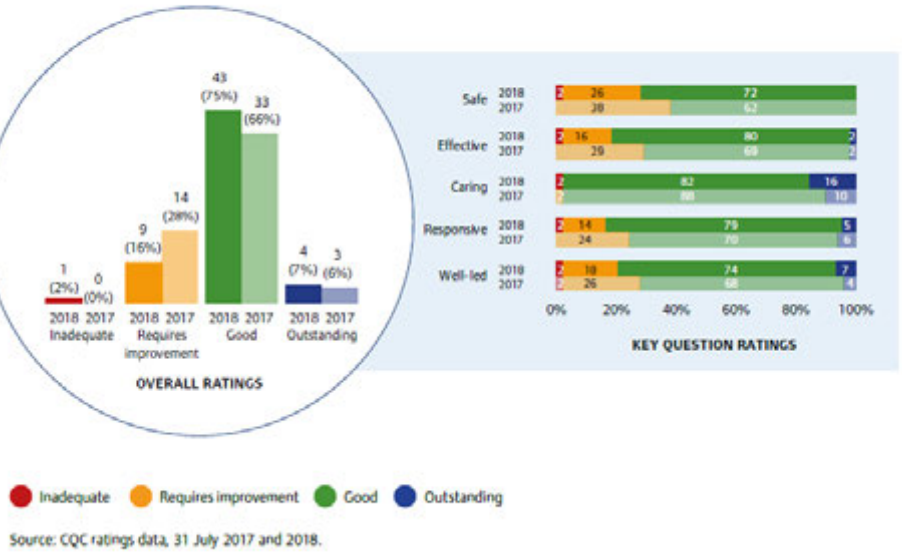
**Figure 2.6 NHS acute hospitals, core service ratings, 2018**




Source: CQC ratings data, 31 July 2018. Since June 2017, the core services of maternity and outpatients do not include gynaecology and diagnostic imaging respectively, which are now inspected as additional services. We show ratings for both the previous and the new core services separately as they are not comparable.

- Independent acute hospitals: 63% of were rated as good and 8% were rated as outstanding. However, 28% were rated as RI and one (0.5%) was rated as inadequate. The overall profile of ratings for core services in independent acute locations is broadly similar to small NHS acute sites that do not provide emergency care, despite not facing the pressures of NHS services. Acute services for children and young people needed most improvement, with 50% rated as good.

**Figure 2.9 NHS and independent community health organisations, overall and key question ratings, 2017 and 2018**

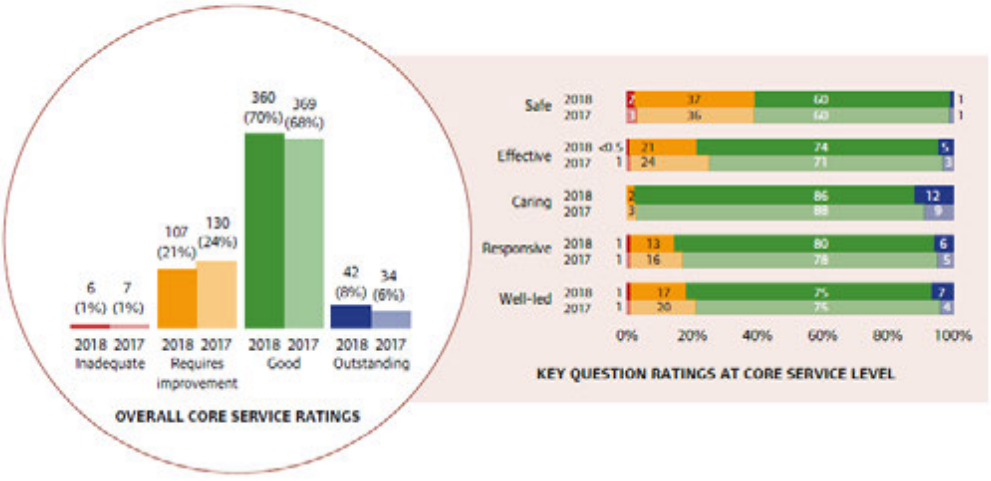



Source: CQC ratings data, 31 July 2017 and 2018.

- NHS community health trusts: 75% rated as providing good care, and 7% outstanding care and more than a quarter of hospices are rated as outstanding.
- NHS Ambulance services: challenges in the wider system set the context for quality, which has not changed since last year and remains variable. Four of the ten trusts were rated as RI and one rated as inadequate. Four are good and one is outstanding. As with NHS acute trusts, the ratings for leadership and safety of ambulance services is closely linked.
- Independent ambulances: quality remains a significant concern, with the most common regulations breached include those relating to governance, safe care, and treatment and safeguarding.

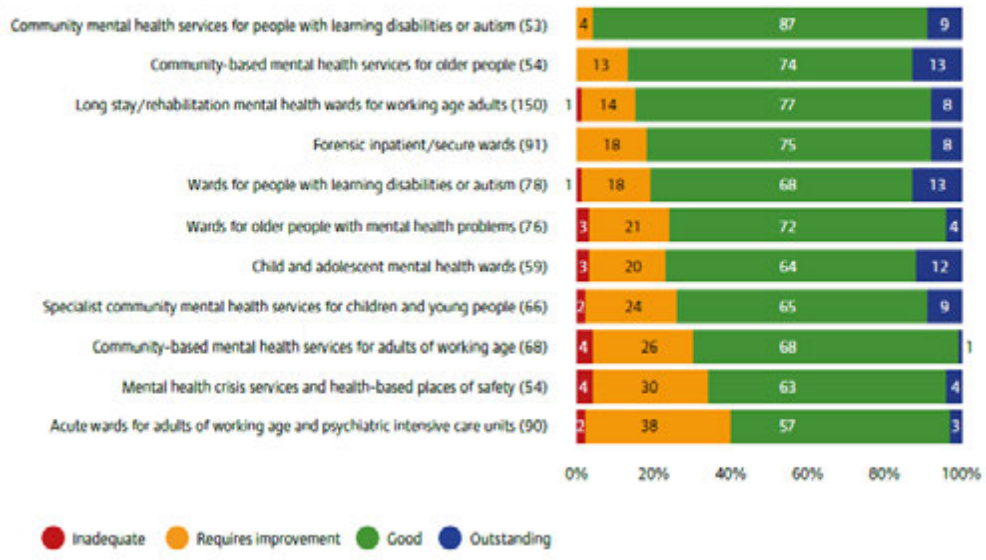
## Mental health services

**Figure 2.11 NHS mental health trusts, overall core service and key question ratings, 2017 and 2018**




- The majority of NHS mental health trusts are continuing to provide good care in their core services, with 70% rated as good and 8% rated outstanding (figure 2.11).
- Safety remains a concern, particularly on adult mental health wards: 37% of NHS core mental health services were rated as RI and 2% were rated as inadequate for safety (figure 2.13).
- 25% of people felt they couldn't access NHS mental health services often enough or have choice about what they received. Providers need to ensure access to a full range of interventions.

**Figure 2.13 NHS mental health trusts and independent providers, core service ratings, 2018**




Source: CQC ratings data, 31 July 2018.

- Overall, there is a general trend of improvement, with 58% of 55 NHS mental health trusts that were re-inspected improving from RI on their first inspection to good following re-inspection. Figure 2.15 shows the great contrast between first and last ratings in the 10 most improved trusts.
- The decisions that commissioners make have a direct impact on quality, with feedback from inspection staff suggesting that a lack of investment impacts both the availability and quality of mental health services and the capacity of the system to respond effectively to care needs.
- The report also provides updates on policies to accelerate progress with respect to particular challenges for quality in mental health services, including out of area placements in locked rehabilitation wards, inappropriate use of physical restraint, risks to sexual safety, dormitory accommodation, staffing in high secure and children's and young people's services, and residential substance misuse services.

## Adult social care

- More than four-fifths of adult social care services were rated as outstanding (3%) or good (79%), 17% of services were rated as requires improvement and 1% as inadequate.
- Of services that were originally rated as inadequate and have been re-inspected since 1 August 2017, 89% improved their rating. The 42% rated RI failed to improve and 7% dropped to inadequate.
- Community social care services were generally rated safer and better than nursing homes.
- There were 869 services of varying types and quality that by 31 March 2018 were no longer active.
- Staff are rated highly for caring, with 91% of services rated as good and 4% rated as outstanding.
- Problems with management and leadership support can exacerbate pressures and impact on quality.

## Primary medical services

- In general practice, 91% of surgeries were rated as good, 5% as outstanding, 4% as RI and 1% rated as inadequate. The quality of most urgent primary care services is good including walk-in and urgent care centres, NHS 111, and GP out-of-hour services. Greater public awareness is needed about them.

- Military personnel generally receive good quality primary health care, with issues mirroring the challenges for NHS services.
- In criminal justice settings, regulations were breached in almost half of the 41 prisons inspected, mainly because of a lack of appropriate policies and processes to run services safely and effectively, and poor physical environments.
- For children in the care of a local authority, the complex arrangements of health services make it difficult to share information, and agencies fail to agree ways to deal with it to improve children's health outcomes. Mental health and substance misuse services did not always consider the whole family and the impact of adults' behaviour on children.
- For primary health care in all settings, collaborative working as part of a local system can enable people to have a better experience of care. This needs commissioners to look at the needs of people in an area and resource them appropriately.

## Equality in health and social care

- There is evidence that some inequalities in experience are slowly reducing for some people. Improvements in person-centred care and values-led cultures in services play a big part in advancing equality and inclusion but overall progress is very slow and more leadership engagement is needed.
- People in some equality groups still have a poorer experience, particularly people with a learning disability, mental health condition or dementia who need to use acute hospital services, and people from Black and minority ethnic (BME) groups using acute mental health inpatient services.
- More work is needed to implement the Accessible Information Standard to improve communication with disabled people using health and social care services.
- Progress is slow to improve equality for NHS BME staff, with the NHS staff survey showing 87% of white NHS staff respondents agreed that their trust acts fairly about career progression and promotion, compared with 72% of BME staff. Discrimination related to race affected 15% of BME staff.
- New gender pay gap reporting shows 215 trusts have a pay gap that favours men, 10 trusts where the gap favours women and seven with no pay gap. There are more, larger pay gaps in acute trusts.
- Some gaps in access to services and in health outcomes are widening that can only be addressed by better local partnership working specifically based around needs of specific population groups.

## The Deprivation of Liberty Safeguards

- Good practice in applying the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA) closely aligns with putting the person at the centre of care and focusing on human rights.Ÿ
- Variation in how providers implement DoLS and the MCA continues to be an issue, as are delays in local authorities assessing and authorising DoLS applications. Over four years, applications for DoLS authorisations have risen from 13,715 in 2013/14 to 227,400 in 2017/18. The average length of time it took to complete an application in 2017/18 was 138 days, ranging from 68 days in London to 188 days in the South East. This increases the risk of people being unlawfully deprived of their liberty.
- Services that use overly restrictive practices often lack understanding of the MCA and DoLS legislation, and find it challenging to balance safety and freedom with limited staff time and resources.

- Strong leadership and governance with a positive organisational culture are key factors underlying good DoLS and MCA practice. Together with partnership working, adequate staffing levels and embedded staff training, they foster positive risk-taking, and encourage greater autonomy for people.
- A dedicated MCA (including DoLS) lead and team in hospitals can be an important way to drive change and improvement in practice.
- It is important that system partners and providers continue to work together to improve and develop the delivery of the DoLS scheme in its current form, to protect people when they are deprived of their liberty, and to support their families and carers.

# NHS Providers media statement

## Health and care systems need support to deliver for their local populations

Responding to the Care Quality Commission *State of Care 2017/18*, the head of policy at NHS Providers, Amber Jabbal, said:

"It is a testament to hard working frontline NHS staff that, despite the financial and staffing challenges that providers face, patients and the public can still expect good care when they need it.

"As State of care makes clear this pressure across the health and care system is leading to record breaking demand for NHS emergency care. These pressures, once reserved for winter, are now a year round phenomenon.

"To meet growing demand and support the move to integrated care, we need to see investment in other parts of the health and care system. In particular we have to be able to attract and keep the staff we need in social care, mental health, ambulance and community services. This will allow people to access the care they need closer to home and should help to ease pressure on A&E services.

"CQC has highlighted that joined up health and care services are already bringing benefits to patients in some areas, but this should not depend on where people live. Our recent report *Making the most of the money: efficiency and the long term plan* also showed how trust leaders regarded better system working as the most promising route to improving long term efficiency. We must therefore ensure that all local health and care systems are receiving the support they need to improve care for their local populations.

"A key task for the NHS long-term plan is to address these challenges, alongside commitments to improve health outcomes and recover performance. This plan must be realistic. Alongside this, we need the Green Paper for social care to set out proposals to put the sector on a sustainable footing. Missing these opportunities risks storing up problems for the future."

ENDS

NHS Providers
11 October 2018