North Staffordshire Combined Healthcare NHS Trust

MEETING OF THE TRUST BOARD

TO BE HELD IN PUBLIC
ON THURSDAY, 13th July 2017, 10:00AM,
BOARDROOM, LAWTON HOUSE, TRUST HEADQUARTERS,
BELLRINGER ROAD, TRENTHAM LAKES SOUTH,
STOKE ON TRENT, ST4 8HH

	AGENDA	
1.	**APOLOGIES FOR ABSENCE** *To NOTE any apologies for absence*	Note
2.	**DECLARATION OF INTERESTS RELATING TO AGENDA ITEMS**	Note
3.	**DECLARATIONS OF INTERESTS RELATING TO ANY OTHER BUSINESS**	Note
4.	**MINUTES OF THE OPEN AGENDA – 8th June 2017** *To APPROVE the minutes of the meeting held on 8 June 2017*	Approve Enclosure 2
5.	**ACTION MONITORING SCHEDULE & MATTERS ARISING FROM THE MINUTES** *To CONSIDER any matters arising from the minutes*	Note Enclosure 3
6.	**CHAIR'S REPORT** *To RECEIVE a verbal report from the Chair*	Note
7.	**CHIEF EXECUTIVE'S REPORT** *To RECEIVE a report from the Chief Executive*	Note Enclosure 4
	QUESTIONS FROM MEMBERS OF THE PUBLIC	
8	*To RECEIVE questions from members of the public*	Verbal
	ENCOURAGE, INSPIRE AND IMPLEMENT RESEARCH AND INNOVATION AT ALL LEVELS	
9.	**REACH RECOGNITION AWARD ON EXCELLENCE** *To PRESENT the REACH Recognition Team Award* To be introduced by the Chief Executive and presented by the Chair	Verbal Presentation

	TO PROVIDE THE HIGHEST QUALITY SERVICES	
10	**STAFF RETIREMENTS** *To EXPRESS our gratitude and recognize staff who are retiring* To be introduced and presented by the Chair	Verbal
11.	**NURSE STAFFING MONTHLY REPORT - May 2017** *To RECEIVE the assurance report on the planned versus actual staff variances from Ms M Nelligan, Executive Director of Nursing & Quality*	Assurance 5 Enclosure
12.	**SERIOUS INCIDENTS ANNUAL REPORT** *To RECEIVE the Serious Incidents Annual Report for assurance from Dr Buki Adeyemo, Executive Medical Director*	Assurance Enclosure 6
13.	**QUALITY ACCOUNT 2016/17** *To RECEIVE the Quality Account 2016/17 for assurance from Dr Buki Adeyemo, Executive Medical Director*	Assurance Enclosure 7
14.	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 2** *To RECEIVE the Month 2 Performance Report from Miss Suzanne Robinson, Director of Finance, Performance and Digital*	Assurance Enclosure 8
	TO ENHANCE SERVICE USER AND CARER INVOLVEMENT	
15.	**SERVICE USER AND CARER COUNCIL** *To RECEIVE an update from, Ms W Dutton, Vice Chair of the Service User and Carer Council*	Assurance Enclosure 9
	CREATE A LEARNING CULTURE TO CONTINUALLY IMPROVE	
16.	**PLACE OF SAFETY CAPACITY AND PERFORMANCE** *To RECEIVE a report from Dr Nasreen Fazal-Short, Acting Director of Operations*	Assurance Enclosure 10
17.	**LEARNING FROM DEATHS – PROVIDER RESPONSIBLITIES** *To RECEIVE for information the Learning from Deaths Providers Responsibilities report from Dr Buki Adeyemo, Executive Medical Director*	Note Enclosure 11
	MAXIMISE AND USE OUR RESOURCES INTELLIGENTLY AND EFFICIENTLY	
18.	**FINANCE REPORT – MONTH 2 (2017/18)** *To RECEIVE for discussion the Month 2 financial position from Miss S Robinson, Director of Finance, Performance and Digital*	Assurance Enclosure 12

	ATTRACT AND INSPIRE THE BEST PEOPLE TO WORK HERE	
19	**ASSURANCE REPORT FROM THE PEOPLE AND CULTURE DEVELOPMENT COMMITTEE** *To RECEIVE the People and Culture Development Committee Assurance report from the meeting held 3rd July 2017 from Miss L Barber, Chair/Non-Executive Director*	Assurance Enclosure 13
20	**FIT AND PROPER PERSONS** *To RECEIVE a report from for assurance re: Fit and Proper Persons Declarations from Mr David Rogers, Chairman*	Assurance Enclosure 14
	CONTINUALLY IMPROVE OUR PARTNERSHIP WORKING	
21.	**THE TRUSTS APPROACH TO PARTNERSHIPS** *To RECEIVE a report on the Trusts approach to Partnership Working from Mr A Hughes, Joint Director Strategy and Development (NSCHT/GP Federation)*	Approval Enclosure 15
	CONSENT AGENDA	
22.	**FRAMEWORK OF QUALITY ASSURANCE FOR RESPONSIBLE OFFICERS AND REVALIDATION – ANNUAL REPORT AND STATEMENT OF COMPLIANCE (AOA)** *To RECEIVE the Annual Report and Statement of Compliance (AOA) from Dr Buki Adeyemo, Executive Medical Director*	Information Enclosure 16
23.	**ASSURANCE REPORT FROM THE FINANCE & PERFORMANCE COMMITTEE** *To RECEIVE the Finance & Performance Committee Assurance report from the meeting held 6th July 2017 from Mr T Gadsby, Chair/Non-Executive Director*	Assurance Enclosure 17
24.	**ASSURANCE REPORT FROM THE QUALITY COMMITTEE** *To RECEIVE the Quality Committee Assurance report from the meeting held 22nd June 2017 from Mr P Sullivan, Chair/Non-Executive Director*	Assurance Enclosure 18
	DATE AND TIME OF THE NEXT MEETING	
	The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday, 7 September 2017 at 10:00am.	
	MOTION TO EXCLUDE THE PUBLIC *To APPROVE the resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admissions to Meetings) Act 1960)*	
	THE REMAINDER OF THE MEETING WILL BE IN PRIVATE	

	DECLARATIONS OF INTEREST	Note
	DECLARATIONS OF ANY OTHER BUSINESS	Note
	SERIOUS INCIDENTS	Assurance
	BUSINESS PLAN UPDATE	Approve
	LEADERSHIP & WORKFORCE REPORT AND SERVICE REVIEW	Assurance
	ANY OTHER BUSINESS	

ENCLOSURE 2

TRUST BOARD

Minutes of the open section of the North Staffordshire Combined Healthcare NHS Trust Board meeting held on Thursday, 8th June 2017 At 10:00am in the Boardroom, Trust Headquarters, Lawton House Bellringer Road, Trentham, Stoke on Trent, ST4 8HH

Present:

Chairman:

Mr D Rogers
Chairman

Directors:

Mrs C Donovan
Chief Executive

Dr B Adeyemo
Medical Director

Mr P Sullivan
Non-Executive Director

Dr Nasreen Fazal-Short
Acting Director of Operations

Mr T Gadsby
Non-Executive Director

Mr P Draycott
Executive Director of Leadership &Workforce

Mrs B Johnson
Non-Executive Director

Ms J Walley [part]
Non-Executive Director

Ms M Nelligan
Executive Director of Nursing and Quality

Dr K Tattum
GP Associate Director

Miss S Robinson
Director of Finance and Performance

Ms L Barber
Non-Executive Director

Mrs W Dutton
Interim Chair of Service User Carer Council

In attendance:

Mrs L Wrench
Associate Director of Governance

Mrs L Wilkinson
Acting Corporate Governance Manager

Mr J McCrea [part]
Associate Director of Communications

Mr G Thomas [part]
Digital Strategic Lead

Members of the public:
Hilda Johnson
Mr Grant Williams

Staff Retirements
Ron Edwards

REACH Individual Recognition Award -
Children's Community Learning Disabilities Team

The meeting commenced at 10:00am.

737/2017	**Apologies for Absence** Apologies were received from: Mr A Hughes Joint Director of Strategy and Development as representing the Trust at an STP meeting.	**Action**

738/2017	**Declaration of Interest relating to agenda items** There were no declarations of interest relating to agenda items.	
739/2017	**Declarations of interest relating to any other business** There were no declarations of interest.	
740/2017	**Minutes of the Open Agenda – 11th May 2017** The minutes of the open session of the meeting held on 11th May 2017 were approved with the following amendments. Page 14 Item 707/2017 It was agreed for the Benefits Realisation plan to be delivered at the next Trust Board. *Miss Robinson, Executive Director of Finance and Performance advised this report will now be received as part of the CIP programme update contained within the Finance and Performance Assurance report.* Page 7 701/2017 Retirements - P McDonagh. *Remove reference to 'another one'.* Page 16 709/2017 Service User Carer Council. Mr Sullivan raised his frustrations regarding the point; that Clinical notes are read prior to service user attending appointments to avoid having to repeat. *Mr Sullivan raised his frustrations regarding the point; that Clinical notes are not read prior to service user attending appointments to avoid having to repeat.*	
741/2017	**Matters arising** The Board reviewed the action monitoring schedule and agreed the following:- ***666/17 – Safe Staffing 6 Monthly Report*** *– February 2017 The Six month Safe Staffing report for the period of July – December 2016 will be submitted to the next Trust Board in May 2017.* ***Agenda item for today's meeting*** ***668/17 ROSE Update*** *– Mr Thomas urged that the Trust carry out a business contingency exercise led by our Emergency Planning lead. It was agreed to take forward.* ***Agenda item for today's Trust Board meeting.*** ***709/17 Service User and Carer Council -*** *Ms Nelligan agreed to submit a briefing from the Service User Carer Council Open Space Event around Quality priorities to the next Trust Board.* ***Agenda item for today's Trust Board meeting.*** ***715/17 Trust Self Certification - Condition G6*** *– Systems for compliance with license conditions It was further noted that there will be another*	

	Condition FT4 for submission by the end of June 2017. This will be submitted to the June Trust Board. ***Agenda item for today's Trust Board meeting.*** ***716/17 Register of Board Members – Declarations of Interest -*** *It was noted there were some further revisions to be made in respect of Mrs Donovan and Ms Walley. Mrs Wrench to update accordingly.* ***Action complete***	
742/2017	**Chair's Report** The Chair explained that yesterday the BBC reported that as part of the capped expenditure process a number of schemes were being explored. This included a report that South Staffordshire and Shropshire Foundation NHS Trust (SSSFT) Staffordshire and Stoke-on-Trent Partnership NHS Trust (SSOTP) and North Staffordshire Combined Healthcare Trust would merge, he said that the Trust had reassured all staff that this story is not accurate. The idea of a takeover of the Trust by anyone has never been proposed by us. Our local health economy is amongst the most financially challenged in the country with around a £130 million deficit. In response to this challenge, NHS England and the regulators asked every local NHS organisation to produce as many ideas as possible for discussion on how to deal with the situation. One idea is for a merger of SSSFT, SSOTP and North Staffordshire Combined Healthcare NHS Trust. The Trust's clear preference which is already progressing through a Northern Alliance Board is for a Multi-Specialty Community Provider (MCP) across North Staffordshire and Stoke-on-Trent. This is totally aligned with the vision for integration of services and stronger working with primary care. It is also believed this is the best solution for our local communities, will support the urgent care pressures at University Hospitals of North Midlands NHS Trust (UHNM), support pressures in primary care and deliver improved responsiveness and outcomes for service users and their families. The BBC report accurately says that there are many options in the document, although they do not mention our plans for an MCP, that no decisions have been made and that discussions are at an early stage and it is not known when any final plans would be agreed or signed off. He said that we are deeply disappointed that the BBC did not approach us for any comment before running this story, which we know could cause unnecessary alarm for our staff. We have raised this with the BBC. The Chairman advised he was happy to answer questions. ***Received***	

743/2017	**Chief Executive's Report** Mrs Donovan, Chief Executive, presented this report which provides an update on the activities undertaken since the last meeting in May 2017 and draws the Board's attention to any other issues of significance or interest. **NHS CYBER ATTACK** The entire NHS was the victim of a cyberattack of ransomware on Friday 13th May demanding payment in virtual bitcoins. North Staffordshire Combined Healthcare were one of the 48 NHS organisations that were infected. Staff worked tirelessly and professionally over the weekend of 13th – 15th May to continue to provide the highest quality care, to manage the impact and to resolve the problems. All staff pulled together for a considerable team effort, but David Hewitt, Ben Boyd, Joe McCrea, Darryl Gwinnett, Andrew Hughes and the duty senior nurses really did go above and beyond. The Trust worked with colleagues across the health economy to ensure that patient care was not compromised and the Trust is pleased to report that no data was lost or illegally accessed. Social media channels and new website were used to very good effect to ensure local patients and the local media were kept informed and reassured and the Trust were also able to answer any questions through this site that arose. As a result, the attack was dealt with calmly and effectively. The attack came just hours before we were due to 'Go Live' with the new Electronic Patient Record (ROSE). However, the careful planning we had put in place to prepare for the migration of our records from the old CHIP system to the new Lorenzo system put us in good stead to deal with the cyberattack. **RAISING OUR SERVICE EXCELLENCE (ROSE) LAUNCHES** A decision to reschedule the ROSE launch for 19th May was made in consultation with both NHS Digital and DXC, the suppliers of the Lorenzo system we are using. The initial roll out of ROSE has gone extremely well, with no unanticipated issues and plenty of which we can be proud. The Trust has received some great feedback from NHS Digital who told us that they thought the way in which we had prepared and mobilised for the launch was among the best they'd seen and would be held up as an exemplar to other NHS organisations. **DISCOVER YOUR FUTURE RECRUITMENT CAMPAIGN** The summer-long series of one-stop recruitment events has got underway at Harplands as part of our Discover Your Future campaign. The Trust have been advertising for www.discoveryourfuture.co.uk. registered nurses	

mental health (RNMHs), registered nurses learning disability (RNLDs) and registered nurses adults (RNAs) to join Combined, with those applying having the opportunity to apply for available posts on the day, be interviewed by a panel and potentially leave with a job offer. We look forward to welcoming new members of staff to join the Trust over the summer.

CAROL SYLVESTER APPOINTED INTERIM CLINICAL DIRECTOR FOR ADULT MENTAL HEALTH INPATIENT SERVICES

Congratulations to Carol Sylvester, who has been appointed as the Clinical Director of our Adult Mental Health Inpatient services on an interim basis for six months. Carol, a well-respected and well liked members of the Trust. She has been serving as Deputy Director of Nursing and Quality since 2015 and has a wealth of knowledge and experience of collaborative working with clinical directorates and external stakeholders to support the delivery of high standards of clinical care.

CELEBRATING AND NURTURING NURSING EXCELLENCE CONFERENCE

The Trust marked International Nurses Day on Friday 12 May in style with our Celebrating and Nurturing Nursing Excellence conference, held at Port Vale FC. It was a hugely successful event, led by our Director of Nursing & Quality, Maria Nelligan and Julie-Anne Murray, our Head of Nursing & Professional Practice and featured a number of talks and presentations celebrating our nursing staff and the huge contribution they make to improving the lives of our service users.

The talk given by dementia care campaigner Tommy Whitelaw about his mother was extremely touching and left many of our nurses very emotional.

Pledge Tree posters, which staff have been completed by writing individual pledges of care. The event concluded with our Mentor of the Year Award being presented to Mel Hope and Preceptor of the Year Award presented to Deb Scragg.

The event also saw the launch of a competition for staff to design a new Combined Healthcare Nursing Badge. Maria and Julie-Anne will be judging the entries and the badges will be given to all of our registered nurses in recognition of their having completed their nurse training.

TRUST HOLDS FIRST LGBT FOCUS GROUP

The Trust held its first lesbian, gay, bisexual and transgender (LGBT) Focus Group Wednesday 7 June at Harplands Hospital. The purpose of the session was to review the experience that we offer to LGBT service users and staff, identify where improvements could be made and highlight good practice.

Thank you to everyone who attended the session, which was facilitated by

	Abby Crawford from LGBT charity and action group Stonewall. **DEAF AWARENESS TEAM WINS RECOGNITION AWARD** Well done to our Deaf Awareness Team, who have won a Special Recognition Award from the charity DEAFvibe in recognition of the hard work that has gone in to improving mental health services for the local deaf community. **NEW ADMIRAL NURSE PARTNERSHIP PROVIDING SPECIALISED SUPPORT TO PEOPLE WITH DEMENTIA AND THEIR FAMILIES** The Trust are proud to have worked in partnership with the Douglas Macmillan Hospice and Dementia UK to launch the first Admiral Nurse service in Staffordshire. Wendy Mountford has recently joined the service from our Memory Services and, as a newly appointed Admiral Nurse will provide specialist one-to-one support and guidance to people living with dementia and their families and carers. **OPEN DAY FOR PSYCHOLOGICAL SERVICES** The Trust will be holding a second Open Day for Psychological Services on Friday 9 June from 9am-5pm at North Staffs Medical Institute, in Hartshill,. Everyone is welcome and there will be talks throughout the day from psychologists and therapists about the services we offer throughout the Trust to support people with their psychological care. **HSJ VALUE IN HEATHCARE AWARDS SHORTLISTINGS** The Trust were delighted to have two teams invited to the national HSJ Value in Healthcare Awards on 25th May. Learning Disabilities services were finalists in the Community Healthcare Service Redesign Award and the Healthy Minds IAPT Team were shortlisted in the Improving the value of Primary Care Service Award. Although neither won the main award, their inclusion on the shortlist is further example of our growing reputation nationally for innovation, quality and value for money. **HPMA AWARDS PRESENTATIONS ON COMPASSION SCHEME AND FEEL GOOD FRIDAY** The work North Staffordshire Combined Healthcare Trust have led across the health economy on compassion funded by Health Education England and our partnership working with staff Side colleagues have been recognised nationally in being shortlisted for these awards. The winners of the HPMA Awards will be announced on 22nd June 2017. ***Received***	
745/2017	**Questions from the public**	

	CEP (Capped Expenditure Programme) Jenny Harvey, Unison Representative expressed concern that there had been no engagement with trade unions regarding the CEP. Nobody has talked to Staff Side about any merger details. Staff are reading in the newspapers talks of mergers. Staff should not have our staff receiving information via the sentinel/ BBC. This was agreed. Mrs Dutton and Hilda Johnson both expressed their concern that service users will worry about what is going on behind the scenes; it will appear we are not involving service users. Ms Walley stated that she understood the sensitivities around the CEP but highlighted that there is a real importance that discussions we have are transparent and not behind closed doors. Mr Rogers advised that a briefing to all staff will be circulated today.	
746/2017	**Staff Retirements** Mrs Donovan recognised staff who are retiring this month as follows: **Ron Edwards (Senior Art Therapist)** Before starting with the Trust Ron started his work life training as a silversmith in 1962 and had work exhibited in shows throughout Europe and in The Design Centre in London. Ron started his work in the Occupational Therapy unit at St Edwards in November 1970 as a technical instructor, and was soon promoted to Senior Art Therapist. He developed the department from standard craft activities to a fully functioning Wood Work Department. Ron also introduced sessions in photography, cycle maintenance and car interests including engine functions. Recently Ron has introduced video editing where service users have gone on to produce their own work. Over the years Ron has received numerous accolades from both his peers and service users. In 2003 and 2009 Ron was awarded the Chairman's Individual Award. Ron still has the same optimistic outlook he had for his work as when he first started. Ron will be missed by all who have had the opportunity to work alongside him; he is the ultimate professional and a great friend to all. Thank you and good luck in your retirement. Unable to attend - Imogen Hutchinson, Occupational Therapist. **Staff Bereavement** The Board is very sad to announce that Justin Griffiths, Approved Mental Health Professional and Best Interest Assessor Lead for the Trust, passed away on Tuesday 30 May.	

	Justin was a quite exceptional and special person, respected and valued by friends and colleagues alike. His dedication, professionalism and service enriched the lives of his colleagues, service users and their families. He joined the Trust in 1997 as a young Nursing Assistant and dedicated his whole working life to Combined Healthcare, including meeting his future wife, Nicky, whilst they worked together on Wilkins House, St Edwards Hospital. Justin and his family have been part of our Combined family for two decades, which only makes our sorrow at his passing all the more acute and heartfelt. No mere words can replace his loss, or the loss felt by Nicky, who is our County Community Mental Health Team Manager, and their three young children, but I know that everyone involved with Combined Healthcare would wish us to pay tribute to a brilliant man and a much loved friend. We will be talking with Nicky in due course about the best way we can establish a lasting tribute to Justin. In the meantime she has requested that any messages of condolence are sent via card rather than text message. She has also suggested that flowers are not sent, but instead any donations are made to the University Hospitals of North Midlands' Critical Care Unit. Anyone wishing to do so can either donate online at www.uhnmcharity.org.uk/how-you-can-help/donating, over the phone on 01782 676444 or by post to UHNM Charity, Royal Stoke University Hospital, Newcastle Road, Stoke-on-Trent, ST4 6QG. Cheques should to be made payable to 'UHNM Charity'. Please specify your donation is for the Critical Care Unit. Our thoughts are with Nicky and her family at this very sad time. ***Received***	
747/2017	**REACH Recognition Award** **Team Award June 2017** **Children's Community Learning Disabilities Team** CAMHS Community LD are a skilled and experienced team dealing with the many demands placed upon them. They have adapted to working within a new directorate, with a new manager and have implemented many new ways of working to manage the significant demand on the service. The team fulfils many roles, with the largest part of their work focusing on the assessment and treatment of a young person's developmental and behavioural needs. They also promote healthy lifestyles and work closely with special schools and mainstream services providing support to charitable organisations such as Caudwell Children. They not only understand and meet the physical and emotional needs of the children they work with, but also provide support for parents who often have significant	

	emotional challenges to overcome. This is done with patience, sensitivity and great compassion**.** The team ensure those with the highest level of need are seen as soon as possible and keep families up-to-date with a bi-monthly letter or telephone call. The value that best represents the team is 'Responsible'. Working with children, especially those who may be highly vulnerable or at times disadvantaged, not only requires the team to have time to care and be compassionate, but also requires them to constantly ensure the child's wellbeing is safeguarded. This cannot be achieved without a great deal of diligence, dedication and commitment – not only to their existing caseload, but also to those awaiting the service. Mr Forrester, Interim Head of Directorate and Judy Littlehales, Community Nurse delivered a presentation around the service specification, the teams function and purpose and team values they also presented a service users story detailing the teams interventions. Mr Sullivan recognised the difficulties for the team and asked if there was anything the Trust Board can do to support them? Judy Littlehales highlighted that due to the team becoming larger they were looking to recruit more staff. The team thanked the Board for the support they had already received in bringing children's services into the LD Directorate the Adult and Children's team have been able to share processes and strategies. Hilda Johnson commented that a lot of services have worked in isolation previously but this shows how important it is to bring services together.	
748/2017	**Patient Story – Recovery Focussed Care Coordination** Ms M Nelligan, Executive Director of Nursing & Quality presented Simon Wilson, Team Leader Early Intervention Team who displayed a video of a patient story between Jane Simner Care Co-ordinator, Early Intervention and service user Jane Lamb. Mr Wilson described Jane's journey and recovery, describing how Jane had been unwell for a significant period of time. Jane's main concerns were getting back in the home and managing her life. The quality of Janes relationships with Jane and the team were most important as part of her recovery. Jane wanted to share her story and now sits on the Service User Carer Council. Jane was recently discharged from Early Intervention and wants to volunteer. She recently spoke at a Recovery Conference, and a Keele event for junior doctors training. Jane is still working on her recovery and still needs support, being able to share her story validates her experience but sharing her recovery is helping. It was noted that Jane has recently undertook her health certificate and is a	

	volunteer on Ward 6 and a very valued member of the team by staff and patients. Ms Nelligan stated it highlighted just how much Jane is in the driving seat of her care and this is where we want to be. Mr Sullivan highlighted that the patient story shows how important it is when someone is admitted to hospital that the person that supports that initial meeting gets it right, how important relationships are and the importance of recovery. As a Board we are thankful to both Jane Simner and Jane Lamb for allowing the video to be shown. ***Received***	
749/2017	**Nursing Staffing Monthly report – April 2017** Ms Nelligan, Executive Director of Nursing and Quality, presented the assurance report highlighting the following. The performance relating to fill rate (actual numbers of staff deployed vs numbers planned) during April 2017 was 83% for registered staff and 101% for care staff on day shifts and 83% and 109% respectively on night shifts. 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. There were 7 incident forms completed by in-patient wards during April 2017 relating to nurse staffing issues. No harm arose from these incidents. Ward Managers and members of the multi-disciplinary team have clinically supported day shifts to ensure safe patient care. Safe staffing levels reported indicated challenges in staffing wards during April 2017. Vacancies across Acute Adult Mental Health wards in particular and the opening of Ward 4 have contributed to this. The allocation of RNs from Wards 5, 6 and 7 to Ward 4 has reduced substantive RN staffing on those wards temporarily. Recruitment to RN vacancies has had limited success therefore alternative strategies are being investigated with the support of the HR and Communication teams. Ms Nelligan impressed the need to have recruitment levels back to where they were in October 2016. Hilda Johnson commented although low at 1% she was still concerned about staff not taking their breaks the impact this can potentially have on patient care. We need to be careful it does not become the norm. Ms Nelligan advised that we do not encourage this and time in lieu is taken, she also acknowledged the dedication of staff and patients at this time. In preparation for E Roster we will be looking at time in lieu as part of the review to be undertaken in July 2017. ***Received***	

750/2017	**Nurse Staffing Six Monthly Report** Ms Nelligan, Executive Director of Nursing and Quality, presented the report and highlighted the following. This report details the findings of the six monthly review of ward nurse staffing establishment, covering July-December 2016, in line with NHS England and National Quality Board (NQB) requirements. The review included a range of factors impacting on nursing and the potential to deliver high quality care. During the review meetings, quantitative data was gathered, including areas of practice, staffing and leadership and was explored with the ward representatives to inform the conclusions and recommendations of the review. The current and recommended staffing levels remain consistent with the previous two six monthly reviews in January and July 2016. A number of areas are to be strengthened on the wards including an update on progress against the last six month safer staffing review. The Safe Staffing Group will implement the recommendations within the report and SLT will monitor progress. Wards 5, 6 and 7 are staffing to safe staffing requirements however the additional staffing is not within the wards' budgeted establishment and therefore this continues to be a budget pressure. Further work is required to fully understand the impact of variable patient acuity on budgeted establishment. Activities for service users is a key area we want to enhance and make more transparent. Ward Managers Task and Finish group are going to work through this. The next Safer Staffing report will focus on workforce due to the vacancies, national shortage of nurses, apprenticeships online development. Mr Sullivan commented although Ward 4 is being commissioned we potentially have a risk in terms of staffing ratio. We need to consider if we attract people internally we will leave gaps. Ms Nelligan confirmed that we have attracted people as we have widened the scope in terms of registered nurses we are encouraging. In terms of risk, there are potential risks but these are being mitigated and the reports every month flag this up in detail. E Roster will help ward managers with planning and help with efficiencies. We will not see the benefit of this until December 2017. Mr Sullivan asked if there had been further developments with the Acute Care Pathway. It was confirmed that a piece of work is being undertaken to look at the Acute Care Pathways, Personality Disorder Pathway whilst enhancing the Community Pathway. Ms Nelligan confirmed that a staffing review will also be undertaken across	

	all of our 24/7 Services. Mr Grant Williams (member of public) asked if we had considered the harm to a patient when being moved out of area. Dr Adeyemo confirmed moving patients out of area is not something we subscribe to and we are working with our Commissioners as this is an issue nationally. Dr Fazal-Short highlighted when people do go out of area we do have processes in place to bring them back as soon as possible into a local bed. This is not a regular occurrence and is monitored very closely. Ms Nelligan wished to acknowledge and thank Carol Sylvester, AMH Clinical Director, Julie-Ann Murray, Acting Deputy Director of Nursing and Zoe Grant, Quality Assurance and Improvement Manager for writing the report ***Approved***	
751/2017	**Performance and Quality Management Framework Report (PQMF) Month 1** Miss Robinson, Director of Finance, presented this report. The report provides the Board with a more detailed level of summary of performance to the end of Month 1 The following performance highlights were noted; • 100% of IAPT patients were treated within 6 weeks of referral • 93.5% of patients (excluding ASD) have been referred for treatment or intervention within 18 weeks • 99.4% of all service users to the IAPT service have been contacted within 3 working days of referral In Month 1 there are 4 related metrics rated as Red and 2 as Amber; all other indicators are within expected tolerances. **<u>Exceptions</u>** • Delayed Transfers of Care – 14.8% at month 1 from 12.9% at month 12. Deep dive analysis is being undertaken and an action pan being developed Confirm and challenge sessions are also underway. • Agency spend – 6.6% at M1 from 6.2% at M12 • Core agency spend – 1.9% at M1 from 2.9% at M12 this was acknowledged as a good achievement • CPA - 94.3% at M1 from 96.2% at M12 • Readmissions –15.0% at M1 from 8.8% at M12. A deep dive is being undertaken. • RAID - 94.0% at M1 from 95.0% at M12 • CPA Care plans - 93.4% at M1 from 96.6% at M12	

	Received	
752/2017	**UK Alert Level Critical Trust Board Report** Dr Fazal-Short, Acting Director of Operations provided a report which was taken as read. It was noted that the critical alert was reduced from critical to severe. The Trust Board acknowledged the approach and approved and supported the actions taken. ***Received***	
753/2017	**Service User and Carer Council** Ms Dutton, Vice Chair of the Service User Carer Council updated the Board in respect of the Service User Carer Council on meeting activity and achievements to-date. - Terms of Reference were reviewed increasing membership - Reformat of the Service User Carer Council will look Alternate Formal/Business meeting with less formal Educational/Workshop meeting to deep dive into specific areas. Ben Boyd will be attending to look at care plans and Lorenzo. - Election of new chair closing date 5th June 2017. - Service User Carer Strategy will be reviewed in July workshop. - Citizens Jury full report when available will be discussed at Service User Care Council in October 2017. ***Received***	
754/2017	**Feedback from Service User and Carer Council Open Space / Quality Priorities** Ms Nelligan presented the report. Following the Open Space event held on 29th March 2017 the Service User and Carer Council completed a workshop to highlight the quality improvement issues it wished to prioritise with the Trust. A summary of these were presented to the Board as part of the Service User and Carer Council report in May 2017. It was agreed to draft a briefing in response to the priorities agreed by the Service User and Carer Council and highlight where these would be addressed within the Trust`s Improvement Programme. Action plan was agreed. Individual items will be discussed at Quality Committee. Ms Barber enquired as to whether the Service User Carer Council will be monitoring the improvements. Mrs Dutton advised this will be discussed when looking at the strategy.	

	Mrs Johnson asked for a progress update on the 'key questions you should be asking' cards for new patients. Ms Nelligan advised she had agreed to have reprinted and she will be following this up. Ms Nelligan has also discussed with Mr McCrea the possibility of having a Proactive Page on our website with information for service users and carers. This is included within the action plan. ***Received***	**MN**
755/2017	**Raising Our Service Excellence (ROSE) 'Go Live' Update** Mr Thomas, Digital Strategic Lead, was in attendance to present this item and highlighted the following Lorenzo Go Live was rescheduled from 13th May to 20th May due to the cyberattack. Downtime preparations for Go Live helped deal with the cyberattack and there was no negative impact on patient care. Feedback from NHS Digital and DXC that transition from old system to new was excellent. All services were live on the system by 22nd May 2017. There have been some teething issues as staff are becoming more familiar with the system. System update on the 24th May 2017 lead to performance data reporting issues but were quickly resolved. Priority plan for development over next 3 months and measures of success were presented Mr Thomas reflected on why he thought the transition had gone so well. This Board has made it a priority. DXC have reported the level of Board engagement they have had here is by far the best they have received within the NHS. The Trust have met hard deadlines. Two way engagement and communications has worked well. Project Team have said that the staff have made this work on the ground. He also felt the Trust had captured the statement of being an 'exemplar'. Dr Tattum asked if we had a plan of how we going to move forward and develop the system for things such as electronic prescribing. Miss Robinson advised we have started to put some infrastructure in place so we can start to prioritise how the system will be developed. Mrs Donovan acknowledged Mr Thomas's hard work and contribution. ***Received***	
756/2017	**Monthly Finance Reporting – Month 1 (2017/18)** Miss Robinson, Director of Finance, presented this report which contains the financial position at Month 1	

	The Trust Board was asked to note: - The reported deficit of £37k against a planned deficit of £56k. This is a favourable variance to plan of £19k. - The M1 CIP achievement. In month achievement of £2k (1%); an adverse variance of £135k; 2017/18 forecast CIP delivery of £1,798k (56%) based on schemes identified so far; an adverse variance of £1,409k to plan. The recurrent forecast delivery at month 1 of £2.265m representing a recurrent variance to plan of £932k. Miss Robinson highlighted the need to look at transformational schemes. - The cash position of the Trust as at 30th April 2017 with a balance of £4,945k; £2,119k worse than plan. - Capital expenditure for 2017/18 is £20k compared to a plan of £364k. We are behind on capital this relates to PICU construction which is due to commence in June 2017. - Use of resource rating of 3. ***Received***	
757/2017	**Finance and Performance Committee Assurance Report – 1st June 2017** Mr Gadsby, Chair of the Finance and Performance Committee/Non-Executive Director, presented the assurance report to the Trust Board from the Finance and Performance Committee held on 1st June 2017. Mr Gadsby credited the team for being able to supply Month 1 figures so quickly but commented it did raise concerns going forward. In relation to CIP the Trust are likely to require some form of consultation for a small number of transformational programmes which can take time. If not identified soon the Trust is in danger of not achieving CIP. Capital - An evaluation of the Meridian Phase 1, demonstrated that Meridian delivered an actual return on investment of 274% against a proposal of 479%. The committee noted that although the investment did not achieve its proposed ROI, the savings realised were significant and a key aspect of the 2016/17 CIP delivered. Mrs Donovan acknowledged the challenge and advised we have been working on MCP as a transformational plan we are looking to be going live in Quarter 3. ROSE and Meridian were additional transformational plans to change culture although we did not get the full benefit of Meridian. Mrs Donovan highlighted another real opportunity is repatriation across STP. We are hoping this will give some benefit in year in terms of efficiency. ***Received***	

758/2017	**Audit Committee Assurance Report – 31st May 2017** Mrs B Johnson, Audit Committee/Non-Executive Director, presented the assurance report to the Trust Board from the meeting held on the 31st May 2017. The following was highlighted: - The committee received a draft version of the document for assurance. The final version will go to the Quality Committee for their approval in June 2017. - ISA Audit. The Trusts external auditors, Ernest Young, presented their findings to the Committee. They were pleased to report unqualified opinion of the 2016/17 accounts. - Annual account. Approved. - Business conduct policy. Approved - Information Governance – The committee were notified of a recent information governance breach. The committee were informed that this was reported accordingly by the Trust and an investigation is underway. The completed action plan will be presented to the Audit committee. ***Received***	
759/2017	**Trust Self Certification - Condition FT4** Mrs Wrench, Associate Director of Governance, presented this report for approval. The approved self-certification of G4 has been submitted in line with NHSI requirements. Trust Board must self-certify and confirm compliance against condition FT4 by 30th June 2017. The FT4 describes controls and assurances we have in place to declare compliance against a number of key areas. ***Approved***	
760/2017	**Any other business** None	
761/2017	**Date and time of next meeting** The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday, 13th July 2017 at 10:00am, in the Boardroom, Lawton House, Trust HQ.	
762/2017	*** Motion to Exclude the Public** The Board approved a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted.	

The meeting closed at 1.07pm

Signed: _____ Date_____
Chairman

Board Action Monitoring Schedule (Open Section)

Trust Board - Action monitoring schedule (Open)					
Meeting Date	Minute No	Action Description	Responsible Officer	Target Date	Progress / Comment
11-May-17	700/2017	Questions from the public - Mrs Donovan commented that the Trust would be supporting Mr Williams and thanked him for highlighting these issues. It was agreed to bring back a report on Place of Safety capacity and performance	Dr Fazal-Short	13-Jul-17	Agenda item
11-May-17	705/2017	Serious Incident Q4 Report - The Serious Incident Annual report will be submitted to the next Trust Board	Dr Adeyemo	13-Jul-17	Agenda item
11-May-17	708/2017	Board Assurance Framework - 2017/18 - The BAF Q1 2017/18 will be submitted to the Trust Board in July 2017.	Mrs Wrench	13-Jul-17	Agenda item
08-Jun-17	754/2017	Feedback from Service User and Carer Council Open Space / Quality Priorities - Key Questions Cards - Following a request for a progress update on the 'key questions you should be asking' cards for new patients. Ms Nelligan advised she had agreed to have reprinted and she will be following this up.	Ms Nelligan	13-Jul-17	Currently being developed by Communications Team following which will be sighted at Service User Carer Council

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REPORT TO: Trust Board

ENCLOSURE 4

Date of Meeting:	13 July 2017		
Title of Report:	Chief Executives Report to the Trust Board		
Presented by:	Caroline Donovan, Chief Executive		
Author:	Caroline Donovan, Chief Executive		
Executive Lead Name:	Caroline Donovan, Chief Executive	Approved by Exec	☒

Executive Summary:		Purpose of report	
This report updates the Board on activities undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☐
Seen at:	SLT ☐ Execs ☐	Document Version No.	
Committee Approval / Review			
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☒ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☒ 4. Encourage, inspire and implement research & innovation at all levels.☒ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☒ 7. Continually improve our partnership working. ☒		
Risk / legal implications: Risk Register Ref	None identified		
Resource Implications: Funding Source:	N/A N/A		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	None identified		
Recommendations:	For information		

Chief Executive's Report to the Trust Board
13 July 2017

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. CAPPED EXPENDITURE PROCESS

The Staffordshire health economy is one of 13 areas across the country undergoing a process introduced in April 2017 by NHS England and NHS Improvement called the Capped Expenditure Process (CEP).

As the NHS entered the new financial year, Commissioners and Providers within the Staffordshire economy had not, in aggregate, been able to agree a set of affordable 2017/18 Operating Plans, or, in some cases, confirm delivery of financial Control Totals. The objective of the CEP therefore was for NHSE and NHSi to support Providers and Commissioners to work together to prioritise the financial resources they have on behalf of the populations they serve and ensure they live within their budgets.

According to NHSI, "the health economies selected to participate in the process are those with the greatest gap between their planned expenditure for 2017/18 and their budget allocation for the year. We will work with NHS England and the Department of Health in the next few weeks to understand the impact of implementing these plans'.

To facilitate the process, the Trust Board will be considering the following actions which we believe are critical to the assurance and acceptance of any CEP plans, a process endorsed by NHSi:

- Board assurance, on a self-assessment basis, must take place so that the consequences of proposed trust CEP proposals are fully considered and will safeguard patient safety and quality.
- Ensure that CEP plans are consistent with constitutional rights for waiting times (referral to treatment RTT) and patient choice.
- Where service reconfiguration proposals trigger the NHS' public consultation duties, this is followed. In addition, we shall ensure that service users, carers and staff are engaged throughout the planning and implementation stages of agreed CEP proposals that impact on the services they receive/provide.
- We will work collaboratively with commissioners in agreeing plans, engagement, undertaking impact assessments and taking forward delivery.

Whilst we will continue to play an active role to help shape the future of a sustainable Staffordshire, we remain committed to our journey towards outstanding mental health, learning disability and substance misuse services via our SPAR quality priorities and the exciting development of population based integrated care through the Multi-Specialty Community Provider (MCP).

2. AWARDS SUCCESS ENJOYED BY COMBINED

Congratulations to our staff and teams, who have scooped a string of awards. The Finance team won the Great Place to Work Award at the Healthcare Finance Management Association (HFMA) West Midlands Branch Awards on 23 June. The award recognises the team that best demonstrates a culture and development programme that enables individuals to perform at their very best. This follows on from their success at the national 2017 HFMA Awards where they won the Costing Award.

We enjoyed further success at the Healthcare People Management Association (HPMA) 2017 Awards. The Leading with Compassion scheme, where staff, patients and carers can nominate someone who they believe has demonstrated compassion won the Academi Wales Award for Excellence in Organisational Development. The scheme was launched at Combined and has been rolled out across 11 NHS organisations in the region. To date, almost 500 Leading with Compassion nominations have been made in Combined, with staff receiving a personalised badge and card. A Leading with Compassion nomination can be made via **www.nhscompassion.org/nscht/**.

In addition, our Feel Good Friday health and wellbeing initiative was a runner-up in the HPMA Social Partnership Forum Award for partnership working between employers and trade unions. Feel Good Friday was set up in October 2016 to enable staff to receive information and advice on a range of things aimed at enhancing health and wellbeing. As well as getting cholesterol checks, for instance, attendees can also speak to our Staff Support and Counselling Service, staff side union reps and the diversity and inclusion team.

3. CARE QUALITY COMMISSION (CQC) TO RETURN TO TRUST

When we published our fantastic CQC results in February this year, where 10 out of 11 of our core services received ‘Good’ or ‘Outstanding’ ratings, we asked the CQC to return to inspect our Community CAMHS services.

The CQC has introduced a new inspection regime and has informed us they will be revisiting the Trust to do core service unannounced inspections and a well-led review. Alongside this, the CQC has asked for a series of data requests from our various services.

We will be working with the teams involved and their clinical directors and heads of service to ensure they receive the fullest support possible and, of course, thank them in advance for their efforts and dedication.

The new CQC regime will now include annual reviews and this is our opportunity to demonstrate how the improvement programme we embarked upon years ago is continuing to bear fruit and that we are really delivering on our vision ‘to be outstanding’.

4. NEW CLINICAL LEADERSHIP ARRANGEMENTS FOR LEARNING DISABILITIES AND CHILDREN AND YOUNG PEOPLE'S DIRECTORATES

Following discussion with clinical directors and in light of Dr Jo Barton stepping down as our Clinical Director for Children and Young People (CYP), the decision was made for the Learning Disabilities (LD) and CYP directorates to come together – with the leadership arrangements therefore changing. Thank you to Jo for her leadership over the past two years; we wish her the very best success in the future.

Dr Matt Johnson, our Clinical Director for Learning Disabilities, is offering Clinical Director Interim support for the two directorates in order to continue to support CYP and also to enable support for all clinical and other matters. We have been delighted with the leadership achievement to date of Matt in his LD role.

As our plans towards becoming a multispeciality community provider (MCP) move forward, we will have the further opportunity to work with staff and leadership to co-determine and co-design the best long term organisational structures and leadership arrangements.

5. DISCOVER YOUR FUTURE RECRUITMENT CAMPAIGN

Our summer-long Discover Your Future recruitment campaign continued on 7 July with the latest in our one-stop recruitment events at Harplands Hospital. The events are for registered nurses mental health, registered nurses learning disability and registered nurses adults. To help promote this event, we have been running a series of adverts on Signal Radio – further ads will appear in the coming weeks to promote the one-stop events on Tuesday 15 and Wednesday 16 August and Friday 29 and Saturday 30 September. Those applying have the opportunity to apply for available posts on the day, be interviewed by a panel and potentially leave with a job offer. We also held a one-stop recruitment event held for Ward 4 at Harplands on 17 June. The ward has now been permanently commissioned as a shared care service with University Hospitals of North Midlands NHS Trust (UHNM), providing 15 beds for patients with dementia and physical health needs. It's important that we ensure our inpatient wards, alongside our other services are fully staffed. Staff are being encouraged to support the campaign by sharing the one-stop events and www.discoveryourfuture.co.uk recruitment website via social media.

6. TRUST HOLDS SERIES OF SUCCESSFUL CONFERENCES

June was a busy month at Combined for conferences, with several successful events held. Our Psychological Services Open Day on 9 June featured talks throughout e day from psychologists and therapists about the services we offer throughout the Trust to support people with their psychological care.

On 27th June, we hosted the latest in our nationally recognised Neuropsychiatry conferences. This was the sixth Neuropsychiatry conference we have hosted and the focus of this year's event was Huntington's disease (HD). This year marks the 30th anniversary of providing HD services in North Staffordshire, one of only a few NHS-based services in the country for this condition. We were delighted that Dr Ken Barrett, the founder of this highly regarded service chaired the event and shared how it came to life. The conference was supported by a number of distinguished international speakers, with contributions from eminent academic professors, clinicians and researchers from Europe and the UK national and international organisations. A very big thank-you to Dr George El-Nimr for organising the event.

28th June saw the first in what we hope will be a long running series of Primary Care and Combined Integrated Psychiatry conferences - with the theme of this one being psychopharmacology. We welcomed dozens of GPs, psychiatrists and students to the event, which featured a keynote presentation from Professor Ian Anderson, Professor of Psychiatry at the University of Manchester. A further talk was given by our Medical Director Dr Buki Adeyemo, while there was a focus on MCPs by Andrew Hughes, Joint Director of Strategy and Development for Combined and North Staffordshire GP Federation, and Dr Mark Williams, Clinical Director for Primary Care.

Our final event of June saw service users, carers, partners and staff attended our first Inclusion Conference - called **Symphony for Hidden Voices**. The event celebrated diversity and shared stories from a number of different individuals whose lives have been shaped in different ways by their experiences of both inclusion and exclusion. Among those who gave a talk was Jenny Harvey, Unison Staff Side representative, who spoke about her transgender story. Her story, called 'Overcoming hate' has also been published in Unison's magazine and can be viewed here.

Other talks included those given by Joy Heal, who spoke eloquently about the impact of her son Jonathan's suicide; Wahida Mohammed, Human Resources Administrator, and Sophia Hussain, Senior Pharmacist, who both spoke about their lives as Muslim women; Kirsty Booth and Jaymee Smith from the Child and Young Peoples' North Staffordshire IAPT Youth Council, who gave a young persons' perspective of mental health; Abby Crawford from LGBT campaign organisation Stonewall UK; and representatives from Sanctus, who spoke about the work they are ding to support asylum seekers.

We have created a playlist on our YouTube channel with contributions from the day. See https://youtu.be/GwibxP-Al1s

We have also created a live social 'word cloud' - bringing together in real time material published on Twitter or Facebook by anyone using the hashtag #inclusionsymphony or any mentions on the web. It constantly updates as new material is created. Anyone can use it to engage with the participants from the day as well as keep the conversation going.

We are immensely grateful to everyone who supported all of these fantastic events - they should all be very proud.

7. NORTH STAFFORDSHIRE AND STOKE-ON-TRENT MULTISPECIALTY COMMUNITY PROVIDER (MCP) GATHERS PACE

There has been an enormous amount of effort and energy put in by Combined to develop a model of multispecialty community providers (MCPs) across North Staffordshire and Stoke-on-Trent. A significant step forward was taken at the most recent meeting of the North Staffordshire Alliance Board, which unanimously agreed that Newcastle-under-Lyme would be the first locality that will begin to bring forward the new ways of working. We are planning to go live with the new locality from September.

What this means is that we will now start planning to align our teams with other multi-disciplinary teams. There is already great work going on in Newcastle led by Dr Emma Sutton, a GP who is employed some of her time at Combined Healthcare also working with Dr Mark Williams, our Clinical Director for Primary Care.

A palpable sense of momentum is growing around our plans and I am delighted that as part of the preparations for the MCP, we will be supported by the NHS Chief Transformation Officer, Helen Bevan and her Horizons team – working with the Sustainability and Transformation Plan (STP) system leadership organisations development team – to design and deliver an Accelerated Design event. I look forward to sharing more information about this exciting new venture.

8. CAMHS – NO CHILD WAITING OVER 18 WEEKS FOR AN ASSESSMENT

Thanks to a concerted effort by our Children and Young People's services, I am delighted to announce that **no child is now waiting over 18 weeks for an assessment**, with 75 per cent of children and young people assessed within four weeks. This is a fantastic achievement and is testament to the hard work of all of our Community CAMHS teams who have been working to improve services for children and young people.

9. FIRST TEAMS TAKING PART IN TOWARDS OUTSTANDING ENGAGEMENT PROGRAMME

Our first 15 pioneering Trust teams are embarking on their six-month Towards Outstanding Engagement journeys. These teams cover the whole organisation and the programme will encompass a wide range of staff engagement tools, including listening events, team building and back to the floor. Staff will be able to highlight issues within their team and make choices about how they can improve or sustain staff engagement. Participants on the programme will reflect both the skill and professional mix within that team.

10. RECOGNISING EXCELLENCE AND ACHIEVEMENT IN COMBINED HEALTHCARE (REACH) AWARDS LAUNCHED

Nominations are open now for our annual REACH Awards. REACH takes place on Thursday 5 October at the Moat House, Stoke-on-Trent and celebrates staff and teams who have made a truly outstanding contribution and have gone above and beyond as part of their work. The ceremony will feature nominees, service users and carers, partner organisations and sponsors and will recognise outstanding achievements in the following categories:

1. Leading with Compassion Award
2. Rising Star Award
3. Volunteer/Service User Representative of the Year Award
4. Innovation Award
5. Valuemaker Award – NEW AWARD
6. Service User and Carer Council Award – NEW AWARD
7. Developing People Award
8. Partnership Award
9. Unsung Hero Award
10. Team of the Year Award
11. Chairman's Award

Another new award this year will be the Proud to Care Award – this exciting addition will involve anonymised voting in advance solely by our own staff. Please visit **www.reachawards.org/nscht** for more details on the categories, criteria and how to make a nomination

11. STOKE PRIDE EVENT

On the 24th of June, Combined attended Stoke Pride in Hanley Park. The event was a huge success with over 5000 local residents attending. Our stall acted as a drop in for the public to discuss and raise awareness of mental health and local services, as well as offering fun activities to help people have pride in their own identity. It was a very worthwhile event with the stall proving very popular. Presence at the event also helped us strengthen our links with local voluntary groups.

One key action from the day is to include both CAMHS services and the Young Peoples council as part of our presence at pride 2018. This reflects the age range attending pride and enquiring about ways to improve their mental health. The event this year was attended by many young people who were coming to terms with both their sexuality and gender identity. Our new NSCHT LGBT+ focus group will continue to raise awareness and enhance service access over the year ahead. If you wish to get involved and join this group please contact Lesley Faux.

NATIONAL UPDATE

11. NHS ENGLAND ANNOUNCES NEW SITES TO TEST NEW APPROACHES TO DELIVERING MENTAL HEALTH SERVICES

On 23rd June, NHS England announced a new tranche of sites to test new approaches to delivering mental health services – cutting the number of people travelling long distances for care. Eleven new sites will be tasked with bringing down the number of people who receive in-patient hospital treatment and for those who do need more intensive care, that this is available closer to home.

The pilot sites, made up of NHS mental health trusts, independent sector and charitable organisations will work together, sharing a local budget, to effectively reorganise services in their area to provide the best care for patients.

Local managers and clinicians will take charge of managing budgets and providing inpatient and specialised mental health services, tailoring them to their area's individual needs.

In recent years, there has been an increase in the number of young people and adults being sent for mental health care inpatient services many miles from their homes.

This can make visiting very difficult for the individual, their families and local clinicians, potentially affecting a person's recovery, leading to increased lengths of stay.

As well as this, reducing inpatient hospital care also offers the opportunity to save money, which means savings can be made and will be reinvested in wider mental health services.

The first phase of wave two will go live on 1 October 2017, with nine sites covering inpatient services for children and young people (CAMHs tier 4), adult secure care, and adult eating disorder services. The total budget of the programme across both waves is around £640 million, representing approximately 35 per cent of the Specialised Commissioning mental health budget (£350 million for wave one).

Six sites were chosen to take part in the first wave of this project which went live on 1 April 2017. The six sites plan to use 283 fewer beds as a result of admission avoidance, shorter lengths of stay, and bringing back hundreds of patients from out of area placements. This will save more than £50 million over the next two years.

https://www.england.nhs.uk/2017/06/new-sites-to-redesign-mental-health-services/

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REPORT TO: OPEN TRUST BOARD ENCLOSURE 5

Date of Meeting:	13TH JULY 2017		
Title of Report:	May 2017 Monthly Safe Staffing Report		
Presented by:	Maria Nelligan Executive Director of Nursing & Quality		
Author:	Julie Anne Murray, 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 May 2017 in line with the National Quality Board requirements. The performance relating to fill rate (actual number of staff deployed vs numbers planned) during May 2017 was 84% for registered staff and 102% for care staff on day shifts and 84% and 106% respectively on night shifts. Overall a 95% fill rate was achieved. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover and Ward Managers supporting clinical duties. The data reflects that Ward Managers are staffing their wards to meet increasing patient needs as necessary.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☒ Date: 4TH JULY 2017	Document Version No.	
Committee Approval / Review	• Quality Committee ☒ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	Delivery of safe nurse staffing levels is a key requirement to ensuring that the Trust complies with National Quality Board standards.		
Resource Implications: Funding Source:	Temporary staffing costs Budgeted establishment and temporary staffing spend.		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	None		
Recommendations:	To receive the report for assurance and information		

1 Introduction

This report details the ward daily staffing levels during the month of May 2017 following the reporting of the planned and actual hours of both Registered Nurses (RN) and Health Care Support Workers (Care Staff) to Unify. Appendix 1 also details the establishment hours in comparison to planned and actual hours.

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. The next 6 month review covering the period July 2016 – December 2016 was reported to SLT and Board of Directors in May 2017. The next 6 monthly review will concentrate on workforce planning and will be undertaken in July 2017.

3 Trust Performance

During May 2017 the Trust achieved staffing levels of 85% for registered staff and 102% for care staff on day shifts and 84% and 106% respectively on night shifts. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by nurses working additional unplanned hours, cross cover, ward managers and the multi-disciplinary team 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 in Appendix 1.

4 Issues impacting on fill rates

WMs report the impact of unfilled shifts on a shift by shift basis. Themes and mitigating actions are summarised below appendix 2.

4.1 Impact on Patient Safety

There were 6 incident forms completed by in-patient wards during May 2017 relating to nurse staffing issues. No harm arose from these incidents. Breakdown by ward is summarised as follows:

Ward	Incident
A&T	3 incidents of short episodes of reduced staffing resulting in challenges in maintaining staffing increased clinical observation levels, there was no impact on patient safety.
Edward Myers	2 incidents, 1 due to bank member of staff not reporting for duty, 1 due to staff being moved to support other ward.
Ward 4	1 incident where baseline staffing levels were not met.

4.2 Impact on Patient Experience

Staff prioritise patient experience and direct patient care. During May 2017 it was reported that 4 activities were cancelled or shortened due to nurse staffing levels. Of these 2 were rearranged.

4.3 Impact on Staff Experience

In order to maintain safe staffing the following actions were taken by the Ward Manager during May 2017:

- 25 staff breaks were cancelled (equivalent to approximately 0.5% of breaks)
- 2 staff breaks were shortened (equivalent to approximately 0.04% of breaks)
- 477 hrs of ward cross cover (nursing staff were reallocated to cover shortfall within other clinical areas

4.4 Mitigating Actions

Ward managers and members of the multi-disciplinary team have clinically supported day shifts to ensure safe patient care. Skill mix has been altered to backfill shortfalls. A total of 215 RN shifts were covered by HCSW where RN temporary staffing was unavailable. A total of 29 HCSW shifts were covered by RN staff where HCSW temporary staffing was unavailable. Additionally, as outlined in section 4.4, staff breaks have been shortened (time is given in lieu) or not taken and wards have cross covered to support safe staffing levels.

5. Summary

Safe staffing level reporting indicated challenges in staffing wards during May 2017. Vacancies across acute AMH wards in particular and the opening of ward 4 have contributed to this. The allocation of RNs from wards 5, 6 and 7 to ward 4 has reduced RN staffing on those wards. Additionally the use of temporary staffing to support ward 4 has reduced the availability of temporary staff to backfill other wards. Recruitment to RN vacancies has had limited success therefore alternate strategies are being investigated with the support of the HR and communication teams.

Appendix 1 May 2017 Safer Staffing

May-17	DAY						NIGHT						DAY		NIGHT						
	Registered nurses			Care staff			Registered nurses			Care staff											
Ward name	Establishment Hours	Clinically required Hours	Total monthly actual hours	Establishment Hours	Clinically required	Total monthly actual hours	Establishment Hours	Clinically required	Total monthly actual hours	Establishment Hours	Clinically required	Total monthly actual staff hours	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Overall fill-rate	Safe staffing was maintained by:	Vacancies	Bed occupancy	Movement	Provisional sickness data
Ward 1	1463	1478	1034	1350	1527	1808	643	643	343	965	986	1210	70%	118%	53%	123%	95%	Nurses working additional hours and altering skill mix	3 B5 3 B3	98%	↑	6.94%
Ward 2	1433	1433	1066	1350	1365	1570	638	638	493	638	639	793	74%	115%	77%	124%	96%	Nurses working additional hours and altering skill mix	6.6 B5	96%	No change	10.17%
Ward 3	1560	1560	1148	1395	1560	1702	665	665	364	665	665	986	74%	109%	55%	148%	94%	Altering skill mix	3.8 B5 1.6 B2	73%	↓	2.26%
Ward 4	1628	1395	1277	1395	1395	1511	290	290	290	698	698	698	92%	108%	100%	100%	100%	Altering skill mix and support from the outreach team	13 B5	85%	↓	n/a**
Ward 5	1103	1568	1138	930	1395	1653	290	290	298	871	871	834	73%	118%	103%	96%	95%	Altering skill mix	2 B5	91%	No change	0.00%
Ward 6	1080	1193	998	1860	1935	1823	291	291	300	863	985	947	84%	94%	103%	96%	92%	Nurses working additional unplanned hours	1 B5	98%	↑	2.99%
Ward 7	1050	1050	974	1395	1395	1312	290	290	284	581	581	581	93%	94%	98%	100%	95%	Nurses working additional hours, cancelling and rearranging patient activities and altering skill mix	1 B5	94%	↓	0.00%
A&T	1571	1369	1240	1395	1860	1726	333	333	333	1000	2000	1967	91%	93%	100%	98%	95%	Nurses working additional hours and altering skill mix	3 B5	91%	↓	6.91%
Edward Myers	1069	1114	1030	945	945	832	291	291	285	581	581	553	92%	88%	98%	95%	92%	Nurses working additional unplanned hours	0.6 B3	Not yet received		12.09%
Darwin Centre	1214	1214	1199	1212	1212	1197	333	333	333	667	667	667	99%	99%	100%	100%	99%	*	2.8 B5 1 B3	89%	↓	0.00%
Summers View	1016	935	913	930	805	757	332	332	332	665	643	643	98%	94%	100%	100%	97%	The multi-disciplinary team supporting the nursing team	1 B5 1 B3	100%	↑	9.71%
Florence House	551	551	560	930	830	680	332	332	332	332	332	332	102%	82%	100%	100%	93%	The multi-disciplinary team supporting the nursing team	1 B5	83%	↓	9.85%
Trust total	**14736**	**14858**	**12573**	**15087**	**16224**	**16570**	**4730**	**4730**	**3989**	**8525**	**9647**	**10212**	**85%**	**102%**	**84%**	**106%**	95%	*** over 95% in all areas**	****n/a due to transition of ward**			

Appendix 2 Staffing Issues – May 2017

- Ward 4 opened at short notice to support the local health economy and was initially commissioned as a nursing assessment unit from November 2016 until the end of May 2017. This resulted in an adverse impact on staffing levels across the site as registered nurses and health care support workers were seconded into Ward 4 supplemented by bank and agency. The ward has recently been commissioned to open permanently as a shared care ward and whilst recruitment to the ward manager, deputy ward manager, clinical lead and HCSW posts have been successful there has been limited success in recruiting band 5 RNs. Therefore there will be a transition period whilst staffing, equipment, processes and procedures etc are put in place to safely open the ward as shared care.

- There has also been staff turnover across wards and further vacancies have arisen since October 2016. These have been difficult to fill and despite several adverts there are currently 38.2 WTE RN vacancies reported within in-patient wards. Thirteen of these relate to Ward 4 and 25.2 relate to the other wards. This is a further increase from last month and is in line with the national picture where nursing shortages are being experienced across sectors. To proactively attract new nurses to the trust twenty two student nurses, due to qualify in Oct 2017, have been offered posts. Sixteen have accepted offers of employment. Those who have not accepted an offer have indicated that they are moving away from the area following graduation. Monthly one-stop shops are also taking place alongside a rolling recruitment campaign. From a long term perspective the DoN and Head of Nursing have met with UHNM with regards to pre-registration nursing and nursing associate apprenticeships. A joint proposal is being drafted to take this forward in partnership. This will help us to 'grow our own' nursing associates and registered nurses over coming years.

- The highest RN vacancies are across the Acute AMH wards with wards 1, 2 and 3 currently having B5 vacancies of 3, 6.6 and 3.8 WTE respectively; these posts have been advertised externally with limited success. Further recruitment events have been held during May 2017 with limited success despite a rolling advert for band 5 RNs.

- The ward 5 RN fill rate on days was 73% during May 2017. The previous 2 six monthly safe staffing reviews have recommended that ward 5 require an additional 4.26 RNs, additionally Ward 5 have 1 RN seconded to Ward 4 and 1 RN seconded to RAID. These factors are impacting on the RN fill rate. In terms of day shifts the ward are attempting to staff to the uplift in staffing recommended in the safer staffing, that is 3 RNs on the early shift and 3 on the late shift. Currently the ward establishment will only allow for staffing of 2 RNs on the early and late shifts therefore, as a maximum, they can only achieve 72% fill rate within their current establishment. This situation has been reviewed by the Modern Matron (MM) and Head of Directorate and agency RN cover has been agreed to backfill the RN seconded to ward 4.

- The ward 1 RN fill rate on days was 70% during May. During May 2017 the ward has 2 RN vacancies and one RN redeployment. Skill mix was altered to increase HCSW numbers during May bringing the overall day shift fill rate to 95%. The MM continues to oversee roster practices to ensure that resources are used effectively.

- Ward teams are supported by Modern Matrons and a Duty Senior Nurse who are further supported by an on-call manager out of hours. These staff are not included in the safer staffing returns.

- In June 2016 the planned RN night shift cover was increased from 1 to 2 RNs on the acute wards (1, 2 and 3); this has led to a temporary decreased RN nightshift fill rate on these wards. It was expected that once the Oct 2016 newly qualified nurses had completed preceptorship the WMs have been directed to prioritise 2 RNs being rostered on nights. The number of vacancies have made this challenging however given that more registered nurse support is available on the day, through WMs, MMs and NPs, night shifts are the time when RN support needs to be strengthened. Therefore the WMs have been directed to ensure that 2 RNs are rostered onto nights although this continues to be difficult to achieve. This will be considered as part of the next 6 monthly review which will concentrate on workforce planning.

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

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REPORT TO: Trust Board

ENCLOSURE 6

Date of Meeting:	13 July 2017		
Title of Report:	Serious Incident Annual Report 2016/17		
Presented by:	Dr Buki Adeyemo, Executive Medical Director		
Author:	Jackie Wilshaw, Patient & Organisational Safety Manager Sandra Storey, AD MACE		
Executive Lead Name:	Dr Buki Adeyemo, Executive Medical Director	Approved by Exec	☒

Executive Summary:		Purpose of report	
This report provides an overview of the learning from Serious Incidents for the period 2016/17		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☒ Execs ☒	Document Version No.	
Committee Approval / Review	• Quality Committee 22 June 2017		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☒ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☐ 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	None identified		
Resource Implications: Funding Source:	N/A N/A		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	None identified		
Recommendations:	For assurance/information		

North Staffordshire Combined Healthcare NHS Trust

Serious Incident Annual Report 2016-2017

1. Introduction

This report provides a review of trust Serious Incidents processes, progress made and incidents reported during the period April 2016- March 2017.

2. Background

Serious Incidents (SIs) in healthcare are events where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations is so significant that they warrant our particular attention to ensure these incidents are identified correctly, investigated thoroughly and, most importantly, trigger actions that will prevent them from happening again.

Responding appropriately when things go wrong in healthcare is a key part of the way that the trust can continually improve the safety of the services we provide to our patients. It is known that healthcare systems and processes can have weaknesses. These can lead to errors occurring and, tragically, these errors sometimes have serious consequences for our patients, staff, services users and/or the reputation of the organisations involved themselves. It is therefore essential that we continually strive to reduce the occurrence of avoidable harm. [1]

The SI framework (NHS England) identifies SIs as:

- Acts or omissions in care that result in unexpected or avoidable death
- Unexpected or avoidable injury resulting in serious harm
- Never Events
- Incidents that prevent (or threaten to prevent) our ability to deliver an acceptable quality of healthcare services
- Incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

The trust as a healthcare provider is responsible for the safety of our patients, visitors and others using our services. Therefore we must ensure robust systems are in place for recognising, reporting, investigating and responding to Serious Incidents and for arranging and resourcing investigations. We use a recognised framework of Root Cause Analysis, advocated by the National Patient Safety Agency (NPSA) to support staff in undertaking investigations. This includes the exploration of what happened, how it happened and why it happened.

3. Trust policy and process

SIs attributed to the trust are those that occur where the person was either in receipt of services or had been in receipt of services within the preceding 12 months of the incident. All investigations are subject to the timeframes outlined in trust Serious Incident Policy (Health and safety policy 5.32) with approved reports submitted to the appropriate external bodies. For the period April 2016- March 2017, this was the North Staffordshire Clinical Commissioning Group, Stoke-on-Trent Clinical Commissioning Group and Staffordshire County Council.

[1] Serious incident framework. Supporting learning to prevent recurrence. NHS England 2015

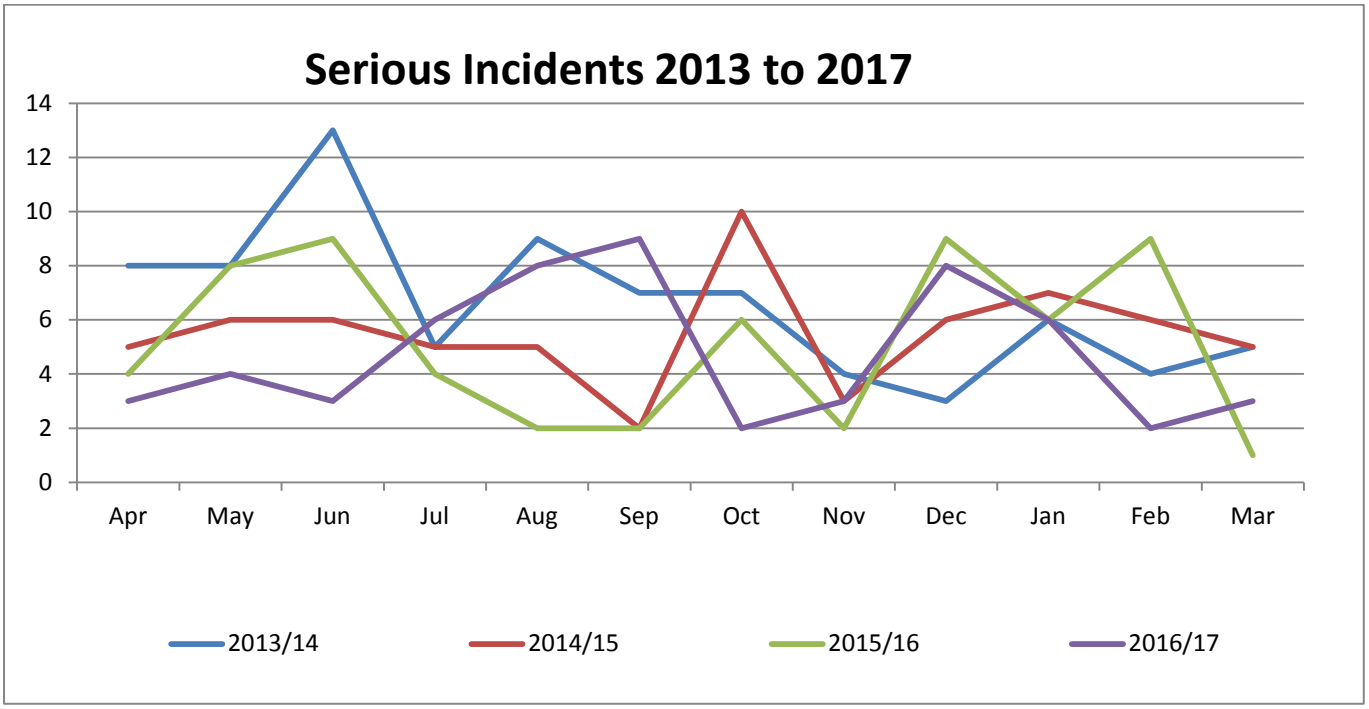
During the reporting period we submitted completed investigation reports to our commissioners within 60 working days. Extensions to the time frames were agreed when required and therefore 100% of all investigations were submitted within agreed timescales.

During 2016/17 the CQC reviewed the trust processes relating to Serious Incidents and found these to be robust and transparent. The CQC were satisfied that the trust was proactive in managing SI processes which it does through a series of reporting mechanisms. In addition, external data and reports are shared with the monthly Clinical Quality Review Meeting chaired by commissioners. Whilst the directorates are members of the internal corporate governance forums, the directorate governance leads are also responsible for ensuring that service user safety is an agenda item at directorate meetings.

4. Incidents reported 1st April 2016 to 31st March 2017.

During 2016/17 the trust reported and investigated 57 serious incidents. This is a 10% reduction when compared to the 62 SIs reported and investigated during 2015/16.

The reporting of SIs from 2013 to 2017 is shown in graph 1 below. There are no trends by month or by season.



4.1 Increase in unexpected/potentially avoidable deaths

During Quarter 2 (Q2) 2016/17, the Head of Patient Safety identified an increase in unexpected/potentially avoidable deaths; initial investigations of the unexpected deaths resulted in no causal factors being identified. However a number of recommendations were made in recognition of the need to improve identification of those service users with a dual diagnosis and the subsequent care that they receive.

The initial investigation also showed that the highest number of unexpected deaths (6) occurred within the locality of the Greenfield's Centre. For the same reporting period in 2015 (i.e. Q2) there was 1 unexpected death in this locality. It was this information that prompted the Medical Director to commission a thematic review in order to determine any possible linking factors. The thematic review focused on 11 unexpected deaths within the locality of Greenfield's over a 9 month period (April – December 2016).

These reports and the action plan from the Greenfields review were submitted to Quality Committee and Trust Board. The themes from a multidisciplinary review of the incidents showed some inconsistencies in

care and process but as with the SI investigations there were no causative factors in cases reviewed. An overarching action plan was developed and implemented which aimed to bring together all the SI action plans and to ensure sharing of learning across the whole directorate and the wider trust. The lessons learnt are identified and discussed in section 7 of this report.

4.2 Never Events

A Never Event is defined as 'a serious, largely preventable patient safety incident that should never occur if available preventable measures have been implemented by healthcare providers.[2]

During this reporting period, April 2016 to March 2017, we did not have a Never Event.

5.0 Serious Incidents by Category

SIs are categorised using the definitions provided by the Strategic Executive Information System (StEIS) held by NHS England**.**

Table 1 below provides an overview by category of the SIs reported by the trust during 2016/17.

	Qtr 1	**Qtr 2**	**Qtr 3**	**Qtr 4**	**Total (YTD) 16/17**
Homicide by Outpatient (in receipt)	0	0	0	0	**0**
Slip Trip Fall	2	0	1	2	**5**
Pending review - unexpected/potentially avoidable death	0	10	7	6	**23**
Apparent/actual/suspected self-inflicted harm meeting SI criteria (non-fatal)	0	1	1	1	**3**
Disruptive aggressive behaviour meeting SI criteria	1	0	0	0	**1**
Apparent/actual/suspected self-inflicted harm meeting SI criteria (suspected suicide)	7	11	4	2	**24**
Unexpected/potentially avoidable injury causing harm	0	1	0	0	**1**
Total	10	23	13	11	**57**

The highest number of SIs (47) relate to unexpected/potentially avoidable deaths. These include those categorised as 'pending review' and self-harm (suspected suicide). The method of self-inflicted harm in incidents of suspected suicide may provide some indicator of suicidal intent. This is reported as apparent/actual/suspected self- inflicted harm however the final determination of suicide is made by HM Coroner.

The trust has recognised the need to strengthen the way we support bereaved families immediately following an unexpected death, as well as during and after the inquest process. To address this, the trust has reviewed the SI Policy. Moving forward the Heads of Directorates and the Clinical Directors will complete training to support the implementation of the policy.

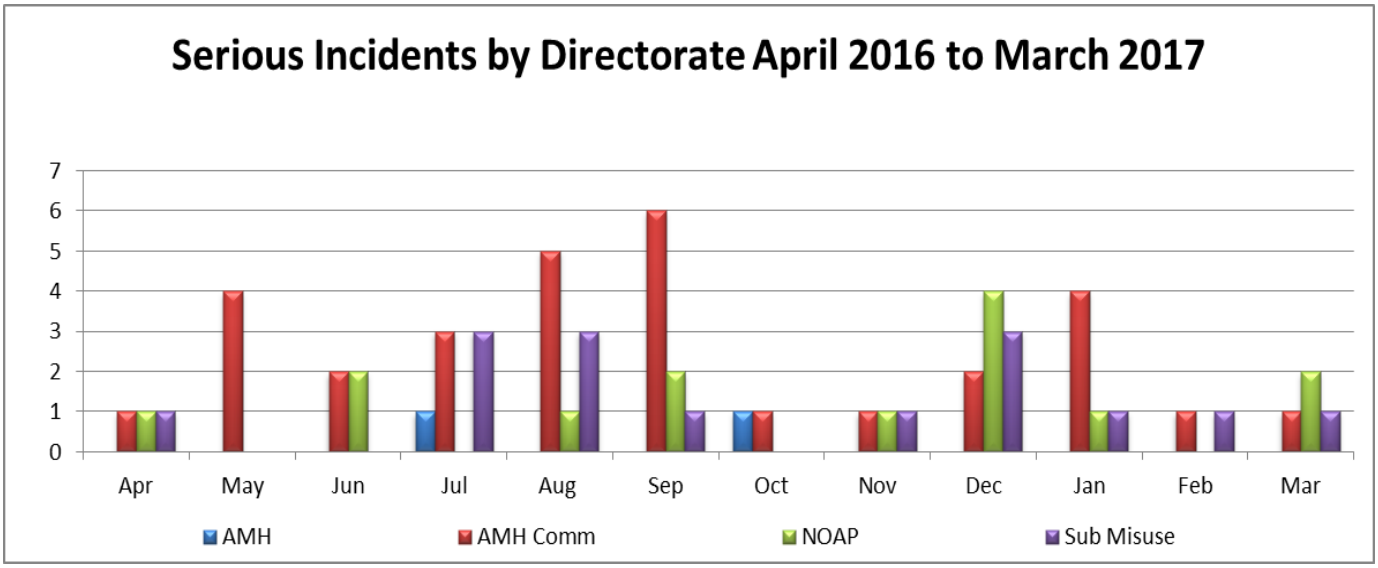
[2] NHS England. The never events list update 2015-16

In all reported SIs the trust undertakes a thorough investigation, using the recognised framework of Root Cause Analysis (RCA) which supports staff in the exploration of the care provided/service delivery to each individual.

In terms of overall SIs during 2016/17, there are no themes or trends to note by team, directorate or season. Incident investigations showed incidental findings by person or process, none of which were causal links to incidents. Actions plans were developed and implemented across teams, directorates and the trust. Additionally examples of good practice were identified by the investigating officers.

6.0 Serious Incidents by Directorate

The table below demonstrates the number of SIs which occurred in each directorate during 2016/17.



The chart above shows that the Adult Community Directorate had the highest number of incidents during 2016/17, with a marked increase during Q2. This has been discussed in section 4.1

There have been no SIs reported in the Children's and Young People's Directorate or the Learning Disabilities Directorate during this period.

Table 3 below shows the number of SIs by directorate over the last two years.

2015/16		2016/17	
Substance Misuse	17	Substance Misuse	14
AMH- Community	23	AMH- Community	28
NOAP	10	NOAP	13
AMH-In Patient	5*	AMH-In Patient	1
CYP	1	CYP	0

This comparison of the last two years shows that the highest number of incidents is recorded in the Adult Community Directorate.

In the Adult Mental Health In-Patient Directorate, there has been one death as a result of a self-harm incident during 2016/17. An external review was commissioned by the Trust in relation to this SI and from the investigation an action plan has been developed and implemented. This has been submitted to the Trust commissioners in May 2017.

The table shows that during 2015/16 year there were 5 serious incidents* in the Adult In-Patient Directorate. However due to changes in the reporting categories in the national SI Framework if the same

incidents were to occur again, the trust would be expected to report 1 incident only; therefore these years would be comparable in terms of the number of serious incidents within AMH –inpatients (i.e. one in each year).

The total number of serious incidents for 2016/17 is comparable with the previous 12 months; however the incident category breakdown for 2016/17 shows an increase in the number of unexpected deaths investigated by the trust across the Adult Community and NOAP directorates. As previously discussed no themes or trends were found in relation to these. There was a reduction in the number of unexpected deaths in the Substance Misuse Directorate.

It should be noted that not all SI investigations relate to unexpected deaths. In the NOAP directorate, there were 4 incidents where individuals sustained fractures due to falls and one person who sadly later died after a fracture which resulted from a fall. In response to this the clinical teams reviewed the falls policy and practice guidelines in order to improve clinical practice. New guidance was issued and training delivered to support staff in the assessment and care of people at risk of falling. An initiative to provide a physiotherapy assessment all newly admitted patients on to ward 6 was piloted. As a result of this, increased physiotherapy input has been implemented across all the NOAP wards.

7.0 Lessons Learnt

Professor Don Berwick made a set of recommendations, following a review of patient safety in England in response to the Francis Inquiry report February 2013 (A Promise to Learn: A Commitment to Act - August 2013)

- Recommendation 1: The NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning.
- Recommendation 2: All leaders should place quality of care and patient safety at the top of their priorities for investment, inquiry, improvement, regular reporting encouragement and support.
- Recommendation 7: Transparency should be complete, timely and unequivocal. We know from the considerable body of research into patient safety that fear of blame may deter staff from reporting an incident or near miss event.

In recognition of the Berwick recommendations, the trust recognises the need to continually improve the safety of services that we provide to our patients and their families, to reduce avoidable harm. It is important that we learn from incidents and take action to prevent future harm. The trust supports the view that the response to incidents should not be one of blame and recrimination but of organisational learning and improvement. The trust aims to encourage staff in participation in the process of improving service delivery and safety. This is done through improved participation in the investigative process and through the Learning Lessons framework. The Learning Lessons framework is an innovation of the Patient and Organisation Safety Team and has been well received by the trust clinicians. The framework has also been presented at a regional SI network event hosted by NHS England. As a result of this presentation, the team has received several visits from patient safety teams across the West Midlands who are interested in this model of sharing learning. Furthermore learning from investigations is not restricted to events that happen within the organisation. As part of Local Health Economy, we have participated in two multi-agency learning forums, which allowed for learning to be shared from incidents involving staff from different organisations (clinical teams/social care teams/police services etc.).This is with the aim of improving the quality of the patient journey across organisational boundaries and increasing staff understanding of the role, skills and knowledge of the partner agencies.

7.1 Thematic review lessons

As previously stated the largest number of incidents occurred in the Adult Community Directorate and this was subject to an initial investigation and followed by a thematic review of the Greenfield's centre.

The reviews highlighted some areas for improvement even though no causal link was made to the incidents. The areas for improvement included:

- Strengthen team approach in supporting service users with Dual Diagnosis: A review of the investigations revealed a need to improve staff knowledge and skills in relation to the identification of substance misuse issues with people experiencing mental health problems, in order to ensure that timely referrals are made. As a result of this additional training sessions have been planned to improve staff skills.
- Improve communication with families: The investigations showed that there is a need to improve communication with those family members who are identified by service users as providing 'protective factors' against actions of self-harm. There is a need to ensure that the individuals identified are aware of the beliefs of the service user and to consider their understanding of the situation; there is also a need to consider the implications of 'protective factors' when children are identified as being protective factors against a person's thoughts of suicide. There is planned review of policy which will identify required support for clinical teams to improve general communication with families with regards to information that can be shared. However a Standard Operational Procedure (SOP) has been developed and implemented by the clinical team leaders in order to immediately address the learning from the review.
- Strengthen our communication around follow up plans after discharge: There is a need to ensure that all staff implement the discharge policy with particular regard to the seven day face-to-face follow-up appointments. This information has been included within the SOP and cascaded to all community and inpatient clinical teams.

7.2 Further lessons learnt themes

As with the thematic review, we take the opportunity to learn from incidents and themes which may emerge from all serious incident investigations. In order to address all of the learning identified, the Adult Mental Health from SI investigation clinical team leaders produced an overarching action plan, which took into account all of the actions from multiple SI investigations. The broad themes of the action plan are listed below and the actions have been implemented through the SOP:

7.2.1Documentation: Documentation, the written evidence of assessment and communication, is a vital component of healthcare provision. Issues were identified in a number of areas which are detailed below:

- Documentation of discussion between clinical teams/practitioners: A need was identified, to ensure accurate recording of conversations in order to improve clarity for those clinicians not present at MDT discussions. There is now an improved handover process in place.
- Documentation of risk assessments and care plans: As previously stated, training and supervision for staff in the co-production of timely risk assessments and care plans has been implemented.
- The use of 'opt in' letters for people who fail to attend for appointments: This practice was discontinued by all community teams in order to ensure that people are contacted and an initial assessment completed following referral to services.
- Recording of urgent telephone messages in the clinical records: In order to improve communication, all telephone conversations are now recorded in the electronic patient notes. This aims to aid communication between duty professional staff and care coordinators/clinical teams in order to ensure that information is timely and available to all practitioners.

7.2.2 Communication

- Involvement of families and carers and obtaining consent to share information: A need was identified to ensure that families and carers are fully involved in the support of service users through

the sharing of information, as agreed by the service user. This was reinforced in the care planning and risk assessment training.

- Interagency information sharing: Partnership working across the local health economy involves the sharing of information when it is right and appropriate to do so. Improving staff awareness of the process promotes the sharing of good practice and aims to minimise service user risks to self and others. Again this was reinforced in the care planning and risk assessment training.

7.2.3 Clinical Education

- Clinical risk assessment and care planning: Additional training has been delivered, to ensure that all staff provide robust risk assessment and care planning. As a result all clinicians are able to access the most up-to-date information when delivering patient centred care.

8.0 Duty of Candour

The Francis Inquiry report into Mid Staffordshire NHS Foundation Trust made a clear recommendation that a statutory Duty of Candour be introduced for health and social care providers. The introduction of Regulation 20 of the Health and Social Care Act 2008 is a direct response to this recommendation.

Candour is defined in Robert Francis' report as: "The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made."

The trust's operating principles are contained within the Trust Policy, 'Being Open (including Duty of Candour)'. This policy provides Trust staff with guidance as to their roles and responsibilities in relation to this statutory duty.

In order to support the implementation of this policy, a series of initiatives, (detailed below) have been delivered to raise staff awareness and embed practice. These initiatives form part of an on-going programme of education for all employees and are facilitated by the Patient and Organisational Safety Team.

- Inclusion of Duty of Candour awareness within the Trust mandatory training curriculum.
- A series of workshops, using the "Learning Lessons" forum to discuss the duty and to set out responsibilities.
- Awareness sessions in individual clinical teams.
- Inclusion in the Trust Preceptorship programme.
- Inclusion in the Student Nurse learning programme.
- Training sessions facilitated for Governance Leads to support their quality and safety role within clinical directorates.
- An Open Learning Event in which the Trust Solicitors, Mills and Reeve facilitated a workshop setting out the requirements and responsibilities.

The Patient and Organisational Safety Team has oversight responsibility in determining patient safety incidents that may meet the criteria for the Duty of Candour requirements. The team provide alerts to clinical teams and support clinicians in meeting their responsibilities in relation to this.

During 2016/17 there has been no SIs which meet the reporting criteria for Duty of Candour.

9.0 National Confidential Inquiry into Suicide and Homicide in Mental Health.

In October 2016, the latest National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) was published. This report by the University of Manchester uses data from across the UK for the period 2004-2014. This year the report also looked back on the last 20 years, providing analysis of

the data collected and previous reports in an attempt to draw on lessons learnt and changes to the way in which mental health providers manage risk. The trust was able to use this report as a benchmark against our own data. Nationally, the number of people who die by suicide has risen across the whole of the reporting period. However the percentage of patient suicides has fallen; this is due to an increase in the number of people who access mental health services. The number of mental health patients who die by suicide remains high with 28% of all suicides known to community mental health services.

The latest Public Health figures for 2013-15 show that against a national (England) figure of 10.1 per 100,000, Stoke-on-Trent has 10.5 and Staffordshire has 10.4 suicides per 100,000 population. It should be noted that the Stoke-on-Trent figure is separate from the Staffordshire figure and that North Staffordshire cannot be separated from the overall Staffordshire figure. Previous data in 2010-14 showed that Stoke-on-Trent in particular had a higher than national figure for suicide and was approximately 30% above the national average; these latest figures show that the rate has reduced. However the suicides rates in men in both Staffordshire (16.2) and Stoke-on-Trent (17.7) remains higher than the England figure of 15.8 per 100,000. This data results from HM Coroner determined suicides and therefore relates to all suicides. This means that from this data it is not possible to determine the number of people who died by suicide who were in receipt of secondary mental health services. Before 2015 the trust did not collect any data in relation to the outcome of the inquests people known to services. Therefore we are unable to reach any conclusion in respect of services offered by the trust in relation to the effectiveness of any suicide preventative measures taken with our service users. In future annual reports this information will be collated and analysed. We continue to work in partnership with our local Public Health department in implementing the Staffordshire Suicide strategy.

Nationally suicide by mental health in-patients continues to fall, with a decrease of 60% between 2004 and 2014. This fall is largely accredited to the removal of ligature anchorage points in in-patient areas and a subsequent decrease in deaths by hanging. Our trust has developed an action plan to address the issues identified in the annual environmental ligature risk assessment regarding ligature anchorage points. The action plans are monitored by the Health and Safety and Well-Being group which reports to the Quality Committee. In 2015/16, 8% of all ligature attempts involved an anchorage point however in 2016/17 the number of ligature attempts using an anchorage point has fallen to less than 1%. Nevertheless trust staff remain vigilant to the possibility of people identifying new ligature anchorage points and so we have introduced ‘ligature walkarounds’ for all staff during ward/unit inductions. These introductions aim to highlight known potential risk areas for new staff and allow existing staff the opportunity to reconsider inpatient environments.

A review of trust ligature incidents showed that people with a diagnosis of Emotionally Unstable Personality Disorder accounted for the majority of incidents. Therefore the development of a care pathway for people diagnosed with Personality Disorder was completed in 2016 and the Trust is currently in discussions with our commissioners with regards to how this may be implemented.

Over the duration of the time frame for the NCISH report, mental health services have seen the establishment and embedding of Crisis Resolution/Home Treatment teams (CRHT), providing an alternative to hospital admission. However the NCISH report identifies that three times as many people die by suicide whilst under the care of CRHTs than those who die in hospital. One third of people who die by suicide have been in receipt of CRHT care for less than one week and a further third have been discharged from hospital in the previous two weeks; nationally this raises concerns. It is pleasing to note that the NCISH findings are not repeated in our Acute Home Treatment service. In order to maintain this position, suicide prevention awareness is on-going with the AHT team and the in-patient teams regarding improving their understanding of suicide prevention and the risks associated with recent discharge from hospital.

10.0 Health Select Committee Report: National Suicide Prevention Strategy.

In 2012, the Government published a national suicide prevention strategy for England. The Health Committee, a select committee appointed by the House of Commons to examine the expenditure, administration and policy of the Department for Health reviewed the strategy and published their review findings December 2016. Following the review, a refreshed strategy was published in January 2017 in response to the Health Committee findings and recommendations.

The report concluded that the refreshed suicide prevention strategy must be underpinned by a clear implementation strategy, with strong national leadership, clear accountability, and regular and transparent external scrutiny and that a clear message from Government that suicide prevention plans are mandatory.

A trust suicide prevention strategy was presented to the Trust Board in March 2017. The strategy was developed in partnership with service user, carer and staff involvement and reflects the broader national and Staffordshire wide strategy action areas. The trust strategy reflects learning and improvement arising from the investigation of suicides.

An annual work plan was developed to ensure delivery of strategy objectives and will be monitored by the Quality Committee.

11.0 Summary of Trust progress during 2016/17

During 2016/17 the trust has continued to embed robust process in relation to serious incidents. This has included ensuring that the trust governance processes are fully understood by directorate team leaders and that sharing the learning from investigations retains a high profile within the trust.

Upon reviewing the SIs reported during 2016/17, there are areas where progress or organisational change has occurred which have a positive effect on the themes identified.

- Development and implementation of risk management and care planning training to improve clinical skills. The training sessions were well attended and a good practice guide for staff was developed, with each receiving very positive feedback from clinicians.
- Development and implementation of suicide prevention awareness sessions for clinical staff.
- Completion of the ‘Sign up to Safety’ action plan; the trust ‘signed up’ to the national safety campaign in 2015. During 2016/17 an action plan was developed and implemented to further embed a positive patient safety culture.

12.0 Recommendations

It is important that we understand and respond to issues and themes emerging from our SI investigations in order to reduce future harm.

In the next 12 months we will:

- Monitor, report and take action on areas for improvement identified through investigations.
- Continue to contribute to the trust understanding of patient safety to improve delivery of our services.
- Strengthen the contribution of the Patient and Organisational Safety Team in the directorate quality meetings, to support wider clinical engagement of patient safety issues and to continue the work of the 2015 to 2017 safety culture CQUINs.

End of report

June JW/SS

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REPORT TO (Trust Board)

ENCLOSURE 7

Date of Meeting:	13 July 2017		
Title of Report:	Quality Account 2016/17		
Presented by:	Dr Buki Adeyemo		
Author:	Sandra Storey AD MACE		
Executive Lead Name:	Dr Buki Adeyemo	Approved by Exec	☒

Executive Summary:	Purpose of report	
➢ The Quality Committee has delegated authority on behalf of the Trust Board to approve the Quality Account. The Quality Account 2016/17 was approved by the Quality Committee at its meeting on the 22 June 2017. ➢ The report identified the quality achievements for 2016/17 and quality priorities for 2017/18. The report was endorsed by key stakeholders including commissioners for Stoke and commissioners for Staffordshire, Healthwatch Stoke and Healthwatch Staffordshire, Stoke Overview and Scrutiny Committee and external auditors Ernest & Young LLP, as a true and accurate reflection of the Trust's performance and for its presentation. The Trust was particularly commended for the progress made and achievement of its quality priorities. ➢ The Quality Account was uploaded to NHS Choices meeting the publication deadline of the 30 June 2017 which also fulfilled the statutory duty of sending a copy of the Quality Account to the Secretary of State.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	Execs	Document Version No.	
Committee Approval / Review	• Quality Committee • Audit Committee		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement. ☐ 2. To provide the highest quality services ☐ 3. Create a learning culture to continually improve. ☐ 4. Encourage, inspire and implement research & innovation at all levels. ☐ 5. Maximise and use our resources intelligently and efficiently. ☐ 6. Attract and inspire the best people to work here. ☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	Failure to meet statutory requirement to produce a Quality Account and publish by 30 June 2017		
Resource Implications: Funding Source:	N/A		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	None known		
Recommendations:	To receive for information and assurance purposes		

Towards Outstanding
Our quality journey

NHS
North Staffordshire
Combined Healthcare
NHS Trust

Quality Account 2016/17

Contents

Chair and Chief Executive's Message

We are delighted to introduce this year's Quality Report, to look back with pride on a year of significant success and achievement, to look forward with excitement to the developments we are leading in our own services and our own people, and to celebrate our developing partnerships with health and care colleagues across Staffordshire and Stoke-on-Trent.

Care Quality Commission

In September, following a full inspection, we were delighted that the Care Quality Commission rated Combined Healthcare NHS Trust as a Good Organisation - with 10 out of 11 of our services rated as'Good' or 'Outstanding'.

We were also honoured to be told that they consider us to be the fastest improving mental health trust in the country.

This is a remarkable achievement and is a testament to our excellent staff, described by the CQC as "throughout the inspection, caring, empathetic and considerate towards patients".

It is, we believe, a fair and powerful endorsement of the improvements in outcomes, effectiveness, safety and leadership that Combined Healthcare has achieved as a result of our determined and thorough improvement journey that we commenced over three years ago.

We are immensely proud of the CQC findings. The only service the CQC found to be requiring improvement out of 11 services was our community services for children and young people who had made considerable improvements following an improvement programme since our first inspection 12 months previously.

Our key achievements

This Report sets out what we believe to be amongst our key achievements in improving the quality of our services. These include:

- being informed by the Care Quality Commission that they consider us to be amongst the fastest improving mental health trusts in the country;
- being named in a recent annual report on the use of IAPT services as one of the top performing CCGs for recovery with 56.7% of people being referred to the service moving to recovery last year. This work has been recognised by the Health Education West Midlands with the Leading for Service Improvement and Innovation Award and the Team Outstanding Achievement Award.
- our dementia diagnostic rate for people aged over 65 living in Stoke on Trent rated the highest at 87.9% in the West Midlands. This achievement is among the best nationally as identified by NHS England compared to National average of 67%
- our Growthpoint service chosen as a finalist in the Team Outstanding Achievement Award in the Health Education West Midlands Regional Leadership Recognition Awards. This team has supported dozens of service users in their recovery with a number having gone on to become self-employed or finding work with a local employer;
- officially recognised as the highest performing mental health trust for flu vaccination of front line staff, surpassing the national target of 75% achieving 79.7%.

Our key priorities

We continue to be committed to providing high quality care for our service users and carers. We feel this is only achievable by maintaining our partnerships across the communities we serve. Our clinical services will deliver models of care and will reflect the needs of our service users and their experience of care. We will achieve this by having an on-going conversation with our service users and carers through a variety of both formal and informal feedback mechanisms.

We remain committed to working collaboratively with a range of partners and as such have again included 'three steps to engagement' in the development and publication of this Quality Account. This process included clear engagement in making the final choice of priorities for 2017/18, which were supported by stakeholders.

We set out how we plan to deliver our key priorities for improvement in the year to come.

Delivering leaderership and excellence for safe and high quality services

Delivering services that are safe and high quality is essential. And being seen to do so, in partnership with our service users and partner organisations across our communities is just as important. This Quality Report sets out the steps we have taken and the results obtained to continue to improve our services and our leadership.

We continue to promote new partnerships and new models of care. We are proud to play a leading role in a new alliance of health and care providers to design, deliver and transform NHS and council-led care services in North Staffordshire and Stoke-on-Trent. The new body is known as the "North Staffordshire and Stoke-on-Trent MCP Alliance". It is a bold initiative - drawing together leaders of hospital services, community services, GP practices and local government - to bring about radical improvements and new partnerships that deliver the best possible services to patients and their families. Patients, service users and the voluntary sector will have a powerful voice and influence over the decisions taken by the new body.

We continue to develop our strong and deepening partnership with the North Staffordshire GP Federation. This has included creating joint appointments between our own Executive Team and the Federation – including our new joint Director of Strategy and Development, Andrew Hughes and plans for further joint posts.

We are proud that our Medical Director chairs the West Midlands Medical Directors' Group.

Towards Outstanding

Being 'Good' is not the limit of our ambitions for Combined Healthcare.

During the year we refined our overall vision, to make it even more focused on what we want to achieve for ourselves and our service users. This refined vision is very clear, simple and determined - **"To be outstanding."**

Our Towards Outstanding improvement programme is centred on making this happen and to take us on our journey.

Our vision is underpinned by our quality SPAR priorities. These are to deliver services that are

- Safe
- Personalised
- Accessible
- Recovery-focused.

Our values make clear how we want to go about our business. These are to be "Proud to CARE" - being:

- Compassionate
- Approachable
- Responsible
- Excellent.

We have launched our Behaviours Framework, co-designed with our staff and service users - to ensure we live our values in all we do. The Behaviours Framework takes each of the four CARE values and provides examples of behaviours that would demonstrate that we are adhering to those values in our day to day working lives.

Strengthening the voice of service users

We continue to strengthen the voice and true partnership with people who use our services. We believe that if we are going to continue our journey of transformation we need to encourage real challenge from service users and enable them to work with us in our journey of improvement.

We are delighted that service users are participating in our recruitment and staff induction processes. Our Service User and Carer Council and our Children and Young People IAPT Youth Council are going from strength to strength. The Chair of the Service User and Carer Council is a member of our Board

This has informed the development of a service user engagement strategy. As part of our development of this strategy, we held a hugely successful Open Space Event, bringing together over 50 of our service users and carers to give us their views on:

- How we prioritise the specific approaches we take under our SPAR quality prorities; and
- How we can expand the ways in which service users and carers can get involved with the Trust.

Caroline Donovan
Chief Executive

Delivering the bottom line

Continuing to deliver services that are safe, personalised, accessible and recovery focused in a time of unprecedented financial challenge is a remarkable achievement. We are proud to have been able to achieve a financial surplus for the 18th consecutive year, something that puts us amongst the top financial performers in our region, delivering for taxpayers and the wider NHS economy as well as for our patients.

Hello to new faces

We have also been delighted to welcome onto our Board two new Non-Executive Directors, Joan Walley and Lorien Barber, who bring a wealth of experience from the political and parliamentary arenas and the voluntary sector. We also welcomed Andrew Hughes as our new Director of Strategy, following the departure of Tom Thornber, who leaves with our very best wishes.

David Rogers
Chair

Introduction

Welcome to our Trust

North Staffordshire Combined Healthcare NHS Trust was established in 1994 and provides mental health and learning disability care to people predominantly living in the city of Stoke-on- Trent and in North Staffordshire.

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

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

Our team of 1,285 whole time equivalent (WTE) staff are committed to providing high standards of quality and safe services

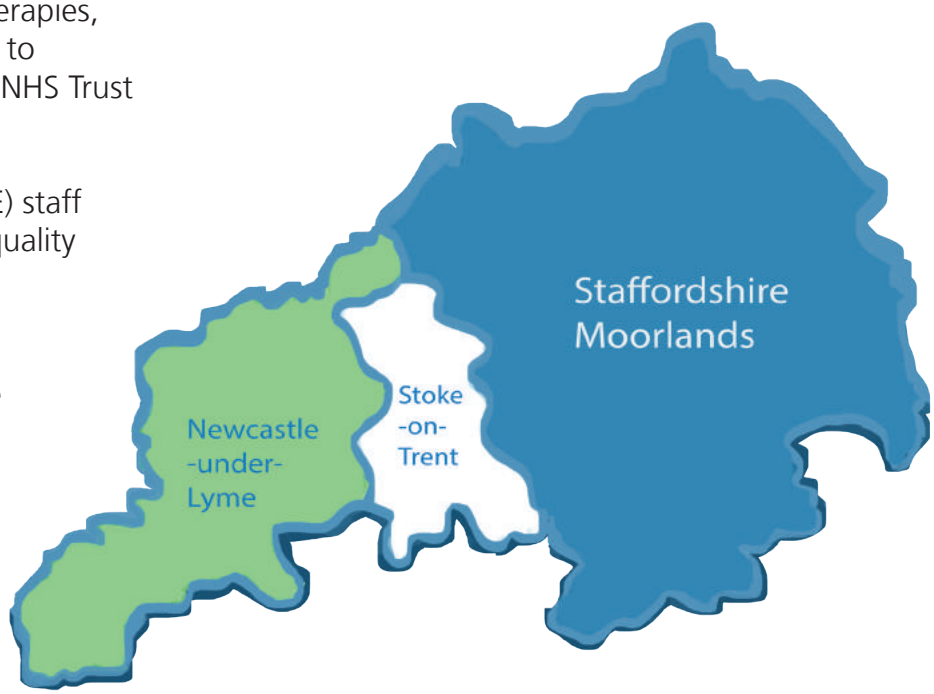
We also provide specialist mental health services such as Child and Adolescent Mental Health Services (CAMHS), substance misuse services and psychological therapies, plus a range of clinical and non-clinical services to support University Hospitals of North Midlands NHS Trust (UHNM).

Our team of 1,285 whole time equivalent (WTE) staff are committed to providing high standards of quality and safe services. We serve a population of approximately 464,000 people from a variety of diverse communities across Northern Staffordshire. The Trust's closing income for the year (2016/17) was £81.9m against a plan of £80.2m.

For 2016/17, our main NHS partners remain the two clinical commissioning groups (CCGs) – North Staffs CCG and Stoke-on-Trent CCG. We will also work very closely with the local authorities in these areas as we progress through 2017/18.

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

Further information regarding our purpose, vision and values is contained in the Trust's Annual Report, which provides an overarching summary of the Trust's services, performance and finances for 2016/17 and will be available on the Trust's website at www.combined.nhs.uk



Welcome to our Quality Account

Welcome to our latest Quality Account, which covers the financial year 2016/17 – 1 April 2016 to 31 March 2017.

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

In 2016/17, Independent Auditors, Ernst and Young, were appointed by the Audit Commission to provide an independent assurance engagement and a limited assurance report to the Directors of the Trust. As a result, based on the results of their procedures, they concluded that the 2016/17 Quality Account was presented in line with requirements of the Regulations.

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

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

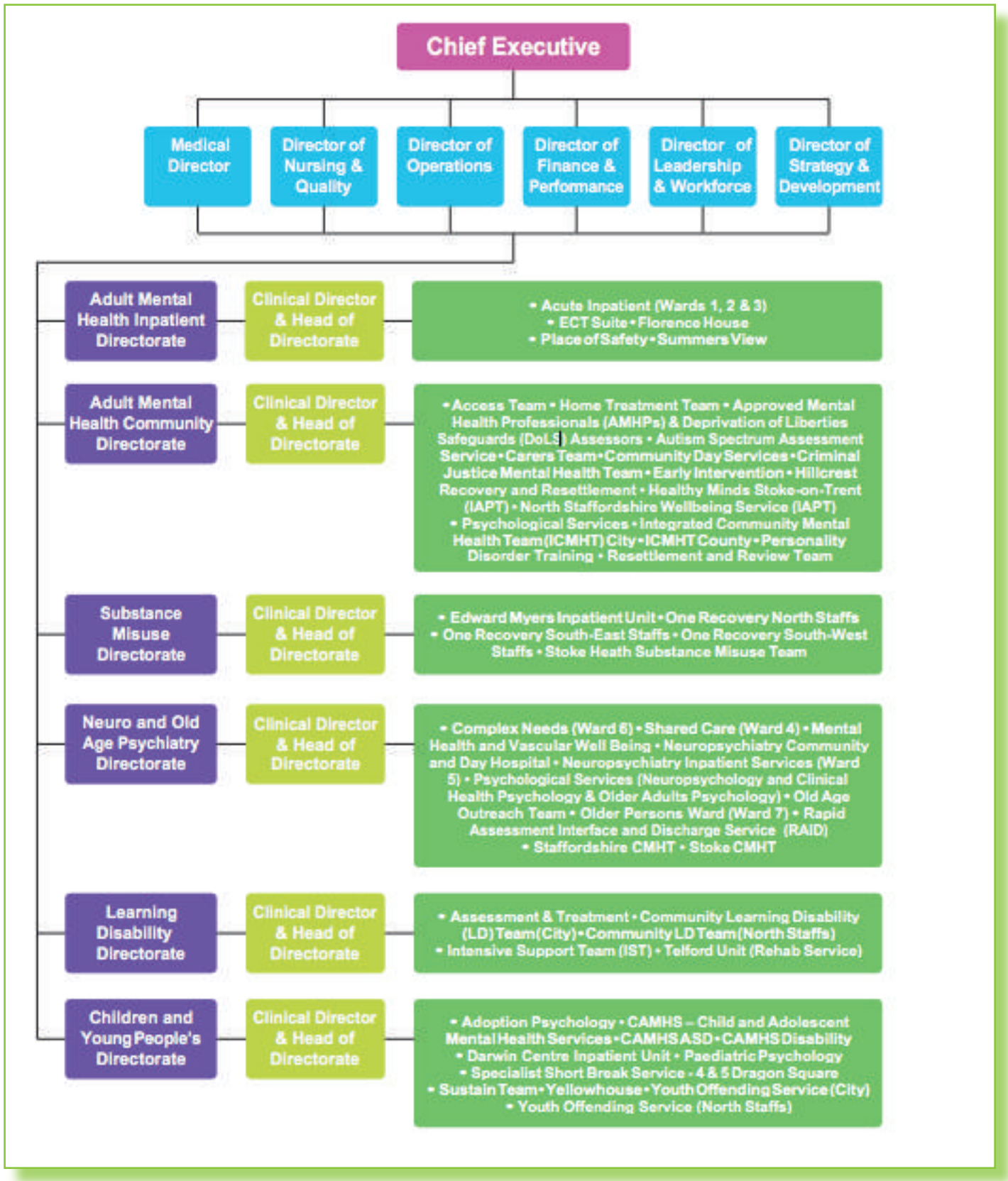
We hope that you find this Quality Account helpful in informing you about our work to date and our priorities to improve services over the coming year.

We also look forward to your feedback, which will assist us in improving the content and format of future Quality Accounts. This can be given through the Trust's website www.combined.nhs.uk or by email to qualityaccount@northstaffs.nhs.uk.

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

Services covered by this Quality Account

This Quality Account covers all six clinical directorates provided by the Trust. During the period from 1 April 2016 to 31 March 2017, the Trust provided or sub-contracted eight relevant health services (the Trust sub-contracts out to two non-NHS bodies in respect of improving access to psychological therapies (IAPT)). The core services we provide are shown below under our clinical structure.



Summary of key Quality Priorities

Quality Priorities

Our Quality priorities are aligned to the four strands of quality known as SPAR:

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

Details of 2016/17 performance against CQUIN metrics developed in line with these key priorities are given in Section 3.1.

Priorities 2017/18

- Ensure CQC core service rating is 'good' or 'outstanding'.
- Improved physical health monitoring.
- Implement our Suicide Prevention Strategy.
- Increase service user, carer and staff feedback to improve service improvement.
- Review of models of care and care pathways.

Detailed objectives have been developed in line with these key priorities, which are outlined in Section 2.2.

We also welcomed over 50 service users and carers to our first Open Space Event in March 2017 which provided an opportunity to give views on how we prioritise the specific approaches we take under our core SPAR priorities.

Strengthening staff engagement and team working through our continued involvement in the Listening into Action programme and Aston team-working model.

1.0 Statement on Quality

1.1 Our vision, values and objectives

The Trust's core purpose is to improve the mental health and wellbeing of our local population, some 470,000 people living across North Staffordshire and Stoke-on-Trent. Our strategic aim, as one of the main providers of care, is to develop enhanced and coordinated health and social care - as well as provide leadership and inspiration to others.

We strive to be recognised as a centre of excellence in both integrated and specialist care, bringing innovative solutions to the services we deliver and the strategies we develop, embedding a culture of continuous learning across our organisation, and supporting and inspiring others.

This is reflected in our vision, values and objectives. These guide not only how we deliver our services on a day to day basis, but also how we support and develop our people and our own organisation, how we manage and develop our partnerships and relationships with our service users, carers and families, as well as our external stakeholders across the local health and care economy.

Our vision and values

During 2016/17 we produced a refined statement of our vision which is **"To be Outstanding" - in all we do and how we do it.** We are on a journey towards that vision that we call "Towards Outstanding".

Our vision is underpinned by our SPAR Quality Priorities - to provide services that are safe, personalised, accessible and recovery focused. These guide all we do and are the benchmark against which we judge how we perform.

In delivering those services - as well as in all of our working relationships with service users, carers, families, stakeholders and each other, we are guided by our Proud to CARE Values - to be compassionate, approachable, responsible and excellent.

Our seven key objectives

We look to deliver our strategic aims and realise our vision by achieving seven key objectives:

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

1.2 Trust Care Quality Commission Comprehensive Inspection

We invited the CQC back to inspect our services following the first comprehensive inspection in September 2015 when we were rated as "Requires Improvement" overall. The September 2016 inspection found considerable improvements had been made and we were rated as "Good" overall.

Inspectors rated the care provided by staff to be "Good" following a review of whether services were effective, caring, responsive and well-led and rated it as Requires Improvement regarding whether services were safe.

Overall, 10 of the 11 core services were rated as either 'good' or 'outstanding'.

The CQC's Deputy Chief Inspector or Hospitals (and lead for mental health) Dr Paul Lelliott said:

"Since our inspections in 2015, the trust has made significant improvements to the quality of its care plans and risk assessments. Documentation consistently showed a collaborative approach to care that involved staff, patients, carers and families.

"Staff throughout the trust displayed a caring attitude towards people who used services. We saw several examples of staff showing kindness, empathy and putting peoples' needs first. Feedback from patients, carers and families was also very positive and staff ensured that delivery of care was carried out in a co-productive manner.

"The Trust board has become more settled and effective which helped to ensure governance systems were embedded.

"Nursing staff spoke very highly of the new substantive director of nursing.

"Staff told us that they now felt they had strong nursing leadership at a senior level in the organisation committed to clinical and leadership development".

The Report highlighted several areas of good practice including:

- ✓ The trust had done impressive work around deaf and hard of hearing patient groups particularly the Deaf Café, British sign language (BSL) training for staff and effectively addressing communication needs.
- ✓ The vascular wellbeing team manager had published a paper on the use of a camera for people with short term memory problems. They have since worked with the local clinical commissioning group (CCG) to incorporate the use of text messaging service and were working on an 'app' for patients with early onset dementia and mild cognitive impairment.
- ✓ The care home liaison team held multi-disciplinary meetings at five care homes. GPs and families reported that this worked well. The input of physiotherapy into care homes with patients at risks of falls had reduced hospital admissions.
- ✓ The community child and adolescent mental health services (CAMHS) had run a 'CAMHS in schools' project with special schools for the past 11 years. They had developed a pilot to introduce the model into mainstream schools.
- ✓ A military veteran's drop-in service had been established. Managers allocated one member of staff two days a week to develop this. It has succeeded quickly and, at the time of our inspection, had a caseload of 42 patients.

CQC Inspection Area Ratings
(Latest report published on 21 February 2017)

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

However, we do not remain complacent and there were areas highlighted to us for action including:

- Ensuring our rapid tranquillisation policy accurately reflects current prescribing guidance from national institute for health and care excellence (NICE) guidelines. Staff must record and have a consistent approach to the use of rapid tranquillisation as well as understanding its risks.

- Ensuring that our process of sending out monthly letters to young people on waiting lists from initial assessment to treatment is followed.

- Recording any prescribed medication that is given, omitted or refused on the patient's prescription charts.

- Ensuring young people are seen within 18 weeks from the point of referral.

To date, significant progress has been made, ensuring that actions identified are completed.

We will continue to monitor implementation and seek assurance that improvements to practice are made.

We are immensely proud of the CQC findings with 10 out of 11 core services rated as either good or outstanding. The only service the CQC found to be requiring improvement out of 11 services was our community services for children and young people who had made considerable improvements following an improvement programme since our first inspection 12 months previously.

The CQC report rated the Trust as "Requires Improvement" regarding whether services are safe, mainly due to improvements required to rapid tranquillisation policy and the need to improve the number of young people seen within 18 weeks of referral. The work to secure improvements has been undertaken, as we recognise that there are still improvements to be made in a minority of our services.

All core services have comprehensive improvement plans in place to address the areas noted in the CQC reports and to date significant progress has been made with many of the 'must' and 'should' do requirements being addressed and rated as 'complete' following a robust assurance process through our performance management arrangements.

Our biggest challenge was reducing the waiting times for our community CAMHS services. However, significant progress has been made and we are now meeting the national target of seeing everyone within 18 weeks for initial assessment with on-going monitoring of performance on a weekly basis. The CAMHS teams have monitoring measures in place to review young people who have been assessed and have introduced screening for the right intervention and if appropriate, sign posting to other services.

	Overall	Safe	Effective	Caring	Responsive	Well-led
Adult Inpatient	Good	Good	Good	Good	Requires Improvement	Good
CAMHS Community	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Good
CAMHS Wards	Good	Good	Good	Good	Good	Good
Adult Community	Good	Requires Improvement	Good	Good	Good	Good
Crisis	Good	Good	Good	Good	Good	Good
Community LD	Good	Good	Good	Good	Good	Good
LD Inpatient	Good	Good	Good	Good	Good	Good
Rehab	Good	Good	Good	Good	Good	Good
OP Community	Outstanding	Good	Good	Outstanding	Outstanding	Good
OP Inpatient	Good	Requires Improvement	Good	Good	Good	Good
Substance Misuse	Good	Good	Good	Good	Good	Good
Overall	Good	Requires Improvement	Good	Good	Good	Good

1.3 Quality of Services - Key Achievements

We have a lot to be proud of

We have a dedicated workforce, excellent feedback from our service users and have managed significant change over the past few years in line with local need as well as national policy. Our on-going commitment is delivering high standards of quality and safe services through engagement with service users and key partners.

Feedback from service users and carers:
The Trust enjoys close relationships with service users, carers, and the very well organised North Staffs Voice for Mental Health.

We are proud of the continued success of the Service and User Carer Council, the Chair of which is a member of the Trust Board

Key priorities for 2016/17

Commissioning for Quality and Innovation Scheme
Last year we aligned our plans for improving the quality of services under our quality priorities, SPAR, with the Commissioning for Quality and Innovation (CQUIN) scheme for 2016/17, which is a national framework for agreeing local quality improvement schemes and makes up a proportion of our total potential income from CCGs (2.5%). This is conditional on the achievement of ambitious quality improvement goals and innovations agreed between commissioner and provider with active clinical engagement.

We identified five priority areas that contribute to improved quality of care. Part 3.1 of this Quality Account provides a statement against each of the priority areas.

Against the CQUIN financial and performance framework, in total we achieved 100% of the schemes.

Key achievements at a glance

- The Trust improved its rating from "Requires Improvement" to "Good" following a CQC inspection of its services in September 2016 and was noted to be the fastest improving mental health trust in the country.
- Officially recognised as the highest performing mental health trust for flu vaccination of front line staff, surpassing the national target of 75% achieving 79.7%.
- Quality improvement given significant praise and recognition by our regulators, our service users and staff.
- Launched "Towards Outstanding", as part of our on-going journey of improvement.
- Launched our Leadership Academy to develop our staff in delivering high quality services.
- Created a joint appointment of Director of Strategy and Development with the GP Federation to further develop strong and effective partnership arrangements.
- Appointment of two new Non- Executive Directors bringing a wealth of experience from the parliamentary and voluntary sectors.
- The Trust has continued to implement a new Electronic Patient Record and its Digital by Choice Strategy, Raising our Service Excellence (ROSE, received endorsement from the Department of Health.
- We remain at CQC risk banding of level 1 (low risk).
- Launched our Behaviours Framework co-designed with service users and staff to ensure we live our values in all we do including "Go Engage" to develop a culture of continuous improvement towards greater staff engagement.
- Taking a lead role in the North Staffordshire and Stoke on Trent MCP Alliance to lead and transform health and social care services.
- A number of successful conferences and events held during 2016/17 including an Open Space event where more than 50 service users and carers gave us their views on our quality priorities.
- Led by the service user and carer Council we have expanded ways in which service users and carers get involved in the trust. Including the establishment of the Children and Young People's Council. They have been innovative in generating new ideas to get young people involved. Their role will continue to grow as our CAMHS service continues on it journey towards outstanding.
- For the first time the trust were the hosts of a nursing conference, held on the 12 May 2016, and attended by 145 nurses. The conference entitled 'Nursing at its Best @combined' was rated as a big success.
- Significant progress made by the Healthy Minds Stoke on Trent team in supporting service users towards recovery and improving access to psychological therapies (IAPT).
- An NHS Digital national report has shown they have achieved the 10th highest rate of recovery out of 211 CCG commissioned services across England in 2015/16.

More key achievements and good news stories

- ✓ In a recent annual report on the use of IAPT services, North Staffordshire was named as one of the top performing CCGs for recovery with 56.7% of people being referred to the service moving to recovery last year. This work has been recognised by the Health Education West Midlands with the Leading for Service Improvement and Innovation Award and the Team Outstanding Achievement Award.

- ✓ Growthpoint service chosen as a finalist in the Team Outstanding Achievement Award in the Health Education West Midlands Regional Leadership Recognition Awards. This team has supported dozens of service users in their recovery with a number having gone on to become self-employed or finding work with a local employer.

- ✓ Best Practice and successes in recovery focussed care was showcased in partnership with service users, Changes and Brighter Futures at our Recovery & Wellness Conference on 27 February 2017.

- ✓ Dementia diagnostic rate for people aged over 65 living in Stoke on Trent rated the highest at 87.9% in the West Midlands. This achievement is among the best nationally as identified by NHS England compared to National average of 67%. The work of the teams has been extremely positive for service users who can access help and support at an earlier stage.

- ✓ We have been shortlisted in the Academic Wales Award for Excellence in Organisational Development for the Leading with Compassion scheme whereby staff, patients and carers are able to recognise someone who they believe has demonstrated compassion.

- ✓ We have progressed our programme of joint quality monitoring visits with Commissioners and Healthwatch colleagues. The focus of the visits is to give Commissioners and Healthwatch an opportunity to feedback to the Trust that services are patient centred, safe, effective and responsive. This feedback supports the Trust's clinical governance and assurance processes and will be used to support the Trust's journey toward providing outstanding services.

- ✓ Introduction of unannounced monthly assurance visits to wards led by an executive director of the board, a non-executive director of the board, a service user/carer representative, peer manager and a member of the Trust's governance team. The visits are informed by team's quality performance and risk indicators, including opportunity for observations of good practice and areas for development.

- ✓ The achievement of our staff and teams recognised at a number of national and regional awards.

- ✓ Allied Health Professional (AHP) Conference was held on the 16 February 2017 promoting and celebrating range of skills, interventions and best practice provided by AHPs. Attendees also contributed to the development of a new Trust AHP Strategy.

1.4 Building Capacity and Capability

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

During 2016/17, the trust board has become more settled with an increase number of directors in substantive posts and this has helped to ensure that governance systems are embedded.

Our GP Associate Board members continued to support and strengthen the Board from a primary care perspective. The Chair/Vice Chair of our Service User and Carer Council continues to play a full part in both the open and closed board.

Workforce
We employ 1,285 (WTE) staff, with the majority providing professional healthcare directly to our service users.

We recognise that our workforce are our greatest asset and continue to develop our staff and the culture within which they work, to enhance our service user's experience, improve performance and increase morale.

Our People and Culture Development Committee meets at least six times a year and has a transformational approach to the workforce agenda.

We focus on:

- **Cultural Development:** Fostering a positive culture that supports health and wellbeing is of great importance. Significant progress has been made this year by focusing on a variety of Health and Wellbeing initiatives for our staff including: healthy eating education, our winter flu fighter campaign and our "Feel Good Friday" and "Wellbeing Wednesday" sessions.

  This initiative has encompassed a wide variety of Health and Wellbeing topics including Staff Counselling services, Occupational Health surveillance Checks, Staff Side advice and HR workshops. This initiative has been extremely well received with many staff reporting taking positive actions to improve their health and wellbeing. Such initiatives demonstrate our commitment to supporting a healthy workforce.

- **Team working and team leadership:** Prioritising development of team working and team leadership across the organisation through the continued rollout of the Aston Team Leadership Programme. Over 170 Managers, Team Leaders and Deputies have undertaken this evidence-based programme which comprises five workshops and an online set of materials to support team leaders implementing the best possible team working practices.

  The evidence shows that by working in this way there are productivity, patient experience and staff wellbeing benefits. We aim to increase the number of our staff who feel that they are part of a 'real' team and as a consequence to increase our relative position on the staff survey in relation to team working indicators.

- **Proactive stress management and resilience approach:** Through our Staff Counselling and Support service, we provide a vast range of services including preventative and responsive mechanisms of support.

  In supporting increased resilience, the service works to identify stress flash points and provide debrief sessions for staff following incidents.

- **Leadership and management development:** Our People Management Programme – a modular scheme that develops managers in multiple aspects of their management competency and participation in the Leadership Academy development programmes.

- **Mentoring / Coaching / 360 Degree appraisal:** The Trust has introduced and begun to embed the Healthcare Leadership Model into leadership training programmes and is using the associated 360 degree feedback tool to help managers and leaders to receive feedback on their leadership strengths and development areas.

  We are further developing our internal mentor resources to help grow leadership capacity and capability and to support leaders at all stages of their development. We are committed to encouraging our leaders at all levels to participate in coaching conversations, utilising internal and external coaches as appropriate to their role. This approach engages our leaders in finding their own solutions to the issues they address and offers a supportive but challenging environment for them to think and explore options available to them.

- **Apprenticeships:** 2016/17 has been a year to prepare for the implementation of the apprentice levy which comes into force in April 2017. We have networked with partner NHS Trusts within the health economy and regionally to develop knowledge about apprenticeships and provide support across the sector. In 2016/17 we had 6 new apprentices start, comprising of 4 newly recruited apprentices and 2 existing members of staff undertaking apprentice qualifications, with 13 apprentices in total on the programme at the end of March 2017. We are delighted that one of our apprentices was highly commended in the Non Clinical category of the Health Education England West Midlands Apprentice Recognition Awards 2017.

- **Care Certificate**: The Healthcare Support Worker Programme assists provides a development pathway for all support workers across the organisation. We have implemented the introduction of the Care Certificate for new staff in bands 1-4 who have no previous experience of health or social care and our existing five-day foundation programme will be converted to align with the requirements of the Care Certificate in the near future.

- **Staff engagement:** We have embedded the NHS Constitution and have developed and enhanced our own values in relation to staff engagement, reinforced through Team Charters, the Aston Team journey, the personal development and review process, our recruitment and induction processes and development of our Trust behaviours framework.

We acknowledge and reward staff through our annual Recognising Excellence and Achievement in Combined Healthcare (REACH) Awards and 'spotlight' the efforts of an individual and a team at our public Trust Board meetings. Nationally we have been nominated for two Healthcare People Management Association (HPMA) Awards.

- Our Feel Good Friday health and wellbeing initiative has been chosen as a finalist in the Social Partnership Forum Award for partnership working. This initiative enables staff to receive information and advice on a range of health and wellbeing aspects.
- We have also been shortlisted in the Academic Wales Award for Excellence in Organisational Development for the Leading with Compassion scheme whereby staff, patients and carers are able to recognise someone who they believe has demonstrated compassion.

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

The National NHS Staff Survey provides us with an annual opportunity both to monitor changes in what it feels like to work for the Trust over time and to benchmark against other mental health trusts.

The Staff Friends and Family Test, which is undertaken on quarterly basis, provides further important comparative analysis. Research shows that trusts with stronger staff recommendation scores are also found to have stronger outcomes in terms of quality of patient care and experience.

Members of the Executive Team also visit teams on a monthly basis for informal Q&A sessions, giving staff an opportunity to share in successes in their services as well as discussing challenges with an executive. This has proven to be a great way of developing two-way conversations and empowering staff to raise issues of concern.

Developing a culture of continuous improvement towards greater staff engagement will be enhanced by adopting the Go Engage programme. This bespoke evidence based approach which is due to be implemented in 2017, provides data at team level to highlight areas for local cultural improvement and has been found to be three times more effective than improving culture at a trust wide level.

Better use of information

The Trust has continued its "Digital by Choice" strategy (Information Management and Technology) during 2016/17 and is underway with the implementation of a new Electronic Patient Record (EPR) under the Raising Our Service Excellence (ROSE) programme. The Lorenzo (EPR) systems will support staff in accessing clinical information more efficiently.

Historic paper records continue to be scanned and added to the electronic system throughout the year. The Trust is working with local health economy partners as part of the Digital workstream within the Staffordshire STP programme and is actively involved in the development of an Integrated Care Record (ICR) and the implementation of a Technology Enabled Care Service (TECS) programme of work.

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

The Trust is continuing it's IT hardware replacement programme for all devices over five years old and has installed Wi-Fi for staff, patients and guests across all Trust-owned sites.

1.5 Quality of Services - Key Priorities 2017/18

We continue to be committed to providing high quality care for our service users and carers. We feel this is only achievable by maintaining our partnerships across the communities we serve. Our clinical services will deliver models of care and will reflect the needs of our service users and their experience of care. We will achieve this by having an on-going conversation with our service users and carers through a variety of both formal and informal feedback mechanisms.

We remain committed to working collaboratively with a range of partners and as such have again included 'three steps to engagement' in the development and publication of this Quality Account, as outlined in Section 3.3. This process included (at step 2) clear engagement in making the final choice of priorities for 2017/18, which were supported by stakeholders.

We will commit to building on our quality systems and learning from CQC inspections to ensure a continuous programme of improvement.

Following the September 2016 CQC inspection we have continued to review areas for improvement through the on-going development of comprehensive action plans and will work in partnership with the CQC, service users, carers and other key stakeholders to implement and sustain improvements.

Strong clinical leadership is critical to the successful completion of our quality objectives and influencing / leading desired changes in our quality and safety culture. To achieve successful and sustainable quality improvement changes, staff have to be engaged in the process. We have a quality strategy and workforce strategy with leadership initiatives such as staff engagement, clinical supervision, staffing and recruitment, thus ensuring staff are supported and engaged to deliver high quality care.

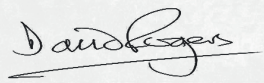
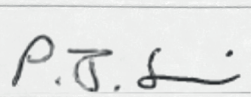
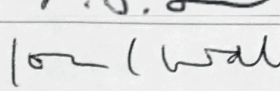
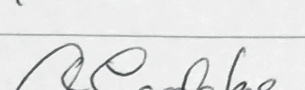
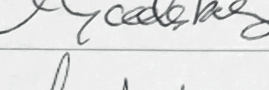
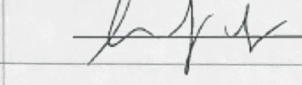
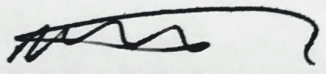
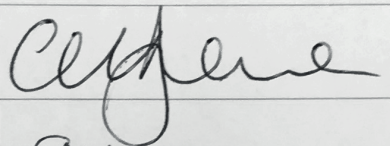
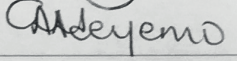
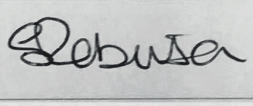
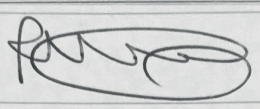
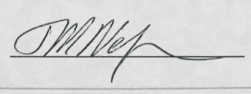
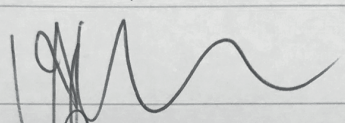
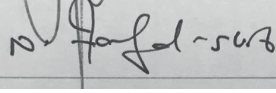
1.6 Trust Statement

We are pleased to publish this Quality Account for the financial year 2016/17, i.e. 1 April 2016 to 31 March 2017. It re-confirms our commitment to continually drive improvements in services and to remain transparent and accountable to the general public, patients, commissioners, key stakeholders and those that regulate our services.

To ensure our Quality Account covers the priority areas important to local people, we have consulted with our key stakeholders in the voluntary and statutory sectors, with local authorities and with our staff. Their valuable comments have been listened to and, where appropriate, have been incorporated into this document to help strengthen involvement in our services going forwards.

In line with the recommendation of the Francis Inquiry, this Quality Account is signed by all Trust Board members to provide assurance that this is a true and accurate account of the quality of services provided by North Staffordshire Combined Healthcare NHS Trust.

We can confirm that we have seen the Quality Account, that we are happy with the accuracy of the data reported, are aware of the quality of the NHS services provided and understand where the Trust needs to improve the services it delivers.

David Rogers, Chairman		28/6/17
Patrick Sullivan, Non-Executive Director		28/6/17
Joan Walley, Non-Executive Director		23/6/17.
Tony Gadsby, Non-Executive Director		23/6/17
Lorien Barber, Non-Executive Director		28/6/17
Bridget Johnson, Non-Executive Director		23/6/17
Dr Keith Tattum, GP Associate		27.6.17.
Caroline Donovan, Chief Executive		28.6.17.
Dr Buki Adeyemo, Executive Medical Director		23/6/17
Suzanne Robinson, Executive Director of Finance and Performance		23.6.17
Paul Draycott, Executive Director of Leadership and Workforce		28/6/17
Maria Nelligan, Executive Director of Nursing and Quality		28/6/17
Andrew Hughes, Interim Joint Director of Strategy and Development		23 June 2017
Dr Nasreen Fazal-Short Acting Director of Operations		23/6/17

1.7 Statement of Directors' responsibilities in respect of the Quality Account

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

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

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

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

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

2.1 Plans for improvement

Engaging our partners and stakeholders – 'Three steps to engagement'

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

Performance quality monitoring framework

This Quality Account is underpinned by a comprehensive Performance Monitoring Framework (PQMF), which monitors the quality of services we provide. It also provides detailed information on other key performance indicators concerned with access and outcomes.

Where performance or quality metrics are not on target, clinical directorates provide rectification plans, including action planning, for performance review by the Trust Executive. The PQMF enables granular reporting of weekly and monthly dashboard reports to clinical teams and Trust committees, with an overview maintained by the Trust Board.

Monthly Clinical Dashboards have been enhanced to provide better visualisation of the most important performance measures and quality indicators, thereby enabling trends to be more easily identified. Key priorities are reviewed to ensure that the pressing indicators of quality are in focus. The review of individual clinical teams' compliance with CQC and Mental Health Act standards continued during the year, with results being used to drive improvements in the services provided to patients.

The Trust uses local and national benchmarking information to add intelligence and insight to our performance management processes. Benchmarking enables the performance of the directorates to be analysed and they are supported in identifying how improvement in quality, productivity and efficiency can be achieved. Benchmarking with others will also help to determine how the Trust will become outstanding in all areas.
The Trust remains a key member of the NHS Mental Health Benchmarking Reference Group.

The Trust's Quality Committee continued to actively monitor the quality of services. Robust assurance is provided to Trust Board, service users and commissioners on performance measures.

2.2 Priorities for improvement and goals agreed with Commissioners

Key priorities for improvement

As previously described, in determining our priorities we have engaged extensively with our stakeholders to ensure the priorities meet the needs of our local population.

We are committed and ambitious in our endeavour to provide the highest quality mental health services. Our Board's business is driven by the quality plan as defined by our four on-going priorities, known as SPAR:

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

Progress monitoring

Progress to achieve these quality priorities will be monitored and measured through individual area milestones, with regular reports to the Executive Team and Quality Committee on progress made, risks identified and mitigation plans developed. Progress will also be reported through the Learning from Experience Report and Clinical Effectiveness Report to each meeting of the Quality Committee and to the commissioner-led Clinical Quality Review Group.

Key quality priorities for 2017/18:

Every CQC core service rating is 'good' or 'outstanding'

- All core services have comprehensive improvement plans in place to address the areas identified in the CQC inspection and to date significant progress has been made with many of the 'must' and should' do requirements being addressed and rated as 'complete'. We will continue this robust assurance process through our performance management arrangements.
- CAMHS Community Services rated as 'good'.
- Adult Community Services will be rated as 'good' for the safe domain.
- Older Persons Inpatient Services rated as 'good' for the safe domain.

Improved Physical Health Monitoring

Our improvement plans include the following action:

- Becoming a smoke free organisation.
- Increased staff recognition of the 'deteriorating patient' in relation to the onset of sepsis.
- Flu vaccination campaign will be delivered achieving national targets of at least 75% frontline staff receiving the vaccination.
- A falls reduction programme will be developed and implemented resulting in a 30% decrease in the number of falls.
- A programme of prevention and assessment of cardiometabolic disease will be developed and implemented in older adult inpatient services.
- 100% compliance with physical health monitoring and recording post rapid tranquilisation.

Implement Our Suicide Prevention Strategy 2016-18

- Continue to facilitate the 'Living Well with Risk Group' to embed this strategy and facilitate participation from people with lived experience.
- Support the development of patient held "apps" or applications that promote recovery from depression, encourage hope and help seeking behaviour at the point of personal crisis.
- Use stories of hope from patients in different media formats to share the recovery messages.
- We will plan to integrate our records digitally with Health and Social Care, within the next 5 years. This will enable us to assist primary care to manage patients who are not in mental health services who are feeling suicidal.
- We will incorporate family/carers views into risk management plans, and highlight any protective factors that these relationships provide.
- We will strengthen our staff training in supporting patients with suicidal ideation.
- We will audit Trust investigations of suicides annually to give a clearer picture of the patients' lives, their presentations and our service responses prior to the incident.
- Strengthen training for dual diagnosis care pathways with a focus on higher risk patients.

Increase service users', carers and staff feedback to improve service development

- The Service User and Engagement Strategy will be refreshed by the Service User and Carer Council.
- We will ensure that there is a service user and carer representative at the mental health Sustainability and Transformation Plans (STP) Board.
- There is service user and carer representation on our trust committees facilitated through the Service User and Carer Council.
- We will develop a network of peer support workers.
- We will provide an enhanced understanding of the financial position for service users, carers and staff.
- To support personal and social recovery we will develop a recovery collage.

Review of Models of Care and Care Pathways

- Review our care pathways underpinned by work on productivity that took place during 2016.
- Plan to deliver directorate specific and cross directorate benefits of productivity improvements linked to a review of the 2 year plan.
- To complete an acute care pathway with a Psychiatric Intensive Care Unit (PICU) with an enhanced Place of Safety.

Additional objectives for 2017/18 aligned to SPAR priorities

Safe

- Further embedding of unannounced assurance visits with quarterly reporting to the Quality Committee and Trust Board.
- Implement an inpatient assessment accreditation framework with 100% of wards participating by March 2018.
- Further investment in environmental ligature improvements in accordance with 2016/19 plan.
- Investment in workforce development – staff knowledge of risk assurance will be strengthened.

Personalised

- Extension of the FLO and autographer innovation to develop a self-managed integrated care pathway for dementia patients.
- Implementation of the Diversity and Inclusion Plan.

Accessible

- Compliance with all national waiting times targets and 18 week waits for definitive treatment for all services.
- Work in collaboration with Primary Care and the University Hospital of North Midlands (UHNM) to become more accessible to patients through the use of video consultation.
- Re-launch Dragon's Den led by the Service User and Carer Council and supported by the Trust's R&D team with a focus on innovation and value makers empowering innovation across our workforce and service users.
- Develop and implement an Allied Health Professional and Social work strategy.
- An Estates (buildings and land) optimisation strategy will be developed with partner organisations.
- Continue to work with health and social care commissioners to ensure that every effort is made to ensure that service users are located in the most appropriate environment and reduce delays in transfers of care.

Recovery focussed

- Recovery principles will underpin our strategic priorities, policies, procedures, risk assessments and care plans.
- Care plans are completed with individuals and are wellbeing and recovery focussed.
- Further education of front line staff in recovery focussed care.
- Consistent use of outcome measures to assess the level of recovery for service users.
- Continue to develop evidence based psychological interventions in our adult acute wards.

A further 'Open Space' event is being held in January 2018 to give views on how the Trust and the Service User and Carer Council will prioritise our quality priorities for 2018/19.

2.3 Statement of assurance from the Board

How progress will be measured and monitored

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

The majority (83%) of clinical services provided by North Staffordshire Combined Healthcare NHS Trust in 2016/17 were commissioned by the two local Clinical Commissioning Groups – North Staffordshire CCG (35%) and Stoke-on-Trent CCG (48%).

Quality was monitored by NHS Staffordshire and Lancashire Commissioning Support Unit (CSU) on behalf of North Staffordshire and Stoke-on-Trent CCGs.

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

The Trust signed the Standard National Contract covering service delivery in 2016/17 on 25 April 2016. The contract is largely block in nature with the two local CCGs, although the associate element of the contract is cost and volume with thresholds. The contract contains specific targets on a range of performance measures.

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

Compliance with the Health and Social Care Act 2008 and the Essential Standards of Quality and Safety

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

Measuring clinical performance

Clinical audit, clinical excellence and research and development all contribute to measuring effectiveness (including both clinical outcomes and patient-reported outcomes), safety and patient experience through quantitative and qualitative information. This includes reporting data regarding the impact of services on patients.

The clinical audit programme is developed to reflect these needs and the national priorities. Further information is contained below.

National Projects and Initiatives

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

Quality governance assurance framework

Our NHSI Oversight segmentation is band 2; the highest segmentation being band 1 which gives Trusts maximum authority.

Litigation cases for 2016/17

The numbers have remained static for non-clinical claims received for 2016/17 with only two being registered for employee liability.

The expenditure on non-clinical claims has seen a 14% reduction from the previous year. The Trust has been able to successfully defend claims where we have been able to provide evidence that policies and procedures have been followed. We continue to work closely with the NHS Litigation Authority (NHS Resolution) to use the intelligence learnt from these cases thereby ensuring quality improvements.

National quality improvement projects (service accreditation programmes): Managed by the Royal College of Psychiatrist's Centre for Quality Improvement (CCQI)

- The Trust's one ECT Clinic is accredited.
- Three wards (1, 2 and 3 at the Harplands Hospital) for working age adults are accredited.
- Two rehabilitation wards: (Florence House and Summers View) are accredited.
- Our Older Person's wards have commenced the accreditation process this year.

National quality improvement projects (service quality networks): Managed by the Quality Network for Inpatient Care (QNIC) - Darwin Centre

The Trust has continued to support the development of the Darwin Centre with further investment in staffing. The unit is now fully compliant with QNIC multidisciplinary staffing levels. A major programme of building work has been undertaken during 2016 to enhance the overall physical environment and it is anticipated this will be reflected in the ratings following the next QNIC inspection in May 2017.

- Environment and facilities 91%
- Staffing and training 93%
- Access admission and discharge 92%
- Care and treatment 98%
- Information, consent and confidentiality 80%
- Young people's rights and safeguarding children98%
- Clinical governance 91%

Learning Lessons

The Trust's Learning Lessons strategy has gone from strength to strength over the past year with 296 staff attending a monthly session over the past 12 month period. We are pleased to note the positive feedback from the CQC inspection with recognition of the Learning Lessons Programme as a model of good practice with staff awareness and bulletins well embedded in the Trust.

Staff feedback has been 100% positive with staff generating ideas for future sessions. We have utilised social media including Twitter to spread the initiative and benefits of wider learning. Future planning will see the development of an intranet web page providing a library of learning resources.

Learning Lessons Sessions

From January 2016 we increased the sessions to monthly in response to increased demand 'taught' with the aim of encouraging ownership of incidents and helping to develop a positive sharing culture.

The new sessions also incorporate health and safety into the learning by facilitating sessions on human factors and learning from incidents in other industries.

The Trust's Health and Safety Advisor has facilitated sessions looking at the systems and processes that required strengthening in order for our staff to consider their own team's working practices.

Video clips from the NHS Institute for Innovation and Improvement on human factors have been shown and discussed at Learning Lessons sessions.

"I would recommend the session, it is a good way to learn and reflect. Very interesting and thought provoking".

"The sessions were interesting and I would recommend them – nice touch with the revalidation forms as well."

Feedback

"Key points for me today were effective communication which is essential.

"It was interesting to know what incidents happened in the trust and why. I enjoyed the video; the main message from this was around reflective practice and learning how to improve on this".

"I would definitely recommend the session as I think it was great for everyone to share experiences of their workplace and how things are done differently".

"I found this morning's session very interesting and thought provoking, as always. I was particularly struck by the discussions around referring to family members as protective factors on risk plans".

"The session's key points were the importance of communication and leadership in our own individual roles and that of others".

Learning Lessons Leads

We have seen the development of Leads across a wider range of teams responsible for disseminating key learning messages.

Site Visits

A new development for 2016 has seen the introduction of site visits by the Health and Safety Advisor and Patient Safety Manager. This has served as an opportunity to look at safer systems of work, share learning from incidents and ensure that the quarterly health and safety assessments are on schedule.

This positive approach assists teams to consider their everyday practice and to ensure that systems are consistent and safe.

Future Learning Lessons Plans for 2017/18

- External speakers at Learning Lessons sessions
  Use of different media and infographics to present learning in easy to understand ways
- Implementation and embedding the Suicide Prevention Strategy, incorporating good practice in managing risk.

2.4 Review of services

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

During the period from 1 April 2016 to 31 March 2017 North Staffordshire Combined Healthcare NHS Trust provided eight NHS services. The Trust has reviewed all the data available on the quality of care in all of the NHS services provided by the Trust.

The income generated by the NHS services reviewed in 2016/17 represents 100% of the total income generated from the provision of NHS services by North Staffordshire Combined Healthcare NHS Trust for 2016/17.

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

2.5 Participation in clinical audit

National confidential inquiries and national clinical audits

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

During 2016/17, two national audits and two national confidential inquiries covered NHS services the trust provides.

During that period the trust participated in both (100%) of these national clinical audits and both the national confidential inquiries, as follows:

- Prescribing Observatory for Mental Health (POMH) – 100%
- Early Intervention in Psychosis – 100%
- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH) – 100%
- Young People's Mental Health (National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – 100%

The national clinical audits and national confidential inquiries that the trust participated in, and for which data collection was completed during 2016/17, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or inquiry.

TITLE	% of cases submitted	% of cases required to be submitted
Prescribing Observatory for Mental Health (POMH): prescribing topics in mental health services:		
Prescribing antipsychotic medication for people with Dementia (topic 11c)	45%	100% [1]
Monitoring of patients prescribed lithium (topic 7e)	45%	100%[1]
Rapid tranquillisation (topic 16a)	100%	100%[1]
Prescribing high dose and combined antipsychotics (topic 1g)	100%	100%[1]
National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/ NCISH)	100%*	100%
Early Intervention in Psychosis Young People's Mental Health (National Confidential Enquiry into Patient Outcome and Death)	100% 100%	100% 100%**

* This data is collected centrally on a rolling basis as part of the NCI process
1 Please note that for POMH audits there is no minimum requirement of cases to be submitted.
For Topics11c and 7e an adequate sample size was obtained without the need to submit 100% of cases relevant to the sample population, therefore the Trust still met the 100% requirement for POMH.

**Please note that this study was still open at the time of writing and the figures not finalised.

The reports of 2/2 national audits (as specified above) were reviewed by the provider in 2015/16 and actions agreed for implementation are detailed below.

In one case the report was released on the 21 March 2017 and is currently under review. In three cases the audit data is still being analysed by the Royal College of Psychiatrists and the reports will be reviewed by the provider on their release.

POMH 11c: Antipsychotic medication for people with dementia	Action completed
A raising awareness of standards presentation with medical staff.	On-going
The presentation will include a reminder to all teams of the importance of documentation.	On-going
The group noted good performance in community teams but some areas for improvement in in-patient services, although the sample of inpatients audited was very small. The results of the audit will be shared with teams to highlight areas of non-compliance and to remind them of the standards.	✓

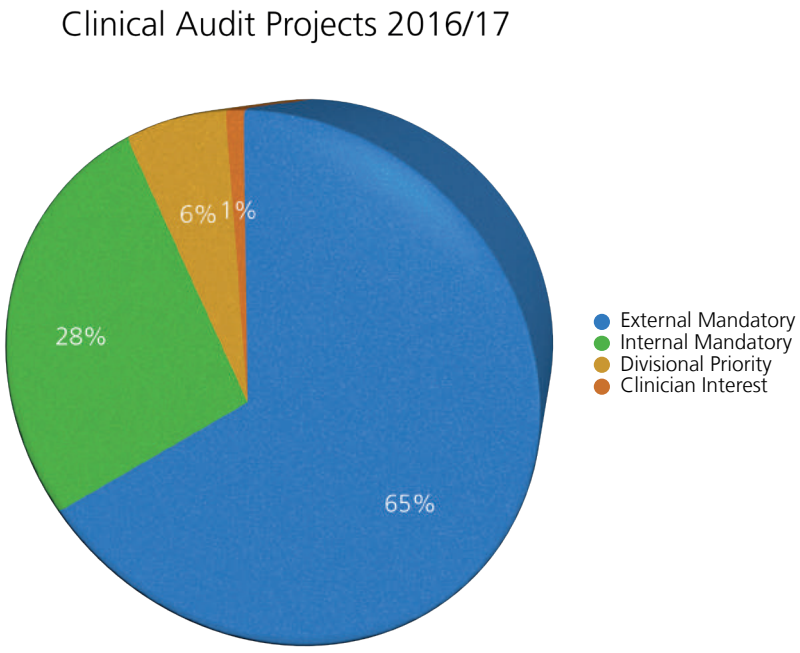
POMH 7e: Monitoring of patients prescribed lithium	Action completed
A review will be undertaken to ensure that weighting scales are available to all community teams and Service Managers will be advised that weight / BMI should be measured before initiating treatment with lithium and documented in the clinical record.	On-going
A laminated aide memoire reminding staff of the tests to be undertaken prior to initiating treatment with lithium will be provided for display in clinic rooms.	On-going
In all cases which did not meet the standard for two or more serum lithium tests being undertaken per year, service areas will be contacted to investigate the reasons for this and any actions identified will be implemented appropriately.	On-going
A laminated aide memoire reminding staff of the tests to be undertaken 6 monthly during lithium maintenance treatment will be provided for display in clinic rooms.	On-going
A review will be undertaken to ensure that weighting scales are available to all community teams and Services Managers will be advised that weight / BMI should be measured during lithium maintenance treatment and documented in the clinical record.	On-going
The new physical assessment tool under development in Lorenzo will be reviewed to ensure that it meets all requirements.	

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

Local clinical audit programme 2016/17

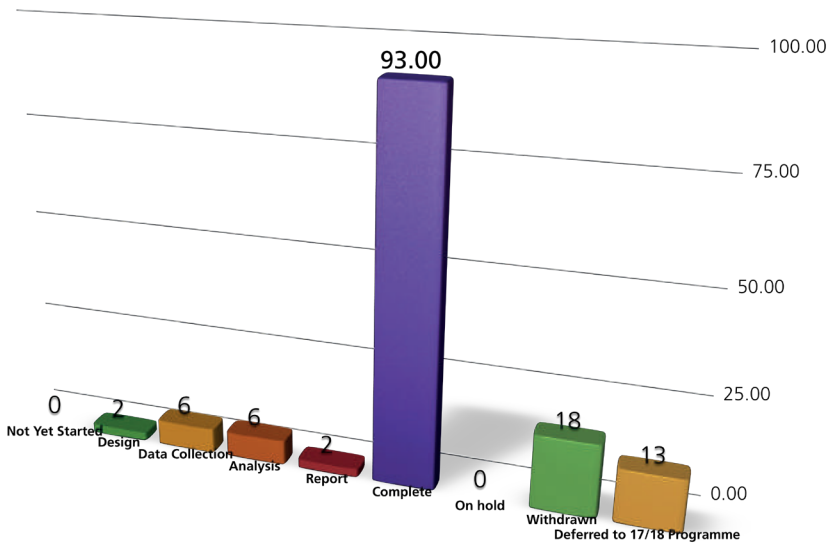
All projects on the clinical audit programme were facilitated by the Clinical Audit department. The programme is split into four priority levels in line with national requirements/ standards, including National Institute for Health and Clinical Excellence (NICE) guidance, POMH and standards produced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

The following chart reflects the total number of projects identified for 2016/17 split by the four priority areas:



During the year a total of 93 projects were completed by the Clinical Audit department and all 93 reviewed by the provider in the reporting period. All completed audits contained a comprehensive action plan agreed by the Trust and all stages of the audit cycle undergo a robust validation exercise to ensure the reliability and quality of data reported.

The graph below outlines project status for the 140 projects registered on the clinical audit programme for 2016/17:



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

Once actions have been implemented, a re-audit is undertaken to determine if the actions made have resulted in improvements to the quality of healthcare. Further information on completed clinical audits and the clinical audit programme can be obtained from the Trust's Clinical Audit Department.

2.6 Participation in Research

During 2016/17 the Research and Development (R&D) team has continued to contribute to NHS national research through the delivery of high quality portfolio and commercial research. The Trust has successfully exceeded its expected recruitment target, demonstrating a marked improvement on last year's figure with a recruitment total of 118, which is 124% of our overall target and represents a 21% increase from 2015/16. Our in-house portfolio is also not restricted to research but provides support to both individuals and projects predominately in the form of evaluation expertise but also in relation to specific elements of project work which draw upon research knowledge and skills.

It would not be possible for us to undertake any form of research without the involvement of our service users and carers.

We recognise that for many individuals research offers an opportunity to take a more active role in care and make an active contribution to the development of new knowledge while at the same time experiencing an enhanced quality of care.

We are committed to increasing the opportunities that our service users and carers have to participate in research and this is illustrated by our recruitment figures.

We firmly believe that service user involvement is crucial to high quality research, not just at the point of implementing a protocol but all through the study design process.

For this reason we are delighted that during 2016/17 with the support of the Service User and Carer Council we have attracted a service user representative to join our R&D Steering group and their contribution will help to shape the future of research within the Trust.

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

The R&D team have continued to work towards developing the research culture through engagement with clinical teams and external partnerships. 2016/17 has seen a real commitment to research as a Trust aspiration, with one of seven Trust objectives for both the one and five year plans being to encourage, inspire and implement research and innovation at all levels.

Research engagement

Within the Trust we have sought to extend the level of engagement across the organisation. One of the "quick wins" identified through Listening into Action was to include research within the annual staff appraisal process. As a result we have had a number of individuals approaching the R&D team to ask how they can become involved in research.

We have also undertaken engagement process with clinical teams. The Edward Myers inpatient unit not only became our first Research Ready Team but were recognised at our Annual Reach Awards for their research activity.

November 2016 saw a re-vamp of our Bi-monthly R&D steering meeting with a shift in emphasis from a business meeting to a research forum. The Research Forum is space in which interested individuals can share their ideas, projects, plans, successes and failures within a supportive community comprising of members from NSCHT and key partners / stakeholders. The feedback received to date has been that this is both a valuable and enjoyable forum and it is our aspiration to continue to extend the membership and reflect the outputs in future reports.

Student Research

Student research is an important part of our in-house portfolio. We recognise that a positive experience will promote an individual's on-going engagement in research, help towards developing our overall capacity and capability, and contribute towards the development of a research culture. The R&D team provide a valuable service to staff conducting research as part of a higher educational programme (e.g. Masters, PhD, other professional doctorates), supporting them through the process of registering their projects, and applying for the relevant regulatory approvals. An evaluation of the service provided has demonstrated that it has taken the stress out of the process, provided advice and guidance, and seen less amendment submissions.

Delivery of Clinical Trials of Medicinal Products (CTIMPS)

Developing our capacity and capability to deliver CTIMP studies is an important aspect of our research development. We recognise that CTIMPS not only offer the potential to generate commercial income but also provide opportunities for our service users to be involved in the development new treatments. During 2016/17 our portfolio has included 1 CTIMP study to which we have recruited 6 participants. We have been selected as a site for an additional CTIMP study which will be run in partnership with the UHNM.

External Engagement

Our research endeavours should reflect the clinical landscape and, just as the value of delivering clinical care in partnership across the community is recognised as an essential requirement for service development so too are our research partnerships. During 2016/17 we have been widening our engagement with our local community, other NHS organisations, academic institutes, voluntary agencies, commercial companies, local authorities and even schools, focussing upon quality engagement and collaborative development. Much of our engagement work has focussed upon developing our network and "sowing the seeds" for future research collaborations As a result of this engagement we have some projects that are moving forward as formal research partnerships.

Key achievements during 2016/17

Autographer plus Flo

The "Autographer plus Flo" approach was developed as a protocoled memory support intervention targeting people with MCI and people with mild to moderate dementia. Participants were given an Autographer wearable camera (formerly known as 'Sensecam') which was theirs to keep permanently or for as long as they found it useful and of benefit. Participants were asked to regularly wear it during their everyday activities as a lifelogging device and to review their images from Autographer on a computer at least three times per week. Participants were signed up to receive Flo text messages based on a once-repeated 13 week protocol. Text messages were of two types: once daily text messages designed to support wellbeing and management of memory problems. Basic reminders to participants to wear their Autographer and to review their images at least three times a week were also sent by text message.

Be-Able App

The idea for a modular App that people with memory problems could use to assist with self-management of their MCI or dementia and other vascular risk factors was a natural development from the Autographer plus Flo work. In February 2017 the Capital Investment Group reviewed a business case for investing in a first stage demonstrator Be-Able app. It was agreed that there would be an investment in building a demonstrator Be-Able app. The preliminary development work on this started in March 2017.

NO GAP

Last year we reported on the development of collaboration between the trust and the University Hospitals of North Midlands (UHNM), in which our research and clinical skills and clinical caseload combined with UHNM's existing clinical trials expertise & clinical support services expertise aim to deliver Neurodegenerative research more effectively.

This year we are delighted to report that the partnership has gone from strength to strength resulting in the team being recognised at the National Institute for Health Research Clinical Research Network West Midlands Annual Awards as the winners of the Collaboration in Research Award. This award recognises the success of the project particularly in terms of the development of a collaborative model and also the development of a joint research coordinator role. The team were also invited to run a workshop at the annual National Institute for Health Research (NIHR) Clinical Research Network (CRN) Conference in order to share their partnership as a model of best practice. The team were also delighted to receive a second award, this time from the University Hospital of North Midlands at their Night of Stars Awards for Research Impact.

The NO GAP team were also successful in securing a further one year's NIHR CRN Strategic funding for 2017/18 for the Joint Dementia Research Coordinator post, shared across both organisations.

Moving forward the team have extended their collaboration to form a partnership - recently re-branded as the NeurO-deGenerative Research Active Partnership (NO GAP). NO GAP aims to ensure that every patient and carer has access to high-quality Neurodegenerative research across North Staffordshire. The NO GAP team consisting of both NHSCT & UHNM Research and Clinical staff promotes a partnership and collaborative approach to research delivery across, building and sharing capacity and demonstrating how working together closes the gaps and strengthens access to Neurodegenerative research.

EDGE data

Edge is a new electronic research patient management system adopted by the NIHR which provides comprehensive data concerning research activity in one system. The system has been introduced on the back of new approval processes for NHS research which aim to streamline and enable faster set up of studies. The changes have presented a considerable challenge for NHS trusts which have been required not only to adopt new working practices but also to migrate existing data onto the new system. This has been a significant additional piece of work which has been achieved well within the prescribed timeframes and our performance has been acknowledged formally with a letter of thanks from the system developers.

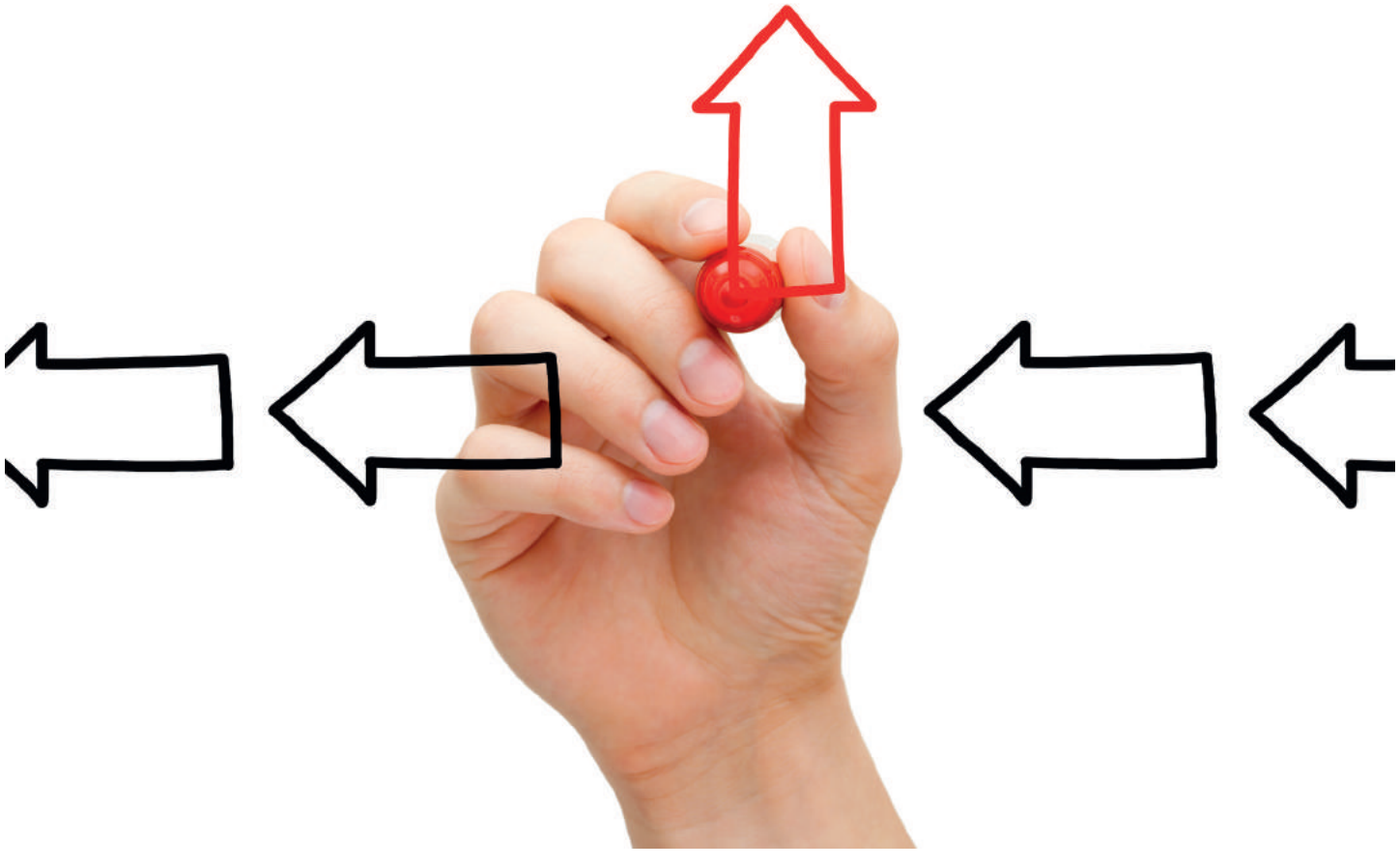
Example of some of the External Engagement Projects undertaken in 2016/17:

- The Autographer plus Flo project was disseminated through a report, poster presentations at two conferences and an exhibition which was developed with and hosted by "Letting in the Light", a local Arts and Health organisation in July 2016.
- Application in partnership with "Letting in the Light", to Nominet Trust's Digital Arts and Creative Ageing investment programme. (August 2016).
- The Alcohol-Related Brain Injury Project brought together representatives from organisations across North Staffordshire to work together on a scoping paper which addresses the management and development of an Alcohol Related Brain Injury pathway.
- Two of our team were successful in securing places on the National Institute for Health Research programme (NIHR-Ashridge Programme for the R&D Function within the NHS). This is a national bespoke leadership programme which promotes shared learning and partnerships across NHS organisations and aims to develop a national network for R&D managers and Directors.
- The Schools Project which is an innovative development of research workshop and engagement tools for schools to inspire and increase awareness & engagement of research in 12-14 year old students. The project was initiated by R&D team members and involves both UHNM and a number of local schools.

2.7 Goals agreed with Commissioners

Commissioning for Quality and Innovation (CQUIN) framework
A proportion (2.5%) of the total potential income from CCGs in 2016/17 was conditional on achieving quality improvement and innovation goals agreed with commissioners through the CQUIN framework.

As an incentive 1.5% of the Trust's total, potential income from CCGs for 2016/17 has been linked to delivery of CQUIN targets and the Trust has agreed five CQUIN indicators with the commissioners. The CQUIN indicators for 2016/17 were identified as the Trust's key priorities last year and as such are reported on in Section 3.1.



2.8 Statement from the Care Quality Commission

Registration

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

- Accommodation for persons who require nursing or personal care
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury.

At the following registered locations:

- Lawton House
- Harplands Hospital
- Dragon Square
- Summers View
- Florence House
- Darwin Centre

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

CQC Inspection

Following the inspection in September 2016 the CQC changed the overall rating for the Trust from "requires improvement" to "good". There has been no enforcement action required by the Trust during 2016/17.

CQC special reviews and investigations

The CQC has not required the Trust to participate in any special reviews or investigations during 2016/17.

CQC Organisational Rating - Good

"Throughout the inspection, staff were found to be caring, empathetic and considerate towards patients.
Feedback from patients, carers and families was consistently positive regarding the quality of care and how staff treated th
Care plans were comprehensive, holistic and recovery-focused in all the teams that we visited"
CQC Inspection Report 2017

2.9 Statement on Data Quality

NHS Number and General Medical Practice Code Validity

The Trust submitted records during 2016/17 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

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

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

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

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

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

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

Information Governance Toolkit attainment levels

The Trust's score for 2016/17 for Information Governance assessed using the national NHS Information Governance Toolkit was 75% (from 73% in 2015/16), and was graded green as all requirements achieved a minimum score of Level 2 resulting in a 'Satisfactory' result (the only results achievable are 'Satisfactory' or 'Not Satisfactory').

External Clinical Coding Audit

North Staffordshire Combined Healthcare NHS Trust was subject to the annual external clinical coding audit during 2016/17 by NHS Digital approved auditors. The audit results reported in the latest published audit for that period for diagnosis and treatment coding (clinical coding) are:

- 94% Primary diagnosis correctly recorded (98% in 2015/16)
- 93% for Secondary diagnosis correctly recorded (98% in 2015/16)
- 100% primary procedures correctly coded (100% in 2015/16)
- 100% Secondary procedures correctly coded (100% in 2015/16)

The services reviewed in the sample were adult mental health, child & adolescent mental health, elderly mental health and substance misuse.

The audit was undertaken by D&A Clinical Coding Consultancy Ltd, who are NHS Classifications Service approved auditors. The Trust was commended for its excellent level of coding accuracy and commended on the strong commitment to coding. It was further noted that there is a strong clinical engagement across all specialties.

Relevance of data quality and action to improve data quality

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

- Increasing the involvement of clinicians in the validation of data held in the IT systems.
- Continuing to actively manage data and key performance indicators.
- Continuing to focus on accurate and consistent patient clustering as part of readiness for Payment by Results.
- Developing new IT solutions for more effective performance monitoring and reporting.

The performance management forums within each directorate continue to operate effectively with a data quality improvement plan in place which is endorsed by our commissioners and forms part of the 2016/17 contract.

These forums are an opportunity to address data governance and data quality from end to end. The group's membership consists of corporate and clinical representatives and these data overseers take a leadership role in resolving data integrity issues and act as liaisons that manage the underlying information management infrastructure.

The primary objective is to mitigate business risks that arise from highly data-driven decision making processes. Setting data policies and standards, ensuring there is a mechanism for resolving data-related issues, facilitating and enforcing data quality improvement efforts and taking proactive measures to stop data-related problems before they occur.

3.0 REVIEW OF QUALITY PERFORMANCE FOR 2016/17 (LOOKING BACK) AND STATEMENTS FROM PARTNERS

This section is in three parts:

Section 3.1
Reviews performance against the key priorities defined in the 2015/16 Quality Account, which were aligned with the Commissioning for Quality Innovation Scheme (CQUINS), agreed with our local commissioners.

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

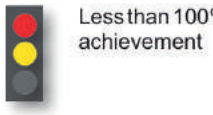
Section 3.3
Includes reference to those involved in the development of this account and statements from key partners.

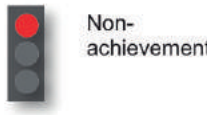
3.1 Performance against 2016/17 Key Priorities

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

For 2016/17, we identified priority areas which contribute to improved safety, clinical effectiveness, patient experience and innovation. Against the CQUIN performance framework, in total we achieved 100% of the schemes.

All schemes were achieved in full resulting in quality improvements for those using our services.





Priority	CQUIN area	Patient Safety	Clinical Effectiveness	Patient Experience	Innovation	Achievement (%)	Financial value (£)
1	**Staff Health and Well-being:** (Initiatives 1a, b & c) Healthy food for NHS staff, visitors and patients, and improving the uptake of flu vaccinations for frontline clinical staff.	✓			✓	100%	£420, 906
2	**Physical health** 2 a & b: Cardiometabolic assessment and treatment for patients with psychoses / communication with General Practitioners	✓	✓			100%	£140,302
3	**Green Light Toolkit:** Supporting service users with learning disabilities and autism in adult mental health settings	✓	✓	✓	✓	100%	£280,604
4	**Person Centred Care Planning:** Supporting service users to become centrally involved in their care and recovery		✓	✓	✓	100%	£280,604
5	**Embedding a Safety Culture:** Reflecting on and improving the Trust's safety culture maturity as defined by the Manchester Patient Safety Framework	✓			✓	100%	£280,604

The following table identifies the CQUIN areas as identified by the CQUIN scheme for 2016/2017:

Staff Health and Wellbeing: Staff health initiatives

SPAR priorities
Safe

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

Our goal
We aimed to introduce innovative schemes to improve the physical and mental health and wellbeing of staff employed by the Trust.

How did we monitor and report on progress?
An improvement plan was developed by the working group to monitor progress in implementing processes across the Trust. Initiatives were agreed with Commissioners and a quarterly report detailing progress was submitted to them for review.

What did we achieve?
As a result of this CQUIN the Trust has consolidated and improved its health and wellbeing offer to staff and the Working Group will continue to take this work forward into 2017-18.

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

SPAR priorities
Safe

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

Our goal
The Trust was tasked with ensuring that where food and drink is sold on Trust premises, healthy food options are available and that foods high in fat, salt and sugar are not advertised or promoted on Trust premises or offered for sale at checkouts.

How did we monitor and report on progress?
An improvement plan was developed by the working group to monitor progress in implementing processes across the Trust. Information on the contracts which the Trust holds with food suppliers was provided to NHS England in June 2016 and March 2017. Local commissioners were provided with a quarterly reporting detailing progress.

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

Staff Health and Well-being: improving the uptake of flu vaccinations for frontline clinical staff

SPAR priority
Safe.

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

Our goal
We aimed to increase the numbers of frontline clinical staff receiving the flu vaccination at the Trust.

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

What did we achieve?
In 2016-17 79.7% of frontline clinical staff across the Trust were vaccinated against flu. We were the top mental health trust in England. This is an excellent achievement and demonstrates a significant improvement on vaccination levels in 2015-16.

Physical Health: Cardiometabolic assessment and treatment for people with psychoses

SPAR priority
Safe.

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

Our goal
The Trust was tasked with implementing appropriate processes for assessing, documenting and acting on six cardio-metabolic risk factors in 90% of 50 randomly selected in-patients, 90% of Early Intervention team services users from a locally determined sample and 65% of 100 randomly selected community service users. National guidance stated that the selected patients should fall into the following categories (based on ICD-10 diagnostic codes):

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

How did we monitor and report on progress?
An improvement plan was developed by the working group to monitor progress by implementing processes across the Trust. The data collected for the Quarter 4 audit was sent to the Royal College of Psychiatrists for central analysis and reporting for the inpatient and community components. The early intervention component data was collected and submitted to local commissioners.

What did we achieve?
As a result of the CQUIN, the Trust has now implemented screening for cardiometabolic risk factors for all inpatient and Early Intervention Team service users. Considerable progress has been made in assessing the physical health of our service users in community services and we will continue to build on progress made.

Physical Health: communication with General Practitioners

Spar Priorities:
Safe, Personalised

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

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

- Primary mental health diagnosis
- Secondary mental health diagnosis
- Physical health diagnosis
- Prescribed medications and recommendations
- Monitoring and treatment needs for cardiometabolic risk factors identified
- Care plan or discharge plan

How did we monitor and report on progress?
An audit was undertaken in Quarter 2 and the results reported to commissioners and discussed within the working group.

What did we achieve?
The results of the audit demonstrated that the required information was communicated to General Practitioners in 95% of cases.
Trust services continue to use the Health Care Information Form and the working group is currently reviewing its use going forward.

Green Light Toolkit

Spar Priorities
Personalised, Accessible

Why was this selected as a priority?
Feedback from patients with learning disabilities who had accessed mental health services was mixed and it was felt that mental health staff might not be confident in addressing the particular needs of this service user group.

Our goal
The CQUIN was designed to improve the quality of care for service users with learning disabilities when accessing Trust's mental health services.

How did we monitor and report on progress?
An improvement plan was developed by the working group to monitor progress in implementing processes across the Trust. A quarterly report detailing progress was submitted to commissioner for review, which included the results of a self-assessment against the Green Light Toolkit in Quarters 1 and 3 and a staff confidence survey in Quarters 1 and 3.

What did we achieve?
As a result of this CQUIN staff on adult inpatient wards and working in Access and Home Treatment and IAPT services have increased confidence in addressing the particular needs of patients with learning disabilities.

This work has also made a difference to patients whose needs have been met more effectively when accessing these services.

Person Centred Care Planning

SPAR priorities
Personalised, Recovery-Focused.

Why was this selected as a priority?
Care planning for service users is a fundamental element of care. Effective care plans have the potential to enhance and benefit patient experience. Nationally, since the Francis Report, the spotlight has been on ensuring that care planning is robust, involves the person receiving the care and is consistently a high standard. The Care Quality Commission (CQC) details in a similar way the need to evidence that care plans are meaningful.

Our goal
In prioritising this CQUIN we aimed to support service users in becoming more centrally involved in their care, with an emphasis on planning, goal setting and recovery.

How did we monitor and report on progress?
An improvement plan was developed by the working group to monitor progress in implementing processes across the Trust. Initiatives in four pilot areas were agreed with Commissioners and a quarterly report detailing progress was submitted to them for review.

What did we achieve?
As a result of this CQUIN we have developed initiatives which will ensure that service users are centrally involved in their care. We have also fed into the Trust's on-going work around recovery focused care which involves working with services users and carers to plan for discharge from services and to discover what recovery means for them.

Embedding a Safety Culture

SPAR priority
Safe

Why was this selected as a priority?
The Manchester Patient Safety Framework (MaPSaF) is a tool to help NHS organisations and healthcare teams to assess their progress in developing a safety culture. MaPSaF uses critical dimensions of patient safety and for each of these describes five levels of increasingly mature organisational culture.

The dimensions relate to areas where attitudes, values and behaviours about patient safety are likely to be reflected in the organisation's working practices. For example how patient safety incidents are investigated, staff education and training in risk management. The Secretary of State for Health set out the ambition of halving avoidable harm in the NHS over the next three years and saving 6,000 lives as a result. This CQUIN ties into this ambition enabling the Trust to examine its current safety practices and how they can be improved.

Our goal
The overall aim was to ensure that the Trust has mechanisms in place to:

- Facilitate self-reflection on safety culture maturity
- Triangulate 'maturity' against other Patient safety metrics to develep localised Team interventions (action plans) to change the safety culture.

The Trust set out to identify higher 'maturity' teams from MaPSaF self-assessment and support teams to buddy up to provide peer support whilst delivering interventions via action plans. The ultimate aim of this was to develop the safety maturity of teams across the Trust in accordance with the MaPSaF and to improve the shared learning across wards/areas. We also looked at our policies around lone working and developed a mechanism for assessing and accrediting wards based on patient safety criteria.

How did we monitor progress?
An improvement plan was developed by the working group to monitor progress in implementing processes across the Trust. A quarterly report detailing progress was submitted to Commissioners for review, which included the results of a self-assessment against the MaPSaF undertaken by community services in Quarters 1 and 4.

What did we achieve?

This CQUIN has raised awareness within teams with regards to their safety culture. The self-reflection exercises have helped teams to identify where their respective strengths and weaknesses lie and the buddy system has helped teams to learn from each other and subsequently developed their practices. Over the 2 years that the CQUIN has run, there has been a shift in culture and teams are continuing to learn from each other.

3.2 Performance in 2016/7 as measured against a range of quality indicators

This section of the Quality Account provides a summary of our performance as measured against a range of quality indicators / metrics, which are of interest to people who use our services, indeed most were selected for inclusion by key stakeholders. The information is presented under the three main headings of: patient safety, clinical effectiveness and patient experience.

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

Patient safety

Environments and cleanliness – Patient Led Assessment Care Environment (PLACE)

Area of performance	Environments and cleanliness
Metric – method of calculating performance:	Trust Key Performance Indicator (KPI) - five environments/cleanliness as assessed by the PLACE) team
Performance:	We are proud of our excellent cleanliness standards. The Trust's overall score for cleanliness was 99.67%. Each PLACE inspection team included 50% patient representation and an independent validator on each assessment.

PLACE 2016	Cleanliness	Food & hydration	Privacy, dignity & wellbeing	Condition, appearance & maintenance	Dementia
Harplands Hospital overall site score	99.58%	97.64%	98.05%	98.15 %	96.26%
Dragon Square	99.63%	-	96.55%	99.39 %	-
A&T and Telford Unit	98.89%	94.08%	100%	97.59 %	-
Darwin Centre	100%	96.66%	94.12%	100%	-
Florence House	99.26%	94.28%	94.17%	100%	-
Summers View	100%	96.16%	97.33%	98.85 %	-
Trust overall score	**99.60**%	**97.20**%	**97.54**%	**98.44** %	**96.26**%

Disability arrangements have been included for the first time in 2016 as part of PLACE. As with the Trust's other PLACE scores, the Trust has scored exceptionally well in this area, scoring well above the national average

2016 PLACE scores for Disability	
Harplands Hospital	95.6%
Dragon Square	100%
A&T and Telford Unit	100%
Darwin Centre (under refurbishment)	82.25%
Florence House	100%
Summers View	100%
Trust Overall Score	
National Average Score	96.4%
	78.84%

Incidents

Area of performance	Incidents (clinical and non-clinical)
Metric – method of calculating performance:	Trust Metric: QI PS
Performance:	Please refer to the table below for performance during 2016/17

	2015/16	2016/17
General incidents	4,037	4,553
Moderate	79	75
Major	6	3
Catastrophic	128	76
Total	4,250	4,750
Incidents resulting in severe harm or death as a % of total	5.0%	3.2%

Safeguard, the Trust electronic reporting system generates weekly and monthly scheduled incident reports / trends for directorates and individual teams which allows them to explore and interrogate incidents in order to further understand and improve patient and staff safety within each area.

The table above illustrates an increase in the number of incidents reported across the Trust for 2016/17. This is a positive reflection of increased staff understanding of the need for incidents to be reported and an indication of a learning and improving culture. All incidents are subject to weekly review and analysis, in order to ensure that issues / trends are quickly identified and actions implemented enabling improved delivery of care services.

Safety Improvement Initiatives

Embedding a Safety Culture CQUIN across community and inpatient teams has achieved either an improvement or maintenance of their previous self-assessment scores for this year. This demonstrates that a focus on patient safety and improving the culture for learning. Further focus on the details of this CQUIN are detailed in section 3.1.

In 2015, as part of the Safety Culture CQUIN, the Trust completed its pledge to "Sign up to Safety", joining a national campaign to improve patient safety in the NHS. An action plan was developed, outlining the actions to be taken in our commitment to reduce avoidable harm. We pledged to make our organisation more resilient to risks by committing to learn from incidents; we have developed our 'Learning Lessons' approach, producing bimonthly bulletins and holding monthly learning workshops designed to share learning from incidents.

This is an approach that has been shared at regional patient safety events and has attracted attention from other trusts interested in developing similar approaches to sharing learning. With support from service users we have developed the Service User and Carer Council thereby ensuring that the trust is more able to 'hear the voice' of the people who use our services and can offer an improved response to service user feedback. We have also embedded the concept of Being Open into everyday practice, encouraging and supporting staff to be candid in the event of something going wrong, through additional training and awareness sessions.

In recognition of the patient journey through the wider health and social care economy, the trust has improved its partnership working with other agencies. There is greater awareness that communication between agencies and an understanding of the role played by others improves overall patient safety. Joint discussions with multiple organisations have been held to review incidents and investigations. These have been well attended and positively reviewed and seen as an excellent example of the trust values (CARE) in action.

Underpinning all of this achievement has been the willingness of the trust staff to report and to learn from incidents. Staff have embraced the concept of 'putting safety first', for sharing learning and demonstrating a desire to understand incidents in order to improve practice and ensure the safety and wellbeing of the people who use of our services. A recent initiative "National Kitchen Table Week" encouraged trusts to host conversations. Like the kitchen table at home, this approach provides an opportunity for people to talk openly and honestly and be listened to. Holding our "Kitchen Table" at Harplands Hospital reception encouraged many conversations and ideas to share safety initiatives and to suggest new ideas that will be taken forward.

Incidents reported to the National Reporting and Learning System (NRLS)

Area of performance	Incidents reported to the National Patient Safety Agency (NPSA)
Metric – method of calculating performance:	KPI Number of incidents reported to the National Patient Safety Agency
Performance:	There were 2,590 NRLS incidents reported during 2016/17 which is an increase in the number of incidents reported from the previous year. Of these, the number of incidents resulting in severe harm or death (64) as a percentage of the total was 2.8%. This is a positive reduction in previous year's data and is a reflection of the reporting culture promoted by the Trust.

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

Our culture of incident reporting has continued to improve as demonstrated through benchmarked data from the NRLS. Latest data illustrates our higher reporting rate per 1000 beds than the national reporting median for mental health trusts. Improved reporting of incidents helps to better identify risks and provides better opportunities to improve patient safety. 72% of all patient safety incidents reported were no harm incidents; this is in comparison to the national average of 64% and is a reflection of a positive reporting culture for reporting both harm and no harm incidents.

We are pleased to report that the national staff survey results for 2016 demonstrate our workforce commitment to reporting incidents, errors and near misses with a 95% respondent reply that they have reported errors, near miss and incidents witnesses over the previous month, a positive response to the fairness and effectiveness of procedures for reporting and an improvement in staff confidence and security in reporting unsafe clinical practice.

We will continue to focus on increasing community reporting to allow for on-going theme and trend analysis to identify areas for quality and safety improvement. We have introduced a peer review facilitated Inpatient Safety Matrix Safe Ward in addition to strengthening clinical pathways to enhance outpatient support and enhancing evidence based psychological treatments in line with NICE guidance. We will continue to use our internal reporting systems and external benchmarking opportunities to monitor progress against our quality improvement initiatives.

Never events

Area of performance	'Never events'
Metric – method of calculating performance:	Trust Metric: QI PS 8 never events A never event is a serious, largely preventable, patient safety incident that should not occur if the available preventable measures have been implemented. An example would be an inpatient suicide using curtain or shower rails.
Performance:	Nil – No 'never events' in the Trust during 2016/17.

We are pleased to maintain our zero reporting of Never Events during 2016/17.

Serious incidents

Area of performance	Serious incidents (SIs) (clinical and non-clinical)
Metric – method of calculating performance:	Trust Metric: KPI 17.17 Investigating and reporting of serious incidents
Performance:	During 2016/17 there have been 57 serious incidents reported by the Trust. During 2016/17 no investigation breached the 60 working day dead-line.

In 2016/17 we have maintained a strong performance in respect of the timely investigation and quality of completed investigations and the approaches taken to learning from serious incident investigation.

We have maintained our performance of 100% of investigations undertaken within the required timescales by staff trained in Root Cause Analysis methodology. Following the CQC re-inspection of trust services in 2016, our management of serious incidents received positive feedback and highlighted the quality of the investigation reports, timely completion, candour responsibilities and approach to learning from incidents in our overall "Good" rating.

Key points learned from incident investigation are captured in a monthly Learning Lessons workshop and further complimented by regular academic learning events and the publication of the bi-monthly Learning Lessons bulletin; the bulletin was shared as an example of good practice on the Sign up to Safety website and there has been subsequent discussions and visits from other trusts, who expressed an interest in developing their own version of Learning Lessons using the approach developed by the Patient and Organisational Safety Team.

The Patient and Organisational Safety Team work in partnership with directorates to ensure that trends arising from incidents are discussed at directorate and team level meetings and reported to the Trust's Quality Committee and Trust Board oversight through the Medical Director as Executive Director Lead for Serious Incidents and Mortality Surveillance. Quarterly thematic review of serious incidents helps to identify emerging themes and trends and thematic reviews will be undertaken to facilitate learning and improvement.

We noted and responded to an increase in the number of serious incidents in the period July-September 2016 and undertook a deep dive review facilitating an opportunity for learning and improvement and the sharing of good practice.

We are pleased to report the development of a trust Suicide Prevention Strategy ratified by the Board in March 2017. The Strategy links to the National and Staffordshire Suicide Prevention strategies. We have highlighted a number of high priority areas from the strategy including staff training and awareness raising relating to national and local risk factors and developing staff with specialist skills in supporting families and carers bereaved by suicide. We welcome the opportunity to influence the Staffordshire Strategy from our own learning and improvement and the part that the trust plays in reducing stigma associated with mental ill health and building community resilience.

We are committed to learning when things go wrong and taking action to improve. Furthermore, we take responsibility to ensure that we share learning in an open transparent and compassionate manner with families and carers through our Being Open and Statutory Duty of Candour Policy Framework.

This policy provides Trust staff with guidance as to their roles and responsibilities in relation to this statutory duty.

In order to support the implementation of this policy, a series of initiatives have been delivered to raise staff awareness and embed the statutory requirements into practice. These initiatives form part of an on-going programme of education for all employees and are facilitated by the Patient and Organisational Safety Team. These include.

- Inclusion of Duty of Candour awareness within the Trust mandatory training curriculum.
- A series of workshops, using the "Learning Lessons" forum to discuss the duty and to set out responsibilities.
- Awareness sessions in individual clinical teams.
- Inclusion in the Trust Preceptorship programme.
- Inclusion in the Student Nurse learning programme.
- Training sessions facilitated for Governance Leads to support their quality and safety role within clinical directorates.

The Trust's responsibility for ensuring compliance with this statutory duty is monitored through a series of reporting mechanisms. In addition to the weekly Incident Review Group minutes reflecting the decision making for Duty of Candour threshold, additional assurance is given to the Board by means of reporting to the Clinical Safety Improvement Group, Quality Committee and Trust Board.

External data and reports are shared with the monthly Clinical Quality Review Meeting chaired by Commissioners. Whilst the Directorates are members of the internal governance forums, the Directorate Governance Leads are also responsible for ensuring that service user safety is an agenda item at Directorate meetings. In order to provide the Trust Board with assurance that there is full compliance with the statutory Duty of Candour requirements, the Trust's Clinical Governance leads carried out an audit of the arrangements within the Trust and concluded that the Trust was compliant in meeting these requirements.

We are pleased to receive positive feedback from our 2016 CQC inspection recognising our embedded approach across the trust and we will continue with this good work during the coming year.

Infection Prevention and Control

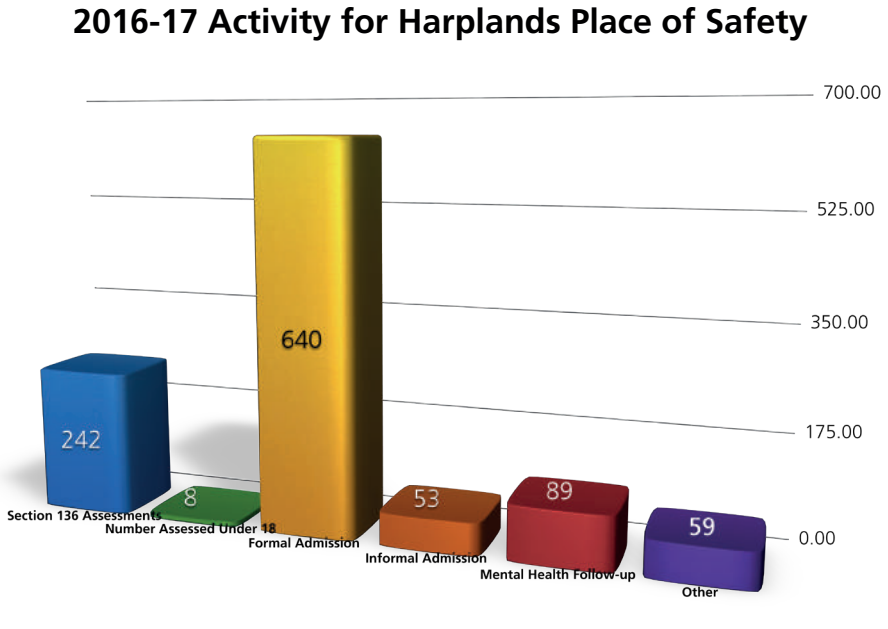
There have been no MRSA blood stream infections and no Methicillin Sensitive Staphylococcus Aureus (MSSA) blood stream infections reported. MRSA screening compliance remains at 100% for all those admissions who fulfil the criteria for screening.

The Trust's target of zero avoidable HCAIs was therefore maintained.

Clinical effectiveness

Area of performance	Mental health activity
Metric – method of calculating performance:	QG.43 Mental health activity
Performance:	242 assessments under Section 136 of the Mental Health Act 1983 took place at Harplands Hospital Place of Safety. Of the 242 assessments completed, 8 were under the age of 18 years. The outcomes of all of the assessments are as follows: • 17% - Formal admission to hospital under the Mental Health Act • 22% - Informally admitted to hospital • 37% - To be followed-up by mental health / social care services • 24% - Other / care of family / own GP From the above data, it can be seen that 60% of those people assessed under Section 136 of the Mental Health Act are not admitted to hospital.

This data shows the number of assessments carried out under Section 136 of the Mental Health Act 1983 (police power to remove a person to a place of safety). The Harplands Hospital Place of Safety Assessment Suite is the first choice designated health-based place of safety and, where possible, all persons are assessed here.

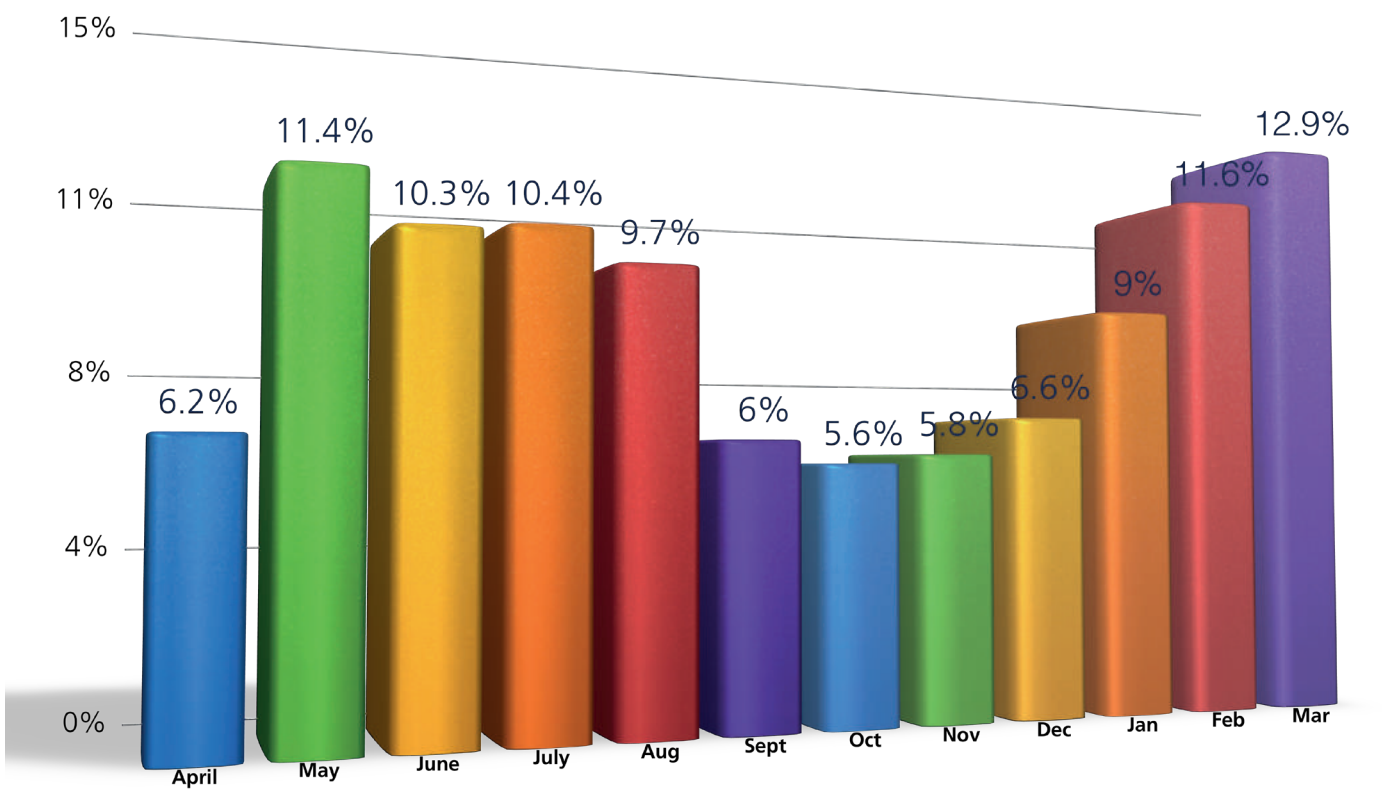


On occasions when the Place of Safety Assessment Suite is full, the Trust will seek to complete the assessment in an alternative health-based place of safety within Staffordshire and only when all health-based places of safety have been exhausted an individual needing support will be conveyed to the Northern Area Custody Facility at Etruria for completion of the assessment.

The data below shows the outcome of the assessments completed at Harplands Hospital's place of safety, in terms of admission to hospital and the number of cases where the person was under the age of 18 years, for the last five years.

Area of performance	Delayed transfers of care
Metric – method of calculating performance:	Delayed transfers of care
Performance:	Overall, for 2016/17 the Trust's rate for delayed transfers of care is 8.4% for the year, against a target of less than 7.5%. This reflects an increase from 5.76% reported for 2015/16 and is in line with the national position where there is an increase in whole system delays associated with high rates of bed occupancy and cuts to social care that are both causing extra pressures to build up across the NHS. The Trust is in discussion with health and social care commissioners to ensure that every effort is made to ensure that service users are located in the most appropriate environment. We are also focussing on this as an additional quality priority for 2017/18.

2016-17 Delayed Transfers of Care



Area of performance	Physical health checks
Metric – method of calculating performance:	Physical health checks
Performance:	100% of physical assessments completed included all of the components listed: • A baseline physical examination • A baseline lifestyle assessment • A baseline haematological screening • A history of past physical, psychotropic and non- prescribed medications • Current use of physical, psychotropic and non-prescribed medications • MRSA screening

Area of performance	Compliance with 18 week waits
Metric – method of calculating performance:	18 week waiting time (all referrals)
Performance:	Performance for 2016/17 is 94.3% at year end.
	The Trust monitors the waiting time from referral for all service users who have been waiting to ensure that treatment is received within 18 weeks. The metric reports on the wait from when the patient is referred into the Trust to the time they are seen by a Trust member of staff.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	86.4%	87.2%	83.3%	87.4%	88.6%	90.4%	92.1%	92.0%	95.9%	95.7%	93.8%	94.3%

Area of performance	Patients re-admitted within 28 days of discharge
Metric – method of calculating performance:	The rate of unplanned readmissions for patients (adults and older adults) within 28 days is a key performance indicator for the Trust. The target for this metric is 7.5%
Performance:	For 2016/17 there were a total of 1825 admissions of which 201 were readmissions. By age range 0-15 yrs – 0, 16yrs or over – 201.

Area of performance	7 day follow up of Care Programme Approach (CPA) patients
Metric – method of calculating performance:	Follow up of CPA patients within seven days of discharge
Performance:	This is strong national evidence that the period following discharge has shown to be a high risk period for service users at risk of suicide and self-harm. To mitigate these risks and provide appropriate support to service users, the Trust ensures that every adult is followed up within 7 days of discharge. There is a 95% national target. Our average for the year was 96.02%

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	100%	100%	100%	100%	97.7%	100%	97.6%	98.1%	95.2%	100%	95.3%	97.0%
2016/17	97.5%	96.8%	96.9%	97.9%	96.2%	97.9%	100%	92.3%	97.5%	95.8%	92.5%	91.0%

Most recent published benchmarking data	Q4 2014/15 (%)	Q4 2015/16 (5)	Q3 2016/17%
Trust	100	97.5	94.6
National Average	97.2	97.2	96.7
Highest	100	100	100
Lowest	93.1	80	73.3

Area of performance	Crisis resolution gate kept admissions – acute
Metric – method of calculating performance:	KPI 17.14 acute admissions gate kept by Crisis Resolution teams
Performance:	Please refer to table below for performance during 2016/17. The national target is 95%

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	100%	95.2%	93.2%	98.4%	97.5%	100%	98.6%	82.7%	100%	98.7%	100%	100%
2016/17	100%	100%	96.6%	100%	100%	98.9%	92.3%	97.7%	100%	100%	100%	100%

Most recent published benchmarking data	Q4 2014/15 (%)	Q4 2015/16 (5)	Q3 2016/17%
Trust	99	99.5	98.3
National Average	98.1	98.2	98.7
Highest	100	100	100
Lowest	59.5	84.3	88.3

Area of performance	Service users on Care Programme Approach (CPA) care review
Metric – method of calculating performance:	KPI 17.14 acute admissions gate kept by Crisis Resolution teams
Performance:	This is a national indicator to monitor compliance with CPA. The Trust has maintained performance and continues to ensure service users receive timely reviews of care to ensure that their care and support needs are met

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	91.6%	90.3%	90.1%	90.8%	92.8%	95.1%	95.0%	92.9%	93.2%	94.7%	94.2%	94.2%
2016/17	94.1%	92.4%	92.1%	92.0%	91.8%	91.4%	91.2%	89.4%	98.3%	95.8%	95.5%	96.2%

Area of performance	Patients in settled accommodation
Metric – method of calculating performance:	KPI 17.6i Percentage of patients who are in settled accommodation
Performance:	The core aim of the employment and settled accommodation outcome measure is to increase the proportion of the most socially excluded adults in settled accommodation and employment. This underpins a long-term vision of ensuring that vulnerable adults have the foundations they need to get their lives back on track. The Trust has maintained the percentage of patients in settled accommodation, with over 90 % for 2016/17, similar to 2015/16 and we have a plan to improve performance for 2017/18

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	91.0%	91.0%	91.0%	90.0%	91.0%	91.0%	91.0%	91.0%	90.0%	90.0%	90/0%	93.4%
2016/17	93.2%	93.3%	94.0%	92.8%	91.2%	86.6%	90.4%	85.7%	89.3%	89.3%	89.3%	88.8%

Area of performance	Patients in employment
Metric – method of calculating performance:	Percentage of patients who are in employment
Performance:	The Trust has worked hard to increase numbers year on year in this well received local programme. The Trust continues to provide vocational support to our service users to increase the proportion of the most socially excluded adults in employment and this work will continue throughout the coming year to improve performance.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	13.0%	13.0%	13.0%	13.0%	13.0%	13.0%	13.0%	13.0%	13.0%	13.0%	13.0%	13.0%
2016/17	12.8%	12.2%	12.0%	12.0%	11.2%	11.0%	11.6%	10.8%	7.9%	8.0%	7.8%	7.2%

Staff satisfaction

Area of performance	Staff satisfaction
Metric – method of calculating performance:	KPI 17.14 acute admissions gate kept by Crisis Resolution teams
Performance:	KPI 11.1 Staff satisfaction as measured by the annual national staff satisfaction survey

The annual NHS Staff Survey took place in September – December 2016.

The results, published on the 7 March 2017, reveal that our staff are feeling increasingly positive about working for the organisation. The responses demonstrate that our efforts and commitment to engaging our workforce is paying off. The NHS Staff Survey gives us an opportunity to understand the views of our staff and their experiences throughout their employment with us. Benchmarked data against other mental health trusts confirms the journey of the trust of its improvement towards outstanding.

A total of 618 NSCHCT staff took part in the latest questionnaire representing 51% of the workforce, slightly above the national response rate of 50%.

Our 2016 staff survey continues to build on improvements made in 2015. We have made a number of improvements on last year:

- Over 20% of the survey's 27 indicators demonstrate significant improvement
- Comparing like for like figures with 2015, over 70% of indicators have an improved score in 2016
- Above average scores posted against comparator NHS organisations in approximately a third of areas
- Strongest areas of performance are in reporting of errors and near misses, plus percentage of staff experiencing harassment, bullying, discrimination or abuse at work.

Perhaps the most positive result this year relates to staff's improving perceptions of the trust, seeing an improving workplace and patient / carer emphasis. All 5 indicators in the survey which measure these perceptions, show marginal improvement.

Areas of strength in terms of external comparison

Relative to other comparative trusts, the 2016 results highlight two key areas of strength. The first relates to the themes of reporting and witnessing errors:

- Percentage of staff reporting errors, near misses or incidents witnessed in the last month
- Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month
- Fairness and effectiveness of procedures for reporting errors, near misses and incidents.

The second theme positively relates to statements that reveal low levels of discrimination:

- Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months
- Percentage of staff experiencing discrimination at work in the last 12 months

Areas for improvement highlighted by 2016 data

The areas for improvement arising out of the staff survey. In this section we will explore the following findings:

- Reduced response rate from 2015
- Our scores are average to the mental health community
- There are large variations within our directorates
- Notable and stubborn areas requiring improvement (e.g contributions towards improvements at work and quality of appraisal)
- New areas of decline relative to mental health average

By adopting the Go Engage approach in 2017, we aim to reduce variation across teams to ensure our staff survey has a more equitable experience at work. We will additionally understand our culture deeper than the staff survey currently permits, meaning we will have more potential to positively influence future annual results and more importantly the experience of our staff.

A range of actions have been developed by directorates. These plans have been informed by sharing the results throughout the trust and in facilitating directorate level conversations about what needs to improve.

Compared to last year's survey, the Trust has improved in a majority of areas, which are scored either as a percentage or a mark out of five. Of the 32 key findings that make up the Staff Survey, the Trust recorded average or above average performance in 26 (81.25%) of them, compared with other mental health trusts nationally. Measures where the Trust performed in the best performing category compared with other mental health trusts included:

- Percentage of staff experiencing discrimination at work in the last 12 months (the Trust's top ranked measure). KF20 10% compared better to national average 14%.
- Staff experiencing harassment, bullying or abuse from other staff in the last 12 months. KF26 19% compared better to national average 22%.
- Staff believing the Trust provides equal opportunities for career progression or promotion. KF21 88% compared better to national average 87%.
- Effective team working. KF9 (score 1 – 5) 3.86% above national average 3.85%.

The Trust's overall staff engagement score has increased from 3.55/5 to 3.71/5; this score represents staff members' perceived ability to contribute to improvements at work, their willingness to recommend the organisation as a place to work or receive treatment and the extent to which they feel motivated and engaged with their work.

The percentage of staff who feel that care of patients and service users is the Trust's top priority has increased by 11%, while the percentage of respondents who believe that the organisation acts on concerns raised by patients and service users has risen by 7%.

Furthermore, the percentage of those who would be happy with the standard of care provided if a friend or relative needed treatment has gone up by 7% and the percentage of staff who would recommend the Trust as a place to work has increased by 4%. In addition, the percentage of respondents who believe that the organisation provides equal opportunities for career progression or promotion has risen by 4%, while the percentage of staff suffering work-related stress in the last 12 months has dropped by 7%. Other areas where the Trust's score has improved upon last year include staff motivation at work and satisfaction with their level of responsibility and involvement.

These improving results follow a series of new initiatives launched by the Trust to improve staff engagement, including the Listening into Action Programme, which puts power into the hands of staff to deliver the way Trust services are run, the Chief Executive's weekly CEO blog, and team visits by members of the Executive Team for informal question and answer sessions. Additionally, the appointment of the Trust's Freedom to Speak up Guardian and continued success of the Dear Caroline website which provides an anonymous way for staff to raise any concerns or suggestions they may have about the quality of our services directly with the Chief Executive and a mechanism for all staff to receive feedback about their concerns and suggestions in a safe and timely manner.

Having considered the results, the trust is taking action to address a number of areas which will be reviewed and monitored by the Trust's People and Culture and Development Committee and progress reported to the trust board.

Patient Experience

In 2016/17 we have seen the development of the Service User and Carer Experience and Involvement Group, development of the Service User and Carer Strategy and work plan and a campaign to improve the response rate to the Family and Friends Test (FFT).

Friends and Family Test (FFT)

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. We are pleased to report a significant increase in FFT returns across the Trust following a campaign. In 2015 we were averaging 50 FFT returns per month. Our latest return rate of 550 in March 2017 is a result of the positive impact of the campaign and importantly, a sense check of the service user experiences of our service and our Q4 report reflects that 90% of people using our services would recommend us as a place to receive care.

Service User and Care Council

The Council continues to meet on a monthly basis, with an active and forward looking agenda.

We have seen the Chair of the Council stand down this year and acknowledge the leadership and support given in guiding the Council over the past year. The Chair of the Service User and Carer Council is a member of the Trust Board.

We have and will continue to seek wider involvement to support the Council, holding a recent Open Space event in March 2017 focussed on increasing service user and carer involvement across a range of trust business and activities. We are pleased to have received many expressions of interest and willingness to be a part of the engagement agenda of the trust.

The Annual Mental Health Community Survey 2016

The 2016 survey of people who use community mental health services involved 58 providers of NHS mental health services in England. We welcome the feedback from this Survey as it provides an additional feedback opportunity on service user experience and perceptions of our service.

While aspects of people's experiences have remained relatively stable, there is more work to do as part of our journey of improvement.

Our response rate of 33% was above the national average of 28%, and is comparable with our response rate for 2015 of 33%.

However, we would like to improve this position.

As a result, an action plan has been drawn up by our Community Directorate to address this and also respond to the points raised and further improve those areas. This will be monitored closely by the Service User and Carer Experience and Involvement Group and the Trust's Quality Committee. It will be reviewed and discussed by our Service User and Carer Council on an annual basis.

Patient Experience

Area of performance	Staff satisfaction
Metric – method of calculating performance:	KPI 16.1 Patient experience as measured by the annual national patient survey in relation to community based care – the most recent survey results were published in November 2016
Performance:	We are pleased with our most recent survey results.

Questions relating to	Score out of 10	How this score compares with other Trusts
Health and Social Care workers	7.6	About the same

"My care co-ordinator is really understanding. I feel this person totally understands me."

Questions relating to	Score out of 10	How this score compares with other Trusts
Organising care	8.5	About the same
Planning care	6.8	About the same
Reviewing care	7.5	About the same

"The care I received was the very best."

Questions relating to	Score out of 10	How this score compares with other Trusts
Changes in who you see	5.4	About the same
Treatments	7.3	About the same
Other areas of life (e.g. physical health, accommodation, involving family members etc)	4.6	About the same
Crisis care	5.9	About the same

I received art therapy and it has changed my life. The staff involved are brilliant, supportive, encouraging and after years of depression/PTSD I'm living a more normal life. Thank you NHS."

Questions relating to	Score out of 10	How this score compares with other Trusts
Overall views of care and services	7.2	About the same
Overall experience	6.9	About the same
Reviewing care	7.5	About the same

My life is improving I feel like I have more determination to overcome obstacles and move forward.Thank you."

Complaints Received

Area of performance	Staff satisfaction
Metric – method of calculating performance:	KPI 15.1 Complaint acknowledgements, response and trends
Performance:	Detail below

	2015/16	2016/17
Number of complaints	65	43
Number acknowledged within three working days	100%	100%

The Trust is committed to providing service users, families or members of the public with the opportunity to make a compliment, seek advice, raise concerns or make a complaint about any of the services it provides. We view all feedback, as valuable information about how trust services and facilities are received and perceived. We will continue to develop a culture that sees feedback and the learning from complaints as opportunities to improve and develop services.

Our focus this year has been on strengthening our complaints procedure to enhance the experience of those using the service alongside ensuring timely and quality investigation and responses. An improvement action plan shared with our external commissioners set out our improvement journey. We have worked in partnership with Staffordshire and Stoke Healthwatch and our Service User and Carer Council to implement improvements through investigation training, revised processes and improved oversight. It is pleasing to note the 2016 CQC inspection reported the trust's approach to managing complaints as effective and confidential and that the trust followed a robust process.

During 2016/17, 1 complaint was referred to the PHSO which following their careful review and consideration was not upheld. A further case referred to the PHSO was returned with a recommendation that further local resolution be explored to resolve the complaint.

Themes, Trends and Learning

During 2016/17 adult community directorate received the highest number of complaints. Whilst the directorate have the highest number of service user contacts, we are committed to analyse themes and trends, learn from feedback and take the improvement actions required to improve the experience of people using our services.

Looking back in 2016/17, complaints received generally fell within the categories of care planning, attitude of staff and communication issues. In response, we have undertaken a programme of customer care training with our clinical teams utilising service user and carer feedback as a means to provide a reflective learning environment in which to develop understanding of the service user perspective of our own behaviours. We emphasise the importance of local resolution and timely signposting where local resolution has been unsuccessful.

Compliments

Each year our staff receive compliments, thank you's and much praise from people they have cared for. Many patients want to write to thank staff personally or to praise the service that they have received. It gives staff a great boost when people take the trouble to pass on their positive feedback We are pleased to report that compliments received directly by the PALS service has increased from 157 in 2015/16 to 244 in 2016/17. This is a positive reflection on the services delivered by our staff and the acknowledgement of the CQC 2016 inspection feedback:

"Throughout the inspection, staff were found to be caring and considerate towards patients. Feedback from patients, carers and families was consistently positive regarding the quality of care and how staff treated them".

Patient Advice and Liaison Services (PALS) contacts

Area of performance	Patient Advice and Liaison Service (PALS) & compliments
Metric – method of calculating performance:	QI 1.8 Numbers and types of contacts via PALS and compliments
Performance:	400 PALS contacts and 244 compliments received during 2016/17

We recognise the importance of our PALS service in being a key source of information and feedback for the Trust and an early warning system for emerging issues and concerns. We are pleased to report the further strengthening of our approach to patient experience with the appointment of a whole time PALS officer.

During 2016/17 there have been 400 contacts compared with the previous year, when a total of 303 contacts were received. Themes identified on analysis relate to access and waiting times, concerns about customer care and signposting to other services. To ensure that concerns raised are addressed and actioned by the right person in a timely way, the Head of Directorate and Team Manager initially respond to outline the action taken and to the satisfaction of the individual concerned.

3.3 Engagement and statement from key partners

Engaging our partners and stakeholders – 'Three steps to engagement'

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

Step 1: Development stage

We have again developed a survey to seek the views of key partners, service user representative groups, local authorities and staff about what they liked and disliked about our previous Quality Account and what should be retained and what should be changed. We sent copies of the survey to all of these groups and included references to the survey in a public Trust Board meeting. All feedback received was responded to and reviewed as part of the engagement and design process for this Quality Account.

Step 2: Agreeing priorities The survey referred to above included a section about the priorities that key partners, service user representative groups, local authorities and staff would expect to see reported in our 2016/17 Quality Account. In addition, we have held a number of engagement meetings including dedicated 'drop-in' sessions, attended events and communications from our partners to agree our key quality priorities as follows:

- Commissioners – North Staffordshire Clinical Commissioning Group (CCG) and Stoke-on-Trent CCG
- Staffordshire Health Scrutiny Committee
- Stoke-on-Trent Overview and Scrutiny Committee
- Healthwatch, Stoke-on-Trent
- Healthwatch, Staffordshire

Step 3: Sharing the draft Quality Account

In line with the Department of Health Guidance, we also produced a draft Quality Account and shared this with key partners as follows:

- Local commissioners
- Local Healthwatch organisations
- Local Authority Overview and Scrutiny Committees
-

We invited each partner to provide a statement for inclusion in the Trust's Quality Account. These statements are shown in the section below.

Comments from key partners

North Staffordshire Clinical Commissioning Group (CCG) and Stoke-on-Trent CCG

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

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

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

Review of 2016/17

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

- The CCGs recognise the considerable amount of work undertaken by NSCHT staff to achieve a 'Good' rating by the Care Quality Commission following the inspection in September 2016.
- Throughout 2016/17 the CCGs have made a number of announced quality visits in partnership with the Trust's Governance Team, North Staffordshire and Stoke-on-Trent Healthwatch, to seek assurance and to support quality improvement of services. The CCG would like to thank staff for their open and honest approach to these visits.
- It is pleasing that the Trust has fully achieved delivery of the CQUIN schemes throughout the year and provided reports detailing the successes and the substantial improvements made for service users. As part of the delivery of the national Health and Wellbeing CQUIN the Trust was recognised as the highest performing mental health Trust in the country for flu vaccination of frontline staff doubling its performance compared with 2015 and was shortlisted as a finalist in the annual Healthcare People Management Association awards in recognition of the innovative Feel Good Friday / Wellbeing Wednesday initiative.
- In November 2016 the Trust attended the CCG's Quality Committee in common to present the Learning Lessons programme which is recognised as best practice by the West Midlands Patient Safety Collaborative. In February the Trust showcased their quality improvement work at the CCGs' Lunch and Learn Quality session. Both presentations were informative and well received.
- It is pleasing to note that the community teams for older people memory services were the top performing service in the West Midlands for diagnostic rates for dementia and the eighth overall in England.

However, 2016/17 has not been without its challenges and these will remain key areas of focus in 2017/18:

- The target number of children in treatment for 16/17 has been exceeded. The additional investment in Tier 3 was phased over a 2 year period 2016/17 and 2017/18 but all posts were recruited to in 2016/17. A waiting list initiative has been in place which has also delivered additional activity and the Trust is now achieving the national target of seeing everyone within 18 weeks for an initial assessment. The CAMHS teams have monitoring measures in place to review young people who have been assessed and have introduced screening for the right intervention and if appropriate sign posting to other services.
- Preventing suicides has been an area of both national and local focus throughout 2016/17 and continues to be of high importance moving forward. Commissioners have been pleased to see the implementation of the internal Suicide Prevention Strategy and active involvement of the Suicide Awareness Strategy for Staffordshire North.

Priorities for 2017/18

The Commissioners have worked closely with the Trust to agree quality improvements for 2017/18 in some areas using the national CQUINs framework to align priorities for development which will drive real improvements in quality and safety.

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

Tracey Shewan
Director of Nursing & Quality
North Staffordshire CCG & Stoke-on-Trent CCG

Marcus Warnes
Accountable Officer
North Staffordshire and Stoke on Trent CCG

Healthwatch Staffordshire

Introduction

Healthwatch Staffordshire was pleased to have been invited to comment on the Quality Accounts of the Trust and welcomes the detailed and comprehensive report. Vision, Values and Mission of the Trust are clearly outlined and the early part of the report is easy to understand and well addressed to the general public.

Healthwatch Staffordshire has been working closely with the Trust and will continue to do so during 2017/18.

It is commendable regarding the overall rating of 'good' for the CQC comprehensive inspection with 10/11 core services receiving either 'good' or 'outstanding'. Within the report there is significant comment and promotion of the Trust's commitment to continuing improvement. It is pleasing to see actions for improvement included as well as areas recognised as good practice. The Trust had received a score of requires improvement for the safety element of the CQC inspection, this is covered in the introductory section under summary of quality priorities and in more detail under 1.2 and 2.2. The fact that the Trust strives to achieve a rating of 'good' or 'outstanding' in every core service is also noteworthy.

The report contains a thorough explanation of its performance against objectives. There is good demonstration of key achievements and good news stories. The CQUINS are reported using the traffic light system is commendable.

The Trust is involved in various national clinical audits, national confidential enquiries and a local clinical audit programme and we acknowledge the level of resource this must involve. The evidence presented within the report includes the results and actions to be taken.

It is pleasing to note that the Trust is actively engaging with staff including learning lessons, research and development opportunities and a positive return from the Annual NHS Staff Survey. The report mentions some notable and stubborn areas requiring improvement and new areas of concern but it is difficult to pinpoint where these are identified and which planned actions match these. We understand this will be made more explicit.

There is clear demonstration of consultation and engagement. The priorities for improvement for 2017/18 are clearly set out with detailed explanations of how these will be met together with a thorough review of the Quality Performance for 2016/17.

The section Performance in 2016/17 as Measured Against a Range of Quality Indicators is well laid out with a good variety of information. With regard to Patients re-admitted within 28 days of discharge (p66) there is a target mentioned of 7.5 for re-admissions within 28 days of discharge and (pg 68) performance relating to Patients in Settled Accommodation and Patients in Employment). We understand commentary will be added in the further version as this will be useful to help the reader understand performance and what is being done to address this.

The Complaints Received section is very informative and addresses the continual improvement of the complaints process which provides reassurance.

Conclusion

Healthwatch Staffordshire looks forward to having the opportunity to review the 2017/18 Quality Account next year and particularly to be able to assess how the quality initiatives have impacted on the Trust's staff and the residents of Staffordshire.

Healthwatch Stoke-on-Trent

The Quality Account was presented and considered by Healthwatch Stoke-on-Trent on 17th May 2017 and following the presentation from NSCHT and responses to the questions raised, Healthwatch Stoke-on-Trent offers the following comments:

We are pleased to note the significant move forward by the Trust in improving all of its' priorities set for the year. The fact that it reached 100% against all CQUINS (such as patient safety, person centred care and staff health and wellbeing) is commendable.

Healthwatch Stoke-on Trent thank the Trust for the support it has given to the mental health sub group with its' CAMHS project While We Were Waiting. The group members visited a CAMHS hub and the unit at Dragon Square where they could talk to staff about the service. Staff also attended some of our meetings to discuss the project. This was very helpful in informing the work we did around the project.

We would note that we have seen steps forward in openness and engagement between NSCHT and its' partners (for example, the regular quality visits in which Healthwatch Stoke participate) and the Trust is seeking to grow this area during the coming year. It is commendable regarding the overall rating of 'good' for the CQC comprehensive inspection with 10/11 core services receiving either 'good' or 'outstanding'.

The fact that the Trust strives to achieve a rating of 'good' or 'outstanding' in every core service is also noteworthy.

Comments from those who attended the presentation include the following:

- We feel that some terms used should be better explained (such as 'CQUIN' and the 'Green Light toolkit'). Such explanations would make the document more understandable by the 'layman';
- We noted that success is measured for the Quality Account when quality priorities agreed with commissioners and key stakeholders have been achieved and validated by internal and external audit processes.
- The group would be interested to discover more about what the Trust does in terms of supporting possible employment for those with mental health issues, such as the Step on Service;
- Although customer care training has been put in place, one attendee felt that effective communication between staff and users should continue to be one of the highest priorities as was noted in the Learning Lessons section of the Quality Account;
- Since there is to be a move towards making development of the document more interactive and web based, we discussed how those without internet access can meaningfully contribute and it was pleasing to hear initiatives in this regard and proposals for a further Open Space Event;
- It would be helpful if performance figures, when used in the document, could show comparisons to other Trusts, accepting when benchmarking is meaningful and appropriate, to give a greater appreciation of the performance.

In conclusion Healthwatch Stoke-on-Trent believes the draft Quality Account presented is a fair reflection of successes achieved and a reasonable reflection of priorities. Healthwatch Stoke will continue to work with the Trust to help achieve its priorities throughout the forthcoming year and would be interested in contributing to independent reviews measuring progress.

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

On behalf of the Adults and Neighbourhoods Overview and Scrutiny Committee, I would like to thank you all for attending the committee meeting to present your organisation's Quality Account 2016/17 and for answering the committee's questions.

The committee would like to respond to the Quality Account by submitting the following statement:-

We welcome the opportunity to comment on the North Staffordshire Combined Healthcare Trust draft Quality Account 2016/17 and would like to thank Sandra Storey, Laurie Wrench and Dr Buki Adeyemo for their detailed presentation of the draft Quality Account to the committee on 22 May 2017.

General Comments

The Quality Account is very well presented with a good level of detail for the reader. There is a clear vision, statement of values and objectives and a detailed list of services provided by the Trust. The structure of the document meets the required format and clearly demonstrates the inclusion of all the mandatory contents as set out in the guidance for NHS Trusts.

The proposed addition, in the final Quality Account, of links to further information and videos to make the document more interactive were welcomed by the committee as a positive approach to improve engagement with the reader.

Statement on Quality

The committee were pleased to note that the September 2016 CQC Inspection overall rating had improved to 'Good' from the previous rating of 'Requires Improvement' in September 2015 and particularly welcomed how quickly the Trust had turned the previous judgement around. Although concerned that three of the five domains within community CAMHS service required improvement, there were 2/11 services requiring improvement around the safety domain. Overall 10/11 core services received a rating of either good or outstanding. We did recognise that the Trust was challenging two of the findings and had also implemented comprehensive improvement plans to address the areas highlighted by the CQC.

Priorities for Improvement (2017/18)

The priorities for 2017/18 are supported by the committee and we acknowledge the consultation undertaken by the Trust with key stakeholders to develop those priorities.

The committee were pleased to note the implementation of a 'Suicide Prevention Strategy 2016-18' as a priority and requested more statistical data around the suicide numbers, including a breakdown of the gender, age etc. of suicide victims and comparisons with statistical neighbours.

Review of Quality Performance for 2016/17

The committee were pleased to note 100% achievement of the schemes against the CQUIN financial and performance framework in 2016/17 and particularly pleased to see the continuation of the traffic light system used to identify last year's priorities identified by the CQUIN scheme, with details of the level of achievement and corresponding proportion of income achieved for each priority.

The committee welcomed the encouraging feedback from staff indicating that they are positive about working for the organisation, whilst recognising that there had been a reduced response rate compared to 2015.

It was disappointing to hear, at the committee meeting, confirmation that a ward opened at Harplands Hospital in response to the acute trust winter bed pressures had been decommissioned, but we were pleased to hear that the ward would be reopened from September 2017 and commissioned on a recurrent basis.

North Staffs Voice for Mental Health

North Staffs Voice for Mental Health (previously North Staffs Users Group) congratulate the Trust on their recent CQC visit in September 2016 in which 10 out of 11 of the Trust's core services were rated as either good or outstanding. We also want to congratulate the Trust in achieving their financial targets for the last 12 months (2016/17) as we feel this is important for the people who use their services.

North Staffs Voice have a good working partnership with the Trust and have found them very responsive to any comments or issues we have raised with them on behalf of service users and their work with us to resolve these if possible.

Over the last 12 months we have continued to be involved in a number of meetings held by the Trust and we attend Trust Board meetings regularly where we can and do raise any concerns there and Trust Board members are also very responsive.

We look forward to working with the Trust over the next 12 months towards achieving their goal of becoming an outstanding Trust and on behalf of service users ask that they involve us at an early stage in any plans/proposals to develop any new services or any proposed changes there might be to existing services so that we can inform, consult and involve service users as soon as possible.

3.4 Statement of changes

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

You Said	
North Staffordshire Clinical Commissioning Group (CCG) and Stoke on Trent CCG	
No changes required	
Healthwatch Stoke-on-Trent	
Explain terminology such as Green Light Toolkit and CQUIN	Described under 3.1
Healthwatch Staffordshire	
Positive return from the Annual NHS Staff Survey noted. To help the reader further, make more explicit areas of progress and action being taken	Described under 3.2 and will make more explicit
Performance data is well laid out with a variety of information. To help the reader further, additional information on readmissions, patients in settled accommodation	Additional information added pg. 54 & pg. 58
Stoke-on-Trent City Council's Adults and Neighbourhoods Overview and Scrutiny Committee	
The Committee were pleased to note the implementation of a 'Suicide Prevention Strategy 2016-18 and requested more statistical data around suicide numbers, including a breakdown of the gender, age, and comparisons with statistical neighbours.	A link to Public Health England on mortality outcomes provided. Contact details provided for Staffordshire Lead for further information, as required.

3.5 Auditor Statement of Assurance

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

We are required to perform an independent assurance engagement in respect of North Staffordshire Combined Healthcare NHS Trust's Quality Account for the year ended 31 March 2017 ("the Quality Account ") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations ").

Scope and subject matter
The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following indicators:

- Crisis resolution gate kept admissions
- Incidents reported to the National Patient Safety Agency (NPSA)

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

Respective responsibilities of Directors and auditors
The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations) .

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate; t
- here are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

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

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations ;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 published on the NHS Choices website in March 2015 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

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

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

- Board minutes for the period April 2016 to May 2017;
- papers relating to quality reported to the Board over the period April 2016 to May 2017; feedback from North Staffordshire and Stoke on Trent CCG dated June 2017; feedback from Healthwatch Staffordshire dated June 2017;
- feedback from Healthwatch Stoke on Trent dated June 2017;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009 dated April 2017;
- feedback from the Stoke Adults and Neighbourhoods Overview and Scrutiny Committee dated May 2017;
- the latest Care Quality Commission inspection report dated February 2017; the 2016 National Staff Survey;
- the 2016 Survey of people who use community mental health services
- The Head of Internal Audit's Annual Opinion over the trust's control environment, dated April 2017
- The Annual Governance Statement for the year ended 31 March 2017 North Staffs Voice for Mental Health comments, June 2017

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

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

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

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations ; and reading the documents.

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

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

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

It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations. In addition, the scope of our assurance work has not included governance over quality or non mandated indicators which have been determined locally by North Staffordshire Combined Healthcare NHS Trust.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

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

Ernst & Young
2 St Peter's Square, Manchester 29 June 2017

The maintenance and integrity of the North Staffordshire Combined Healthcare NHS Trust web site is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the Quality Accounts since they were initially presented on the web site.

Legislation in the United Kingdom governing the preparation and dissemination of the Quality Accounts may differ from legislation in other jurisdictions .

3.6 Glossary

AIMS	Accreditation for Inpatient Rehabilitation Units
ASD	Autistic Spectrum Disorder
ADHD	Attention Deficit Hyperactivity Disorder
ASIST	Advocacy Services in Staffordshire
CAMHS	Child & Adolescent Mental Health Services
CCG	Clinical Commissioning Group (made up of local GPs, these groups replaced Primary Care Trusts (PCTs) as commissioners of NHS services from 2013/14)
CLRN	Comprehensive Local Research Network
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation scheme
CSU	Commissioning Support Unit
DOH	Department of Health
ECT	Electroconvulsive therapy
EngAGE	Stoke-on-Trent forum for people over 50 to give their views Healthwatch Local independent consumer champions,represents the views of the public
HRG4	Health Resource Group (standard groupings of clinically similar treatments)
IAPT	Improving Access to Psychological Therapies team
IM&T	Information Management and Technology
IT	Information Technology
KPI	Key Performance Indicator. Metric Method of calculating performance
Mind	Mental health charity network
MRSA	Methicillin-resistant Staphylococcus Aureus
NDTi	National Development Team for Inclusion
NHSLA	NHS Litigation Authority
NICE	National Institute for Health and Clinical Excellence
NIHR	National Institute for Health Research
NPSA	National Patient Safety Agency
NSCHT	North Staffordshire Combined Healthcare NHS Trust
PALS	Patient Advice and Liaison Service
PbR	Payments by Results
PIP	Productivity Improvement Pathway Programme
POMH	Prescribing Observatory for Mental Health
QIPPP	Quality, Innovation, Productivity, Partnership and Prevention
RAID	Rapid Assessment Interface and Discharge
R&D	Research and Development
Reach	Local advocacy project supporting people with learning disabilities
Rethink	Mental health membership charity
SPA	Single Point of Access (to mental health services)
SUS	Secondary Users Service
TDA	Trust Development Authority
UHNM	University Hospital of North Midlands NHS Trust

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REPORT TO Public Trust Board(Meeting)

ENC No. 8

Date of Meeting:	13th July 2017		
Title of Report:	M2 Performance Quality Management Framework		
Presented by:	Director of Finance, Performance and Digital		
Author:	Performance Team		
Executive Lead Name: **[Approved by Exec Lead]**	Suzanne Robinson	Approved	☒

Executive Summary:	Purpose of report	
This report provides the Board with a summary of performance to the end of Month 2 (May 2017). At Month 2 there is 1 metrics rated as Red, and 3 as amber	Approval	☐
	Information	☐
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☒ Exec ☐ Date: 27th June 2017	Document Version No.	
Committee Approval / Review	Quality Committee ☒ Finance & Performance Committee ☒ Audit Committee ☐ People & Culture Development Committee ☒ Charitable Funds Committee ☐ Business Development Committee ☐ Digital by Choice Board (time limited) ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☒ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐ Comments:		
Risk / legal implications: (Risk Register Ref [if applicable])	All areas of under performance are separately risk assessed and a rectification plan is prepared dependent upon the outcome of the risk assessment		
Resource Implications: Funding Source:	N/A		
Diversity & Inclusion Implications:	Not directly		
Recommendations:	The Board is asked to; - Note the performance reported		

Trust Dashboard
Month: **May**

Key:-

National Operational	NHS Standard Contract Schedule 4 Quality Requirements : Operational Standards
National Quality	NHS Standard Contract Schedule 4 Quality Requirements : National Quality Requirements
Local Quality	NHS Standard Contract Schedule 4 Quality Requirements : Local Quality Requirements (CCG Commissioners)
National Reporting	NHS Standard Contract Schedule 6 Reporting & Information Requirements : National Requirements
Local Reporting	NHS Standard Contract Schedule 6 Reporting & Information Requirements : Local Commissioner Requirements
NHSI	NHS Improvement metric
Trust Measure	Locally monitored metric

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

North Staffordshire Combined Healthcare NHS Trust

				2017-18													
	Metric	**Frequency**	**Target (2016/17)**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD**	**Trend Rate**
NHSI Domain - Responsive																	
National Quality	Early Intervention in Psychosis programmes: % of service users experiencing a first episode of psychosis who commenced a NICE concordant package of care within 2 weeks (Target 17/18-50%, 18/19-53%)	Monthly	50%	83.3%	81.8%											82.6%	↘
National Quality	IAPT % of service users referred treated within 6 weeks of referral	Monthly	75%	100.0%	99.3%											99.7%	↘
National Quality	IAPT % of service users referred treated within 18 weeks of referral	Monthly	95%	99.7%	100.0%											99.9%	↗
National Quality	Zero tolerance RTT waits over 52 weeks for incomplete pathways	Monthly	0	0.0												0	↔
Local Quality	Compliance with 18 week waits (Referral to Treatment or Intervention) (Excluding ASD)	Monthly	92%	93.5%												93.5%	↘
Local Quality	AMH IP	Monthly	92%	100.0%												100.0%	↘
Local Quality	AMH Community	Monthly	92%	89.0%												89.0%	↘
Local Quality	Substance Misuse	Monthly	92%	100.0%												100.0%	↘
Local Quality	LD	Monthly	92%	100.0%												100.0%	↘
Local Quality	NOAP	Monthly	92%	97.4%												97.4%	↘
Local Quality	C&YP	Monthly	92%	100.0%												100.0%	↘
Local Quality	Patients will be assessed within 12 weeks of referral to the Memory Assessment service	Monthly	95%	100.0%	100.0%											100.0%	↔
Local Quality	Percentage of adults who have received secondary mental health services who were on a Care Programme Approach who have had at least one formal review in the last 12 months ***CCG Measure***	Monthly	95%	95.3%	94.4%											94.9%	↘
Local Quality	RAID response to A&E referrals within 1 hour	Monthly	95%	94.0%	94.0%											94.0%	↔
Local Quality	RAID: Referrals in FEAU, other portals and urgent wards seen within 4 hours	Monthly	90%	100.0%	100.0%											100.0%	↔
Local Quality	RAID : All other referrals seen on same day or within 24 hours	Monthly	90%	99.0%	95.0%											97.0%	↘
Local Quality	Percentage of inpatient admissions that have been gatekept by crisis resolution/ home treatment team	Monthly	95%	100.0%	98.5%											99.3%	↘
Local Quality	Patients seen within 7 days of discharge from hospital (CPA)	Monthly	95%	95.7%	96.9%											96.3%	↗
Local Quality	IAPT : All Service Users contacted within 3 working days of referral	Monthly	95%	99.4%	99.5%											99.5%	↗
Local Quality	IAPT : Service Users are assessed within 14 days of referral	Monthly	95%	99.3%	98.7%											99.0%	↘
Local Quality	IAPT : The number of active referrals who have waited more than 28 days from referral to first treatment/first therapeutic session	Monthly	5%	0.9%	Team advised data not avail from Mayden											0.9%	
Local Reporting	S136 (Place of Safety) Assessments	Monthly	No Target	23.0	33.0											56.0	↗
Local Reporting	- Formal Admissions	Monthly	No Target	4.0	6.0											10.0	↗
Local Reporting	- Informal Admissions	Monthly	No Target	4.0	2.0											6.0	↘
Local Reporting	- Under 18 Yrs Old	Monthly	No Target	0.0	0.0											0.0	↔
NHSI	The proportion of those on Care Programme Approach (CPA) for at least 12mths having a (HONOS) assessment within the last 12mths	Monthly	90%	91.4%												91.4%	↘
NHSI	AMH Community	Monthly	90%	91.5%												91.5%	↘
NHSI	NOAP	Monthly	90%	66.7%												66.7%	↘
NHSI	The proportion of those on Care Programme Approach (CPA) for at least 12mnths having formal review within 12mnths *NHSI*	Monthly	95%	94.3%	93.9%											94.1%	↘
NHSI	AMH Community	Monthly	95%	94.4%	94.2%											94.3%	↘
NHSI	LD	Monthly	95%	100.0%	93.6%											96.8%	↘
NHSI	NOAP	Monthly	95%	72.7%	72.7%											72.7%	↔
NHSI	C&YP	Monthly	95%	0.0%	0.0%											0.0%	↔
NHSI	Mental health delayed transfers of care (target NHSI) (M1-4.7%, M2-4.5%, M3-4.2%, M4-4.0%, M5-3.7%, M6-3.5%)	Monthly	4.5%	14.8%	16.6%											15.7%	↗
NHSI	AMH IP	Monthly	4.5%	7.4%	10.1%											8.8%	↗

	Metric	Frequency	Target (2016/17)	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend Rate
NHSI	LD	Monthly	4.5%	0.0%	0.0%											0.0%	⇔
NHSI	NOAP	Monthly	4.5%	23.2%	24.7%											23.2%	↗
Local Quality	Patients seen within the access service (County): Emergency 1 hour	Monthly	No Target	New													
Local Quality	Patients seen within the access service (County): Urgent 4 hour hour	Monthly	No Target	New													
Local Quality	Patients seen within the access service (County): Routine 24 hours	Monthly	No Target	New													
National Operational	The proportion of those on Care Programme Approach(CPA) receiving follow-up contact within 7 days of discharge	Monthly	95%	95.7%	96.9%											96.3%	↗
Local Quality	Readmission rate (28 days). Percentage of patients readmitted within 28 (or 30 days) days of discharge.	Monthly	7.5%	15.0%	6.7%											10.9%	↘
Local Quality	Adult IP	Monthly	7.5%	18.4%	5.2%											11.8%	↘
Local Quality	OA IP	Monthly	7.5%	0.0%	0.0%											0.0%	⇔
Local Quality	Neuro Rehab	Monthly	7.5%	2.3%	0.0%											1.2%	↘
Local Quality	LD	Monthly	7.5%	0.0%	0.0%											0.0%	⇔
Local Quality	MH Rehab	Monthly	7.5%	0.0%	0.0%											0.0%	⇔
Local Quality	All Service Users to have a care plan in line with their needs (North Staffordshire CCG) % on CPA with a Care Plan	Monthly	95%	93.4%	97.1%											95.3%	↗
Local Quality	AMH Community	Monthly	95%	93.9%	98.3%											96.1%	↗
Local Quality	LD	Monthly	95%	100.0%	100.0%											100.0%	⇔
Local Quality	NOAP	Monthly	95%	83.3%	91.7%											87.5%	↗
Local Quality	C&YP	Monthly	95%	66.7%	50.0%											58.4%	↘
Local Quality	All Service Users to have a care plan in line with their needs (Stoke-on-Trent CCG) % on CPA with a Care Plan	Monthly	95%	96.1%	98.2%											97.2%	↗
Local Quality	AMH Community	Monthly	95%	96.3%	98.5%											97.4%	↗
Local Quality	LD	Monthly	95%	100.0%	100.0%											100.0%	⇔
Local Quality	NOAP	Monthly	95%	85.7%	96.0%											90.9%	↗
Local Quality	C&YP	Monthly	95%	66.7%	50.0%											58.4%	↘
Local Quality	IAPT: Service User Satisfaction Local. To include questions on: • Access/referral arrangements • Treatment Options • Communication / Contact • Overall service provided (From a minimum sample of 30% of Service Users less than 15%	Monthly (questionnaire to be agreed with commissioners)	15%	N/A	N/A												
Local Quality	IAPT: Referrer Satisfaction Local. To include questions on: • Response to referrals • Contact / Communication • Treatment Outcomes • Overall Service provision (<15% expressing dissatisfaction)	Methodology to be agreed by September 2014. Application of methodology Q3.	15%	N/A	N/A												
Local Quality	IAPT : Local. Service Users who are referred to employment support services (90% of suitable referrals)	Quarterly	90%	N/A	N/A												
Local Quality	IAPT : Local. Routine: Service User records and associated letters/reports completed and sent to GP within 5 working days of assessment/outcome measures undertaken as part of treatment/discharge (Qtr2 & Qtr 4 90% (sample of minimum 150 patients)	Half-yearly	90%	N/A	N/A												
Local Quality	IAPT: Local. The number of staff who have accessed clinical supervision Requirement is for minimum of 1 hour per week for all IAPT staff, - target % of staff in receipt of required level. (No threshold but there should be a framework in place that the Provider is working to ensure that all staff are approporaitely supervised)	Quarterly	No Target	N/A	N/A												
NHSI	% of clients in settled accommodation	Monthly	No Target	88.5%	87.1%											87.8%	↘
NHSI Domain - Caring																	
National Operational	Mixed Sex Accommodation Breach	Monthly	0	0.0	0.0											0.0	⇔
NHSI	Staff FFT Percentage Recommended – Care	Quarterly	61.5%	N/A	N/A												
NHSI	Inpatient Scores from Friends and Family Test – % positive	Monthly	No Target	89.0%	88.0%											88.5%	↘
NHSI Domain - Safe																	
National Quality	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	⇔
Local Quality	People with LD/ Autistic Spectrum condition or long term mental illness should receive appropriate physical healthcare	Annual	95%	N/A	N/A												
Local Quality	All service users who have been in hospital/long term inpatient health care for more than one year should have a physical health check	Quarterly	95%	N/A	N/A												
Local Reporting	Preventing Category 3 and 4 Avoidable Pressure Ulcer	Monthly	0	0.0	0.0											0.0	⇔
Local Quality	MRSA Screening (% of patients screened on admission)	Monthly	100%	100.0%	100.0%											100.0%	⇔

	Metric	Frequency	Target (2016/17)	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend Rate
National Reporting	Cases of C Diff	Monthly	No Target	0.0	0.0											0.0	↔
National Reporting	Cases of MRSA	Monthly	No Target	0.0	0.0											0.0	↔
National Reporting	Never Events	Monthly	0	0.0	0.0											0.0	↔
National Reporting	Number of Reported Serious Incidents	Monthly	No Target	5.0	1.0											6.0	↘
National Reporting	Total Incidents	Monthly	No Target	363.0	344.0											707.0	↘
National Reporting	Incidents leading to Moderate/Severe harm/death	Monthly	No Target	18.0	16.0											34.0	↘
Local Reporting	Cases of MSSA	Monthly	0	0.0	0.0											0.0	↔
Local Reporting	Cases of E Coli	Monthly	0	0.0	0.0											0.0	↔
Local Reporting	Medication Errors Total	Monthly	No Target	12.0	5.0											17.0	↘
Local Reporting	Medication Errors leading to Moderate/Severe harm/death	Monthly	No Target	0.0	0.0											0.0	↔
Local Reporting	Mental health Absconds/AWOL – rate	Monthly	No Target	12.0	7.0											19.0	↘
Local Reporting	Safety Thermometer - Percentage Harm Free Care	Monthly	No Target	100.0%	100.0%											100.0%	↔
Local Reporting	Safety Thermometer - Percentage New Harm	Monthly	No Target	0.0%	0.0%											0.0	↔
Local Reporting	Preventing Future Deaths Regulation 28	Monthly	No Target	0.0	0.0											0.0	↔
Local Reporting	Proportion of patients who had recorded incidents of physical assault to them	Monthly	No Target	13.0	5.0											18.0	↘
Local Reporting	Proportion of patients who had recorded incidents of physical assault to them leading to Moderate/Severe harm/death	Monthly	No Target	1.0	0.0											1.0	↘
Local Reporting	Suspected Suicides	Monthly	No Target	2.0	1.0											3.0	↘
Local Reporting	Inpatient	Monthly	No Target	0.0	0.0											0.0	↔
Local Reporting	Inpatient on home leave	Monthly	No Target	0.0	0.0											0.0	↔
Local Reporting	Community Patient (in receipt)	Monthly	No Target	2.0	1.0											3.0	↘
Local Reporting	Community patient (in receipt) within 3 months of discharge from service	Monthly	No Target	0.0	0.0											0.0	↔
Local Reporting	Community patient who had an inpatient stay in last 3 months prior to death	Monthly	No Target	0.0	0.0											0.0	↔
Local Reporting	Unexpected Deaths	Monthly	No Target	0.0	0.0											0.0	↔
Local Reporting	Inpatient	Monthly	No Target	0.0	0.0											0.0	↔
Local Reporting	Inpatient on home leave	Monthly	No Target	0.0	0.0											0.0	↔
Local Reporting	Community Patient (in receipt)	Monthly	No Target	0.0	0.0											0.0	↔
Local Reporting	Community patient (in receipt) within 3 months of discharge from service	Monthly	No Target	0.0	0.0											0.0	↔
Local Reporting	Community patient who had an inpatient stay in last 3 months prior to death	Monthly	No Target	0.0	0.0											0.0	↔
Local Reporting	Use of Restraint: Number of patient restraints-prone	Monthly	No Target	1.0	4.0											5.0	↗
Local Reporting	Slips Trips & Falls	Monthly	No Target	43.0	23.0											66.0	↘
Local Reporting	Slips Trips & Falls leading to Moderate/Severe harm/death	Monthly	No Target	6.0	4.0											10.0	↘
Local Reporting	Self Harm Events: Inpatient	Monthly	No Target	48.0	25.0											73.0	↘
Local Reporting	Self Harm Events: Community	Monthly	No Target	35.0	31.0											66.0	↘
Local Reporting	Self-Harm Events leading to Moderate/Severe harm/death:Inpatient	Monthly	No Target	1.0	2.0											3.0	↗
Local Reporting	Self-Harm Events leading to Moderate/Severe harm/death: Community	Monthly	No Target	4.0	5.0											9.0	↗
Local Reporting	DNA Rate Analysis by Directorate (split by CCG)	Monthly	No Target	5.7%	6.3%											6.0%	↗
Local Reporting	AMH IP	Monthly	No Target	6.1%	5.9%											6.0%	↘
Local Reporting	AMH Community	Monthly	No Target	6.3%	6.8%											6.6%	↗
Local Reporting	LD	Monthly	No Target	2.9%	2.5%											2.7%	↘
Local Reporting	NOAP	Monthly	No Target	4.6%	6.0%											5.3%	↗
Local Reporting	C&YP	Monthly	No Target	7.4%	7.5%											7.5%	↗
Local Reporting	Average Length of Stay: North Staffs CCG	Monthly	No Target	18.0	31.6											49.6	↗
Local Reporting	Adult IP	Monthly	No Target	15.7	21.4											37.1	↗
Local Reporting	CYP	Monthly	No Target	0.0	67.1											67.1	↗
Local Reporting	NOAP	Monthly	No Target	117.3	68.4											185.7	↘
Local Reporting	Substance Misuse	Monthly	No Target	10.5	13.5											24.0	↗
Local Reporting	LD	Monthly	No Target	0.0	157.5											157.5	↗
Local Reporting	Average Length of Stay: Stoke CCG	Monthly	No Target	23.6	33.0											56.6	↗
Local Reporting	Adult IP	Monthly	No Target	25.6	34.1											59.7	↗
Local Reporting	CYP	Monthly	No Target	88.2	51.1											139.3	↘
Local Reporting	NOAP	Monthly	No Target	106.3	86.3											192.6	↘

	Metric	Frequency	Target (2016/17)	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend Rate
Local Reporting	Substance Misuse	Monthly	No Target	12.4	9.6											22.0	↘
Local Reporting	LD	Monthly	No Target	0.0	0.0											0.0	↔
NHSI	Never Events Incidence Rate	Monthly	0	0.0	0.0											0.0	↔
NHSI	Proportion of reported patient safety incidents that are harmful	Monthly	2.97%	2.0%	1.8%											1.9%	↘
NHSI	CAS alerts outstanding	Monthly	0	0	0											0.0	↔
NHSI	Safety Thermometer - Percentage of Harm Free Care	Monthly	95%	100.0%	100.0%											100.0%	↔
NHSI	Safety Thermometer - Percentage of new harms	Monthly	No Target	0.0%	0.0%											0.0%	↔
NHSI	Admissions to adult facilities of patients who are under 16 years of age	Monthly	0	0.0	0.0											0.0	↔
NHSI Domain - Well Led																	
National Quality	Completion of Mental Health Services Data Set ethnicity coding for all Service Users	Monthly	90%	100.0%	100.0%											100.0%	↔
National Quality	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS	Monthly	99%	99.8%	98.3%											99.1%	↘
National Quality	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users	Monthly	90%	96.0%	Retrospective reporting											96.0%	↔
NHSI	Agency Spend (of total paybill) (Target M1-6%, M2-6%)	Monthly	6.0%	6.6%	6.0%											6.3%	↘
NHSI	Sickness Absence Percentage: Days lost	Monthly	5.1%	3.1%	3.5%											3.3%	↗
NHSI	Corporate	Monthly	5.1%	1.8%	2.7%											2.2%	↗
NHSI	AMH Community	Monthly	5.1%	3.8%	3.7%											3.7%	↘
NHSI	AMH IP	Monthly	5.1%	4.4%	5.3%											4.8%	↗
NHSI	C&YP	Monthly	5.1%	1.4%	2.6%											2.0%	↗
NHSI	LD	Monthly	5.1%	0.9%	2.8%											1.9%	↗
NHSI	Neuro and Old Age Psychiatry	Monthly	5.1%	3.8%	2.5%											3.1%	↘
NHSI	Substance Misuse	Monthly	5.1%	6.4%	7.4%											6.9%	↗
NHSI	Staff Turnover (FTE)	Monthly	No Target	0.9	1.1											0.97	↗
NHSI	Corporate	Monthly	No Target	0.8	1.3											1.07	↗
NHSI	AMH Community	Monthly	No Target	0.7	0.9											0.78	↗
NHSI	AMH IP	Monthly	No Target	0.7	0.0											0.33	↘
NHSI	C&YP	Monthly	No Target	1.6	1.6											1.63	↔
NHSI	LD	Monthly	No Target	0.9	2.2											1.55	↗
NHSI	Neuro and Old Age Psychiatry	Monthly	No Target	0.8	0.7											0.74	↘
NHSI	Substance Misuse	Monthly	No Target	2.2	2.3											2.25	↗
NHSI	MH FFT response rate	Monthly	No Target	193.0	153.0											346.0	↘
NHSI	Staff FFT response rate	Quarterly	No Target	N/A	N/A												
NHSI	Staff FFT Percentage Recommended – Work	Quarterly	No Target	N/A	N/A												
NHSI	Overall safe staffing fill rate	Monthly	No Target	95.2%	95.3%												↗
Local Reporting	Percentage compliance with data completeness identifiers for patients on CPA: In "employment" SHA measure >10% is performing	Monthly	10%	10.5%												10.5%	↘
Local Reporting	Percentage compliance with data completeness identifiers for patients on CPA; In "settled accommodation" - Monitor measure	Monthly	No Target	83.9%	80.8%											82.4%	↘
Local Reporting	Percentage compliance with data completeness identifiers for patients on CPA; who have had a HONOS assessment in the last 12 months - Monitor measure	Monthly	No Target	91.8%												91.8%	↘
Local Reporting	Percentage compliance with data completeness identifiers for patients on CPA; Who have had a diagnosis assessment in the last 12 months	Monthly	No Target	100.0%	100.0%											100.0%	↔
Other Indicators																	
Local Quality	IAPT : number people referred for psychological therapies (Target tbc)	Monthly	0	385.0	419.0											804.0	↗
Local Quality	IAPT : Balance of Service Users mapped against the local population in terms of : Age	Monthly	95%	100.0%	100.0%											100.0%	↔
Local Quality	IAPT : Balance of Service Users mapped against the local population in terms of : Ethnicity	Monthly	95%	100.0%	100.0%											100.0%	↔
Local Quality	IAPT : Balance of Service Users mapped against the local population in terms of : Gender	Monthly	95%	100.0%	100.0%											100.0%	↔
Local Quality	IAPT : Balance of Service Users from across the geographical Contract Area	Monthly	95%	100.0%	100.0%											100.0%	↔
Local Quality	IAPT : The proportion of people who have depression and/or anxiety disorders who receive psychological therapies (Target 3.75% per quarter)	Monthly	3.75%	1.05%	1.28%											1.2%	↗
Local Quality	IAPT :The number of people who have entered (i.e. received) psychological therapies during the reporting quarter (Target 1,057 per quarter)	Monthly	1057	296.0	362.0											658.0	↗
Local Quality	IAPT: The number of people who have completed treatment during the reporting quarter broken down by age	Monthly	No Target	160.0	151.0											311.0	↘
Local Quality	IAPT: The number of people who have completed treatment during the reporting quarter broken down by sex	Monthly	No Target	160.0	151.0											311.0	↘

	Metric	Frequency	Target (2016/17)	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend Rate
Local Quality	IAPT : The number of people who are "moving to recovery" of those who have completed treatment, in the reporting quarter (Target Qtr 1 to 3 - 224, Qtr 4 - 227)	Monthly	227	102.0	98.0											200.0	↘
Local Quality	IAPT : The number of people who have completed treatment not at clinical caseness at treatment commencement	Monthly	No Target	8.0	8.0											16.0	↔
Local Quality	IAPT : The number of people moving off sick pay or ill-health related benefit	Monthly	No Target	17.0	14.0											31.0	↘
Local Quality	IAPT : The number of people who have completed treatment minus the number of people who have completed treatment not at clinical caseness at initial assessment (Target: !tr 1 to 3 - 447, Qtr 4 - 448)	Monthly	448	152.0	143.0											295.0	↘
Local Quality	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%	67.1%	68.5%											67.8%	↗
Local Reporting	Bed Occupancy (Including Home Leave)	Monthly	No Target	97.0%	89.4%											93.2%	↘
Local Reporting	AMH IP	Monthly	No Target	94.0%	89.0%											91.5%	↘
Local Reporting	Substance Misuse	Monthly	No Target	94.4%												94.4%	↘
Local Reporting	LD	Monthly	No Target	100.0%	79.0%											89.5%	↘
Local Reporting	Neuro	Monthly	No Target	90.6%	91.3%											91.0%	↗
Local Reporting	Old Age Psychiatry	Monthly	No Target	95.0%	92.0%											93.5%	↘
Local Reporting	C&YP	Monthly	No Target	94.2%	88.6%											91.4%	↘
Local Reporting	Bed Occupancy (Excluding Home Leave)	Monthly	No Target	89.2%	85.3%											87.3%	↘
Local Reporting	AMH IP	Monthly	No Target	91.0%	86.0%											88.5%	↘
Local Reporting	Substance Misuse	Monthly	No Target	86.1%												86.1%	↘
Local Reporting	LD	Monthly	No Target	100.0%	76.0%											88.0%	↘
Local Reporting	Neuro	Monthly	No Target	78.0%	87.7%											82.9%	↗
Local Reporting	Old Age Psychiatry	Monthly	No Target	94.0%	88.0%											91.0%	↘
Local Reporting	C&YP	Monthly	No Target	75.7%	83.7%											79.7%	↗
	CYP who are sexually exploited (or at risk of SE) initial appointment to bewithin 10 working days	Monthly	95%	New	New												
	Stoke-Looked after CYP and Young Offenders initial appointment to be 10 working days after receipt of completed referral	Monthly	95%	New	New												
	Children are accepted into the service and are receiving intervention/treatment within 18 weeks of referral	Monthly	95%	New	New												

PERFORMANCE MANAGEMENT REPORT TO PUBLIC TRUST BOARD

Date of meeting:	13th July 2017
Report title:	**Performance & Quality Management Framework Performance Report – Month 2 2017/18**
Executive Lead:	Executive Director of Finance, Performance and Digital
Prepared by:	Performance & Information Team
Presented by:	Executive Director of Finance, Performance and Digital

1 Introduction to Performance Management Report

The report provides an overview of performance for May 2017 covering Contracted Key Performance Indicators (KPIs) and Reporting Requirements.

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

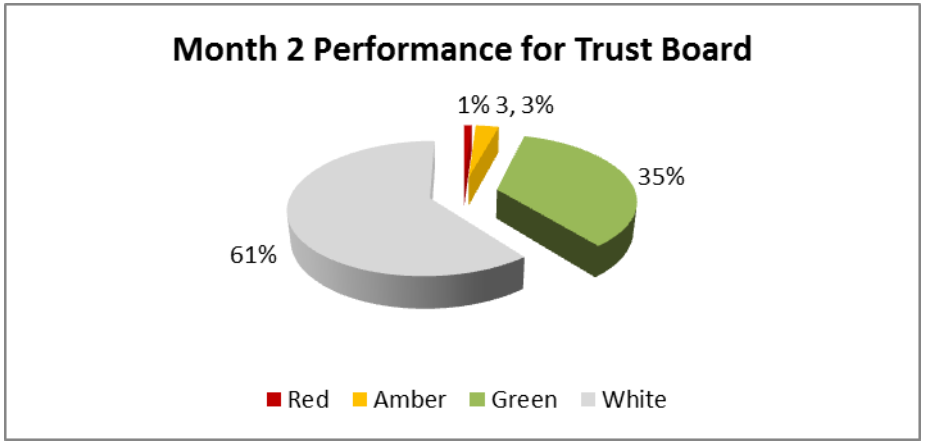
2 Executive Summary – Exception Reporting

The following performance highlights should be noted;

- 68.5% of IAPT patients are moving to recovery (50% target)
- The nursing agency spend (as a % of nursing paybill) has significantly reduced compared the same period last year
- The use of locums (non NHS medical as a % of medical actual pay) is reducing
- 98.2% of all service users have a care plan in line with their needs

In Month 2 there are 1 related metrics rated as Red and 3 as Amber; all other indicators are within expected tolerances. White KPIs are those where measures where the requirement is to report absolute numbers rather than % performance.

Contracted (National/Local CCG) & NHSI KPIs					
Metric	Red	Amber	Green	White	TOTAL
Exceptions – Month 12	2	1	39	67	109
Exceptions – Month 1	4	2	32	62	100
Exceptions – Month 2	1	3	33	57	94

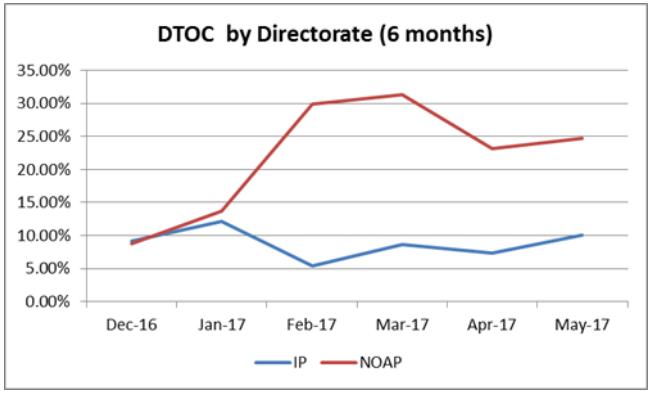


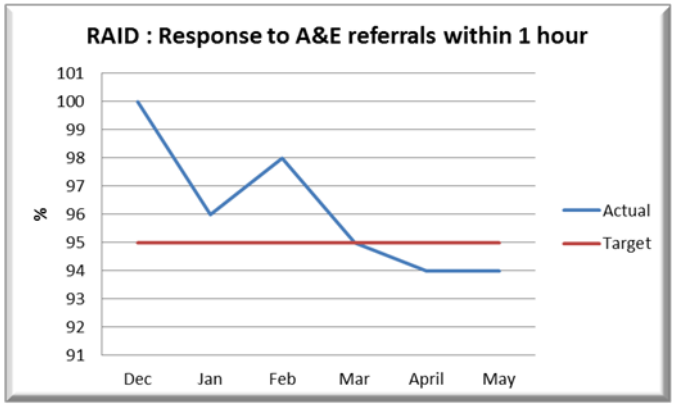
3 Rectification Plans

Rectification plans are produced for any KPI classed as RED/AMBER, OR where an individual directorate is classed as RED/AMBER, for a consecutive 2 month period. These offer a more detailed recovery position, focused actions and improvement trajectory and are scrutinised by the relevant Sub-Committee of the Board.

4 Exceptions - Month 2

KPI Classification	Metric	Exec/Op Lead	Target	M1	M2	Trend	Commentary
NHSI	**CPA:** The proportion of those on Care Programme Approach (CPA) for at least 12 months having a formal review within 12 months	Dir of Ops	**95%**	**AMBER** **94.3%**	**AMBER** **93.9%**	↘	**93.9% at M2 from 94.3% at M1** AMH Community = 94.2% at M2 from 94.4% at M1 Learning Disabilities = 93.6% at M2 from 100.0% at M1 NOAP = 72.7% at M2 from the same as at M1 C&YP = 0.0% at M2 the same as at M1 The numbers are small and following a full process review and updated monitoring reports this is anticipated to recover by month 3. **A rectification plan has been developed.**
NHSI	**Agency** Performance against the NHSi agency cap (all agency spend) **Total** **Ward 4** **Core**	Dir of Workforce	**YTD Target 0%**	**RED** **11%** **9%** **2%**	**AMBER** **6%** **11%** **(5%)**	↘ ↗ ↘	At month 2, the year to date overspend against the agency ceiling was **6%**. At month 1, the year to date overspend compared to the agency ceiling was **11%.** Ward 4 was a key driver of Agency expenditure in M1 & M2, accounting for **9% in M1 and 11% in M2** of overspend against the ceiling. Ward 4 was due to cease in March 2017 and therefore was not included in the Trust operational plan, but remained open for April and May 2017 to support patient flows in the Staffordshire health economy. Ward 4 has been recurrently commissioned from July 2017 and agency is expected to reduce pending successful substantive recruitment. For core agency at month 2, there was a year to date underspend against the agency ceiling of **5%**. At month 1, the year to date overspend compared to the agency ceiling was **2%.**

KPI Classification	Metric	Exec/Op Lead	Target	M1	M2	Trend	Commentary
NHSI	**Delayed Transfers of Care:** The proportion of patients deemed ready to depart from care that are still occupying a bed.	Dir of Ops	**4.7%**	**RED** **14.8%**	**RED** **16.6%**	↗	**16.6% at M2 from 14.8% at M1** AMH IP = 10.1% at M2 from 7.4% at M1 NOAP = 24.7% at M2 from 23.2% at M1 The Trust continues to pilot the **RED** and **GREEN** approach developed by the Emergency Care Programme (ECIP), which focuses on eliminating patient time wasted in the pathway (Red days) and focussing on days which are of value to the patient (Green days). The Trust is an early adopter of Red to Green in Mental Health. A deep dive analysis has identified patient/family choice as being the most significant contributing factor to delays, particularly on older people's wards. Other factors include home care placements, onward funding and housing. A system wide patient choice policy is due to be published in July to facilitate quicker decision making, placement challenge or alternative placement offerings.  **A rectification plan has been developed**

KPI Classification	Metric	Exec/Op Lead	Target	M1	M2	Trend	Commentary
Commissioner Contract measure	**RAID:** RAID response to A&E referrals within 1 hour	Dir of Ops	**95%**	**AMBER 94.0%**	**AMBER 94.0%**	↘	**94.0% at M2 the same as at M1**  **A rectification plan has been developed**

5 Recommendations

The Trust Board is asked to note the contents of this report.

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REPORT TO: TRUST BOARD

Enclosure No:9

Date of Meeting:	13th July 2017		
Title of Report:	Service User & Carer Council Report		
Presented by:	Wendy Dutton, Vice Chair, Service User & Carer Council		
Author:	Wendy Dutton, Vice Chair, Service User & Carer Council		
Executive Lead Name:	Maria Nelligan	Approved by Exec	☒

Executive Summary:	Purpose of report	
This report has been prepared to provide an update of the Service User & Carer Council since the last meeting held in July 2017.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☐

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.X☐ 2. To provide the highest quality services X☐ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☐ 6. Attract and inspire the best people to work here.X☐ 7. Continually improve our partnership working. X☐		
Risk / legal implications: Risk Register Ref	None identified		
Resource Implications: Funding Source:	None identified		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	None		
Recommendations:	The Trust Board receives the update for information and assurance		

Service User and Carer Council update for Trust Board July 2017

North Staffordshire Combined Healthcare NHS Trust

1. Voting of the Chair of The Council

Vote for Chair SUCC, following expressions of interest from Phil Leese and Wendy Dutton, Council unanimously voted Wendy Dutton as a new Chair arrangements will be put in place for the Vice Chair to be elected. The New Chair welcomed and thanked the SUCC for their support.

2. Workshop – Care Planning

The service User and Carer Council have changed their meeting format to bi-monthly business meeting and bi monthly education information meetings the first of the workshop /education meeting was an overview of Lorenzo given delivered by Ben Boyd

The presentation included an overview and brief descriptors initial Care Plan Pathways; STANDARD, Care Plan Approach (CPA) 3rd Intervention plan available on Rose.

- Concerns raised at 3 potential tools being used for same purpose could lead to confusion lots of discussion;
- Actions - Mr Boyd will take away suggestions and see what can be adapted including :
    - Agreed reasonable baseline on discharge to include;
        - Prescribing, how much supplied and subsequent prescribing responsibility
        - Printed care plan for Service User/ Carer
        - Contact name and telephone number

3. Further discussions took place on :

- Multiple computer systems still in use;
- Alcohol and addiction Service – separate computer system
- Nil for Neuropsychiatry – only specific pathway for 'traits' e.g. behavioural problems
- Carer's services – currently using 2 different computer systems and poor communication with Care co-ordinators (Jayne Aston to follow this up with Ben separately)

Acknowledgement of early integration of system which will be further developed, SUCC keen to be involved with this and **all** present felt they had a better understanding of what could be expected at present, and need to be part of journey of future development

4. Other areas of the trust that service user and carer council have been involved in this month include:

- Service User and Carer Council: Service User involved in putting together Standing Operational Procedure for Service User involvement with a team who received negative feedback
- Service users involved in planning group for new PICU
- Service Users and carers attended recruitment training provided by HR team
- Service users and carers continue their involvement in recruitment panels
- Attending events and representing the Service User and Carer Council on behalf of the trust
- Participated in Diversity and Inclusion Conference " Symphony for Hidden Voices"

5. New Issues

Advocacy, concerns were raised that services and there funding is currently under debate and the need to ensure access for service user's/carer's is maintained Sue Carson (Healthwatch Staffordshire) offered to do update SUCC at the next meeting.

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REPORT TO TRUST BOARD

Enclosure No:10

Date of Meeting:	13th July 2017		
Title of Report:	Place of Safety, Capacity and Performance		
Presented by:	Dr Nasreen Fazal-Short		
Author:	Samantha Mortimer – Head of Directorate (Community)		
Executive Lead Name:	Dr Nasreen Fazal-Short	Approved by Exec	☒

Executive Summary:		Purpose of report	
Overview of Place of Safety and Requirement		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☒ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☒ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☐ 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☒		
Risk / legal implications: Risk Register Ref			
Resource Implications: Funding Source:			
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)			
Recommendations:			

North Staffordshire Combined Healthcare NHS
NHS Trust

Place of Safety, Capacity and Performance Report for Board July 2017

Dr Nasreen Fazal-Short
Acting Director of Operations

Working together, developing together.

Executive Summary:

This report summarises the current position in relation to Place of Safety provision and the plans going forwards:

- Under section 136 of the Mental Health Act (MHA) 1983, someone who appears to be experiencing a mental health crisis in a public place can be picked up by the police and taken to a place of safety for an assessment of their needs. In all but exceptional circumstances this should be in a healthcare setting. Currently in North Staffordshire we have access to one place of safety at the Harplands Hospital. Also within Staffordshire, there are an additional two places of safety at St George's Hospital, Stafford, which are utilized when needed.

- The Trust has been working hard to enable those service users who need a place of safety to access this at the Harplands or St George's Hospital, Stafford and reduce those who end up in police custody. The number of people being detained on Section 136 in Police custody has been targeted and we have seen an 85% reduction between 2013-14 and 2015-16, following the introduction of the Community Triage team in November 2014.

- Significantly there is a new Policing and Crime Act which is clear about defining what is meant by "exceptional circumstances", it will remove police custody as a place of safety for people aged 17 and younger, and it will reduce the amount of time a person can be detained under section 136 (from 72 hours to 24 hours). These, and other proposals contained within the Act will likely have the effect of further reducing the use of police custody.

- The Crisis Care Concordat (a commissioner led working group) which includes the Police commissioner's office, has been meeting regularly and focusing on the number of citizens detained both in police custody, the availability of the places of safety and plans going forwards.

- These discussions and local data have indicated that we do not have enough provision to meet the needs of all our citizens. The local North Staffordshire section 136 data clearly illustrates the local need for additional place of safety capacity. Between 2016 and April 2017, 77 individuals were diverted to out of North Staffordshire health based places of safety or to police custody. We also know that between 01/04/17 and 02/0617, St George's Hospital in Stafford have had 69 Section 136 detentions and out of these 20 have been from North Staffs/Stoke, this represents 29% of the total. In May 2017, 4 out of 17 citizens were taken to alternative health based places of safety outside of Staffordshire due to the capacity being full.

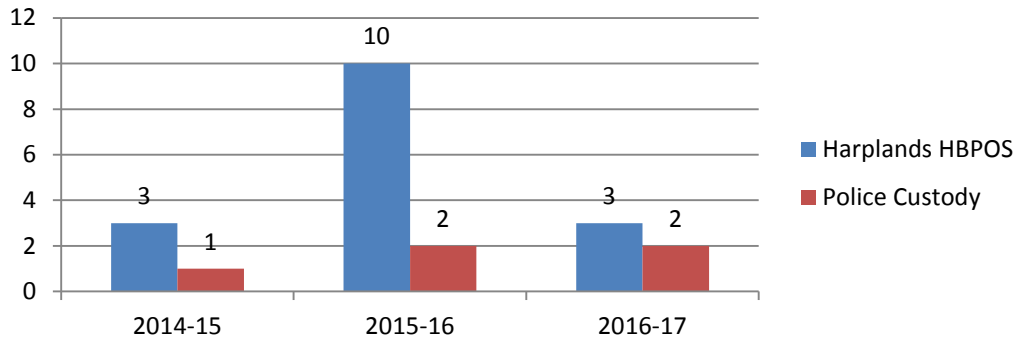
- Locally we have started a dialogue with commissioners about supporting the revenue costs for a second place of safety in Stoke. The business case for this is currently being discussed with commissioners

Places of safety (PoS) are defined under the Mental Health Act 1983, which states that when a police officer finds a person who appears to be suffering from a mental disorder, in a public place, who appears to be in "immediate need of care and control", the officer may remove that person to a place of safety, under the power in section 136 of the Act. This place of safety should ideally be a health based place of safety, where the person can be rapidly examined by a registered medical practitioner and interviewed by an approved mental health professional so that any necessary arrangements for care and treatment can be made. But the Act also allows for police cells to be used as places of safety in "exceptional circumstances".

There has been considerable local success to reduce the number of people being detained on Section 136 in Police custody with 85% reduction between 2013-14 and 2015-16, following the introduction of the Community Triage team in November 2014. However, some concerns about the use of police cells as places of safety remain, given that the number of people needing to be assessed in a place of safety appears to be increasing.

Overall the data also indicates that use of Section 136 is increasing. In 2015-16 there was a 14% increase, and so far in 2016-17 there has been an 11% increase (compared to same months last year).

The graph relates to young people that have been detained on section 136 over the last three years. It indicates that more young people are being detained (bearing in mind that the data for 2016/17 is not complete). The numbers each year remain small, however, the concordat and local Section 136 group are concerned that despite the 2014 local commitment to not using police custody, there have still been five young people taken to police custody on Section 136 or outside of their locality to an alternative Health Based Place of Safety (HBPOS), suggesting an unresponsive and inefficient service provision. Our proposed trust PoS development will address this issue by also providing an appropriate place of safety for young people close to home.



The Policing and Crime Act, agreed in Parliament, seeks to make a number of amendments to section 136. For example, it will seek to define what is meant by "exceptional circumstances", it will remove police custody as a place of safety for people aged 17 and younger, and it will reduce the amount of time a person can be detained under section 136 from 72 hours to 24 hours. These, and other proposals contained within the Bill will likely have the effect of further reducing the use of police custody cells for these assessments.

The local section 136 data clearly illustrates the local need for additional place of safety capacity. Between 2016 and April 2017, 77 individuals were diverted to a health based places of safety outside Harplands or within police custody; these numbers are in addition to 186 citizens assessed within our own POS. We also know that between 01/04/17 and 02/0617, St George's Hospital in Stafford have had 69 Section 136 detentions and out of these 20 have been from North staffs/Stoke, this represents 29% of the total. In May 2017, 4 out of 17 citizens were taken to alternative health based places of safety outside of Staffordshire due to the capacity being full.

Evidence from other areas in the region very clearly indicates that where there is additional health based place of safety capacity, instances of people going to police custody are rare. Increasing capacity and changing the environment of the proposed place of safety will also provide an appropriate place of safety for young people who are detained under section 136 and eradicate the possibility of police custody being used.

The proposal which is articulated in a detailed business case with option appraisals and associated capital and revenue costs suggests that the best option for increasing capacity in Stoke would be to develop two places of safety within the Hazlehurst Centre.

We have recognised the need to ensure compliance with national guidance for the provision of 136 places of safety, in concordance with CQC recommendations, mental health act guidance and the Policing and Crime Act, and therefore the proposal is clear on the environmental aspects to this as well as the safer staffing requirements. In particular, the needs of a young person who might be being assessed have been considered carefully in the design and the staffing requirements.

Locally we have started a dialogue with commissioners about supporting the revenue costs for this plan. The business case for this is currently being discussed with commissioners.

In conclusion, we recognise that there is currently not enough capacity for the place of safety provision in the North of the County and we are working with commissioners to support an additional place so that we can support citizens with this assessment when needed in our local vicinity.

North Staffordshire Combined Healthcare NHS Trust

REPORT TO Trust Board ENCLOSURE 11

Date of Meeting:	July 13th 2017
Title of Report:	Learning from Deaths-Provider Responsibilities
Presented by:	Dr Buki Adeyemo-Executive Medical Director
Author of Report:	Carol Sylvester-Deputy Director of Nursing and Quality
Purpose / Intent of Report:	To set out the requirements of the report detailed below, to highlight areas for development and to agree priorities.
Executive Summary:	Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality noted that the focus on aggregate mortality rates was distracting Trust boards "from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals".This was reinforced by the recent findings of the Care Quality Commission (CQC) report Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. It found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do to engage families and carers and to recognise their insights as a vital source of learning. The attached report summarises the requirements set out for Provider Trust in response to the CQC review and recommendations to the Secretary of State for Health, trust arrangements and will discuss further areas for development.
Seen at SLT or Exec Meeting & date	SLT / EXEC (and date): 11th April 2017 Approved by Exec Lead : Dr B Adeyemo April 10th 2017 Document Version number: 1
Committee Approval / Review	• Quality Committee ☐ • Finance and Performance Committee ☐ • Audit Committee ☐ • People and Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐
Relationship with: *Board Assurance Framework* *Strategic Objectives*	1. To provide the highest quality services ☒ 2. Create a learning culture to continually improve.☒ 3. Encourage, inspire and implement research & innovation at all levels.☐ 4. Maximise and use our resources intelligently and efficiently.☐ 5. Attract and inspire the best people to work here.☐ 6. Continually improve our partnership working. ☐

	7. To enhance service user and carer involvement.☒ Comments:
Risk / Legal Implications: (Add Risk Register Ref [if applicable])	
Resource Implications: Funding source:	The requirements will require identified resource to undertake case note review , training to competently undertake review. Training to support improved bereavement care can be delivered by the Trust Staff Counselling and Support Team.
Equality & Diversity Implications:	None identified
Recommendations:	For information and discussion

North Staffordshire Combined Healthcare NHS Trust

Learning from Deaths- Provider Responsibilities

Introduction

In December 2016, the Care Quality Commission published its review Learning, candour and accountability: A review of the way NHS Trusts review and investigate deaths of patients in England. In response, the Secretary of State accepted the report recommendations and made a range of commitments to improve how the NHS learns from reviewing the care provided to patients who die.

Fundamental to the commitments are strengthened governance and capability, increased transparency through improved data collection and reporting and better engagement with families and carers.

To support Trusts on this agenda, a national framework document Learning from Deaths was published by the National Quality Board in March 2017 setting out expectations for NHS Trusts and Foundation Trusts. The document was published shortly prior to a national Learning from Deaths conference held on March 21 March, providing an opportunity to discuss implementation of the new commitments and requirements.

Background

For many people, death under the care of the NHS is an inevitable outcome and they experience excellent care in the months or years leading up to their death. However, some patients experience poor quality provision resulting from multiple contributory factors which often include poor leadership and system– wide failures. When mistakes happen, providers working with their partners need to understand the causes.
The purpose of reviews and investigations of deaths which problems in care might have contributed to is to learn in order to prevent recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon.

The preventable death of Connor Sparrowhawk in July 2013 led to a number of investigations and enquiries into practice at Southern Health NHS Foundation Trust in whose care he died. Initially classed as natural cause death by the Trust, 2015 a Coroner concluded that failures in care and neglect contributed to Connor`s death.

In December 2015, NHS England published a report *Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015*.

Report Findings

The report Identified failings in the way the trust recorded and investigated deaths and concluded that certain groups including people with a learning disability and older persons receiving mental health care were less likely to have their deaths investigated by the trust Over a 4 year period, fewer than 1% of deaths in Southern Health`s learning disability services and 0.3% of deaths in mental health services for older people were investigated as serious incidents requiring investigation.
The report made 23 recommendations directed at the Trust themselves and 9 at commissioners. Additionally 7 national recommendations were made and detailed below;

- NHS England should highlight learning from this review for other NHS Trusts.
- NHS England's patient safety team should ensure that Mental Health and Learning Disability providers and trusts are provided with focussed MH / LD case examples or a specific framework to inform their own clear and transparent local policies for deciding what deaths to report and investigate.
- NHS England should provide further guidance for Mental Health Trusts on what should be reported to CQC under Regulation 16 and to NRLS.

Care Quality Commission-Learning, candour and accountability.

Following publication of the report, the Secretary of State for Health ask the CQC to look at how acute, community and mental health trusts across the country investigate and learn from deaths to find out whether opportunities for prevention and of death have been missed, and identify any improvements needed.

In order to understand existing problems, a review of processes and systems NHS trusts need to have in place to learn from problems in care before the death of a patient. A key focus of the review was to look closely how trusts review the deaths of people with a mental health problem or learning disability.

The review carried out an information request with all NHS acute, community and mental health providers, visited a sample of 12 acute, community and mental health providers, involved more than 100 families through an on-line questionnaire, held 1.1 interviews and listening events.

The review concluded that families and carers often had a poor experience of investigations, were not always treated with kindness, respect and honesty, in particular within learning disability and mental health cases.

Additionally, the review established that there is no single framework for NHS trusts that sets out what they need to do to maximise the learning from deaths that may be the result of problems in care. This means that there are a range of systems and processes in place and that practice varies widely across providers. Healthcare staff understand the expectation to report patient safety incidents and are using the Serious Incident Framework however, this means that investigations will only happen if the care provided to the patients has led to a serious incident being reported. Criteria for deciding to report as a serious incident varied across trusts and further compounded by confusion and inconsistency in methods and definitions used across the NHS to identify and report deaths.

The review detailed that quality of investigation is variable, with too much focus on individual error rather than system analysis, specialised training is not universally provided to staff undertaking investigation and a lack of protected time to complete the investigation. Moreover, the review established significant issues with the timeliness of investigations and confusion about timescales resulting in the ability to meaningfully involve families.

Inconsistencies were evident that require boards to keep all deaths under review, citing receipt of limited information about the deaths of people using their services other than those reported as serious incidents, a lack of interrogation and challenge from board members with no specific training or dedicated time to undertake this.

Published in December 2016, the review concluded with 7 recommendations to the Secretary of State for Health detailing the need for greater priority for all working in health and social care.

Learning from Deaths-National Quality Board

This national guidance document was published in March 2017 and reinforced by the findings of the CQC review and publication detailed above.

The purpose of the new framework is to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and more embedded learning.

The framework covers how Trusts respond to deaths in care generally, not just those amounting to 'serious incidents', which will continue to be dealt with under the existing 'Serious Incident Framework'

The focus of the new framework is on improving governance processes around patient deaths (including new board leadership roles, a new system of 'case record reviews', quarterly reporting of specific information about deaths in care and a new Trust policy on how individual organisations will be implementing all this) and on ensuring the families/carers of patients who have died in care are properly involved at every stage.

The new framework places a lot of emphasis on the importance of Trust Board leadership in ensuring that learning from patient deaths becomes truly embedded in their organisations and makes clear that mortality governance needs to be a priority for Trust Boards.

Whilst trusts will already undertake some form of mortality reviews, a central focus of the new framework is the requirement for all trusts to introduce a system of 'case record reviews'. This will involve an objective review of the patient's records for all deaths falling within selected categories. Trusts can determine for themselves exactly how the case record review system will work in their organisation, but the guidance sets out minimum requirements for the types of case which should be subject to a case record review, including all deaths where families/carers or staff have raised a significant concern about the death, all deaths of those with learning disabilities or severe mental illness and all deaths in areas where people are not expected to die (e.g. elective procedures)

The guidance suggests that Mental Health Trusts and Community Trusts will want to consider carefully which categories of outpatient and/or community patient will come within the scope for case record review, taking a proportionate approach.

Under the new framework, trusts are now also required to comply with new data reporting requirements relating to patient deaths. This will mean publishing the following information each quarter - total number of deaths in the Trust's specified scope (as a minimum, all adult inpatient deaths excluding maternity), total number of deaths subject to a case record review and total number of deaths assessed to have a more than 50% chance of being avoidable.

Appendix 2 sets out a suggested template for publishing mortality surveillance data.

Trusts will also be required to publish a policy setting out how the organisation responds to and learns from patient deaths by September 2017. The policy will detail the trust approach to selecting cases to review and rationale for this and case note review methodology.

The framework sets out key principles for trusts to follow, including the need to treat bereaved families/carers as equal partners and recognising that paying close attention to what families/carers say can offer an invaluable source of insight to improve clinical practice.

The Trust's policy on responding to patient deaths should include details of how the Trust supports and engages with the family/carers of patients who have died, including ensuring they have a proper opportunity to raise questions or share concerns about the quality of the patient's care.

Looking Ahead

It is worth emphasising that this guidance is described as a 'first edition' and it is envisaged that it will evolve and be revised over time as organisations learn what works best. The National Quality Board has indicated, for example, that some revisions to the guidance may be made following on from a recent national Learning from Deaths Conference.

Under its revised inspection regime, the CQC will strengthen its assessment of how providers learn from deaths - e.g. via proposed new 'well-led' assessment questions specifically related to this.

A review of trust systems and processes has established that the majority of the fundamental requirements are implemented in to policy and practice however, there are areas to further develop to strengthen existing practice and to implement new requirements.

Recommendation
For the Senior Leadership Team to receive this report for information.

References

https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/mazars-rep.pdf

https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf

Appendix 1-CQC Learning, candour an

Appendix 2 learning-from-deaths

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REPORT TO Open Trust Board

ENCLOSURE 12

Date of Meeting:	13TH JULY 2017		
Title of Report:	Finance Report		
Presented by:	Suzanne Robinson		
Author:	Lisa Dodds		
Executive Lead Name:	Suzanne Robinson	Approved by Exec	☒

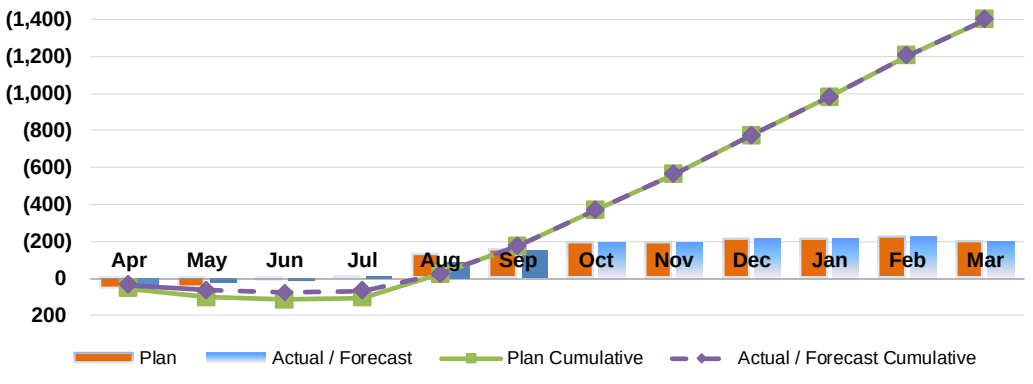
Executive Summary:		Purpose of report	
The report summarises the finance position at month 2		Approval	☐
		Information	☐
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☒ Date: 4TH JULY 2017	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee X • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☐ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.X 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref			
Resource Implications: Funding Source:			
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)			
Recommendations:	Approve The month 2 position reported to NHSI		

Financial Overview as at 31st May 2017

Income & Expenditure - Control Total (Surplus) / Deficit

£000	Plan	Actual	Var	%	RAG
YTD	101	63	(38)	37	G
FOT	(1,400)	(1,400)	0	0	G

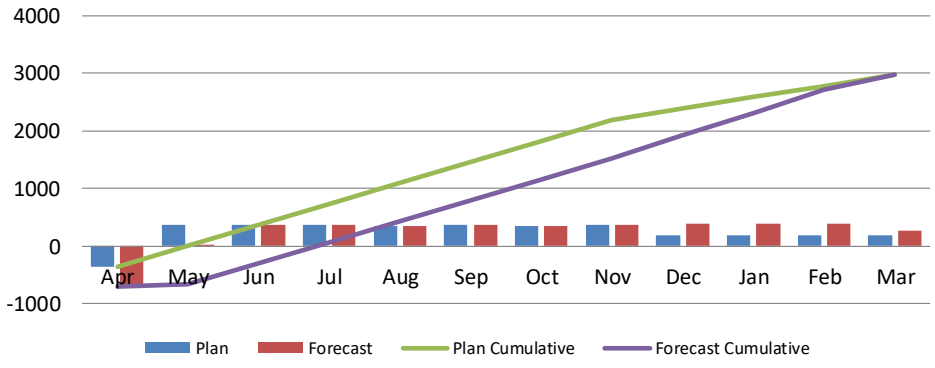
Retained (Surplus) / Deficit Run Rate 2017/18



Net Capital Expenditure / (Receipts)

£000	Plan	Actual	Var	%	RAG
YTD	15	(662)	(677)	(4,513)	G
FOT	2,979	2,979	0	0	G

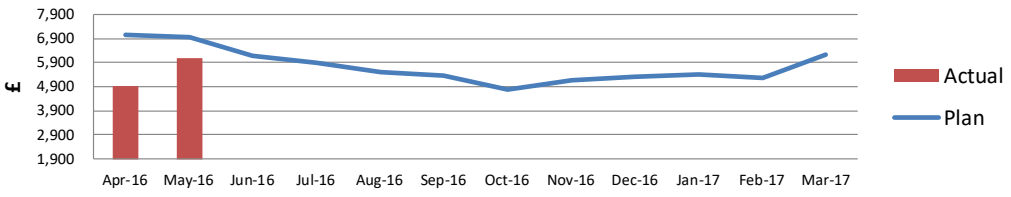
Net Capital Expenditure - Plan / Forecast 2017/18



Cash Balances

£000	Plan	Actual	Var	%	RAG
YTD	6,964	6,059	(905)	(15)	R

Cash Balances - Actual/Forecast against Plan 2017/18



Cost Improvement

£000	Plan	Actual	Var	%	Rec Var	RAG
Clinical	222	35	(187)	(84)	(608)	R
Corporate	57	10	(47)	(82)	(155)	R
Total	279	45	(234)	(84)	(763)	R

Use of Resource

Overall Risk Rating	3
Liquidity Ratio	1
Capital Servicing Capacity	4
I& E Margin	4
I&E Margin Variance to Plan	1
Agency Spend	2

Introduction:

The Trust's 2017/18 financial plan is to deliver a trading position of £0.9m surplus. The Trust has accepted the Control Total from NHS Improvement (NHSI) of £1.4m surplus which includes £0.5m from the Sustainability & Transformation Fund.

1. Income & Expenditure (I&E) Performance

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

- During month 2, the trust had an in month trading position of £52k deficit against a plan of £70k; **a favourable variance of £18k**. Sustainability and Transformation funding has been assumed at £25k for month 2, bringing the overall trust control to a £27k deficit against plan of £45k; **a favourable variance of £18k**.

- The trust has a year to date trading position of £88k deficit against a plan of £126k deficit; **a favourable variance to plan of £38k**. After Sustainability and transformation funding (£50k), the trust has a Control Total deficit £63k against a plan of £101k; **a favourable variance to plan of £38k**.

£'000	Annual Budget	In Month Budget	In Month Actuals	In Month Variance	YTD Budget	YTD Actual	YTD Variance
Income	(80,124)	(6,924)	(6,863)	61	(13,745)	(13,517)	229
Pay	61,819	5,382	5,000	(382)	10,699	10,058	(641)
Non-Pay	14,674	1,384	1,690	306	2,742	3,130	388
EBITDA	**(3,631)**	**(158)**	**(173)**	**(15)**	**(304)**	**(328)**	**(24)**
Other Non-Op Costs	2,731	228	225	(3)	455	442	(13)
Trading Surplus	**(900)**	**70**	**52**	**(18)**	**151**	**113**	**(38)**
Sustainability & Transformational Funding	(500)	(25)	(25)	0	(50)	(50)	0
Control Total	**(1,400)**	**45**	**27**	**(18)**	**101**	**63**	**(38)**

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. The Trust is showing an under performance of £42k year to date on Stoke-on-Trent CCG's, relating to an invoice disputed for 2016/17 for LTC IAPT;

- Under recovery of £34k year to date on Associates Contracts is due to a reduction in activity and £4k over recovery on OATS due to a small increase in activity levels;

- Stoke on Trent public health is under performing by £21k due to a reduction in referrals from community service provided by lifeline to Substance Misuse Inpatients.

		Month 2			Year-to-Date		
Table 2: Income	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
NHS Stoke-on-Trent CCG	(35,473)	(3,022)	(3,022)	(0)	(5,978)	(5,937)	42
NHS North Staffordshire CCG	(24,331)	(2,029)	(2,029)	0	(4,052)	(4,052)	0
Specialised Services	(3,097)	(258)	(258)		(516)	(516)	
Stoke-on-Trent CC s75	(3,659)	(305)	(305)	0	(610)	(610)	0
Staffordshire CC s75	(1,054)	(88)	(88)	(0)	(176)	(176)	(0)
Stoke-on-Trent Public Health	(344)	(29)	(13)	16	(57)	(36)	21
Staffordshire Public Health	(613)	(51)	(51)	0	(102)	(102)	0
ADS/One Recovery	(1,391)	(116)	(116)	0	(232)	(232)	0
Associates	(916)	(76)	(59)	17	(153)	(118)	34
OATS	(600)	(50)	(67)	(17)	(100)	(104)	(4)
Total Clinical Income	**(71,479)**	**(6,024)**	**(6,008)**	**16**	**(11,976)**	**(11,883)**	**93**
Other Income	(8,646)	(900)	(855)	45	(1,769)	(1,634)	135
Total Income	**(80,124)**	**(6,924)**	**(6,863)**	**61**	**(13,745)**	**(13,517)**	**229**
Sustainability Transformation Funding	(500)	(25)	(25)	0	(50)	(50)	0
Total Income Incl. STF	**(80,624)**	**(6,949)**	**(6,888)**	**61**	**(13,795)**	**(13,567)**	**229**

3. Expenditure

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

		Month 2			Year-to-Date		
Table 3: Expenditure	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
Medical	7,544	624	549	(75)	1,257	1,096	(161)
Nursing	27,572	2,383	2,233	(150)	4,686	4,511	(175)
Other Clinical	15,130	1,253	1,093	(160)	2,523	2,180	(343)
Non-Clinical	10,562	898	826	(72)	1,789	1,639	(149)
Non-NHS	1,010	224	298	74	443	631	188
Total Pay	**61,819**	**5,382**	**5,000**	**(382)**	**10,699**	**10,058**	**(641)**
Drugs & Clinical Supplies	2,180	184	177	(6)	367	348	(19)
Establishment Costs	1,687	139	123	(17)	282	234	(48)
Information Technology	453	37	127	89	76	176	100
Premises Costs	2,035	170	166	(5)	340	313	(27)
Private Finance Initiative	4,087	341	353	13	681	713	31
Services Received	3,010	248	277	29	519	538	19
Residential Payments	1,420	118	205	86	237	373	136
Consultancy & Prof Fees	379	32	38	7	63	101	38
Unacheived CIP	(2,692)	(99)	0	99	(234)	0	234
Other	2,116	215	225	10	412	336	(77)
Total Non-Pay	**14,674**	**1,384**	**1,690**	**306**	**2,742**	**3,130**	**388**
Finance Costs	1,293	108	108	0	216	216	0
Local Government Pension Scheme	0	0	0	0	0	0	0
Unwinding of Discounts	0	0	0	0	0	0	0
Dividends Payable on PDC	561	47	46	(1)	94	93	(1)
Investment Revenue	(14)	(1)	(1)	0	(2)	(1)	1
Fixed Asset Impairment	0	0	0	0	0	0	0
Depreciation (excludes IFRIC 12)	891	74	72	(2)	149	135	(13)
Total Non-op. Costs	**2,731**	**228**	**225**	**(3)**	**455**	**442**	**(13)**
Total Expenditure	**79,224**	**6,994**	**6,915**	**(79)**	**13,896**	**13,630**	**(266)**

Pay

- There is a net underspend on pay of £641k year to date due to vacancies across the trust, particularly Other Clinical (£343k), Nursing (£175k) and Medical (£161k) being backfilled with agency and bank.

- Agency expenditure is £631k year to date, with £399k being attributable to implementation of ROSE.
  - M2 YTD agency is £40k above the agency ceiling.
  - This is mainly driven by Agency expenditure for the implementation of ROSE, which is £81k above the planned spend.

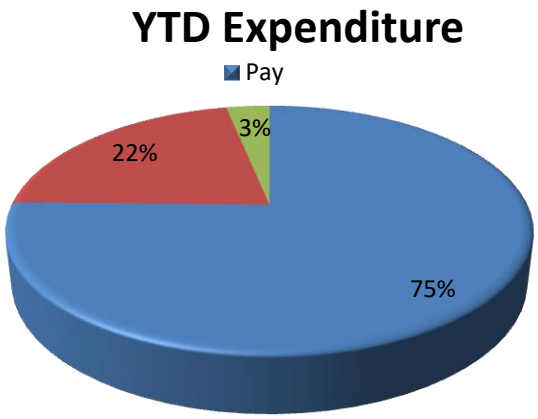
Non Pay

- Residential payments are overspent by £136k in year to date. NSCHT and City Council are jointly reviewing to establish further assurance around the accuracy of the charges, which are currently prudently reflected in NSHCT M2 position.

- IT is overspent by £100k year to date. This is mainly due to:
  - Over-recovery of 2016/17 VAT pending a HMRC inspection (£53k.) This is being disputed with HMRC.
  - £30k Microsoft Licenses agreed to be funded in 2017/18 but not captured during budget setting.

- Consultancy and Professional Fees are overspent by £38k year to date on Trust Board and PMO. This is mainly for Consultancy Services around Digital and STP, the majority of which is invoiced to other organisations.

- Unidentified CIP is £234k. Directorates are working on robust plans to close this gap, further



4. Directorate Summary

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

	Year to Date											
	Pay			Non Pay			Income			Total		
Table 4: Expenditure	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
AMH Community	2,990	2,706	(284)	635	823	188	(359)	(266)	94	3,266	3,263	(3)
AMH Inpatients	1,057	1,081	24	35	55	20	0	(1)	(1)	1,092	1,135	43
Children's Services	1,094	967	(126)	89	104	16	(112)	(98)	14	1,070	974	(97)
Substance Misuse	377	390	13	107	86	(21)	(79)	(68)	11	405	408	3
Learning Disabilities	920	826	(94)	64	42	(21)	(9)	(6)	3	975	863	(112)
Neuro & Old Age Psychiatry	1,838	1,780	(57)	82	97	16	(152)	(164)	(11)	1,767	1,714	(53)
Corporate	2,423	2,307	(117)	2,187	2,365	178	(13,083)	(12,964)	119	(8,473)	(8,293)	181
Total	**10,699**	**10,058**	**(641)**	**3,198**	**3,572**	**374**	**(13,795)**	**(13,567)**	**229**	**101**	**63**	**(38)**

- AMH Community is underspent on pay due to a vacancies not fully covered by Agency and Bank. The adverse variance on Non Pay results from under delivery of CIP against the target and overspends against residential payments.

- AMH Inpatient is overspent on pay mainly due to vacancies on medics being covered by Agency at a premium cost. Overspends on Non Pay are driven by under achievement of CIP against the plan.

- Learning Disabilities, Children's Services and NOAP underspent due to vacant posts. Any vacant posts are currently being reviewed by Directorates as part of CIP plans and may be recognised as Cost Improvement and service redesign and may be adjusted following a full Quality Impact Assessment.

5. Cost Improvement Programme

The trust target for the year is £3.197m, as reported to NHSI. This takes into account the requirement to deliver a £1.4m control surplus for 2017/18. The table below shows the achievement by Directorate towards individual targets at M2. The Trust wide Cost Improvement achievement is 16% at M2 compared to plan.

		YTD @ M2			Forecast					
CIP Delivery	**Annual CIP Target 2017/18**	**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	1,084	95	10	(85)	1,084	740	(344)	68%	66	651
AMH Inpatients	379	33	0	(33)	379	42	(337)	11%	0	114
Children's Services	333	29	0	(29)	333	278	(56)	83%	0	335
Learning Disabilities	256	22	23	1	256	256	0	100%	102	219
NOAP	495	43	2	(41)	495	496	1	100%	223	621
Total Clinical	**2,547**	**222**	**35**	**(187)**	**2,547**	**1,813**	**(734)**	71%	**391**	**1,939**
Corporate										
CEO	49	4	0	(4)	49	21	(28)	43%	0	40
Finance, Performance & Digital	61	5	9	4	61	124	63	203%	71	145
MACE	62	5	0	(5)	62	19	(43)	31%	5	20
Operations	29	3	0	(3)	29	33	4	114%	10	35
Quality & Nursing	13	1	1	(0)	13	11	(2)	85%	13	13
Strategy (Core)	10	1	0	(1)	10	16	6	160%	20	20
Trustwide	365	32	0	(32)	365	48	(317)	13%	0	142
Workforce & OD	61	5	0	(5)	61	76	15	125%	20	80
Total Corporate	**650**	**57**	**10**	**(47)**	**650**	**348**	**(302)**	54%	**139**	**495**
Total	**3,197**	**279**	**45**	**(234)**	**3,197**	**2,161**	**(1,036)**	**68%**	**530**	**2,434**

Below 75%	
Below 90%	

Target	**3,197**
Variance	**(763)**

- The 2017/18 year to date CIP achieved stands at £45k (16%);
- The recurrent value of schemes transacted is £530k against £3.2m target. The recurrent forecast as at **M2 is £2.434m (76%)**; this represents a recurrent shortfall against the target of £763k (24%).

6. Statement of Financial Position

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

Table 6: SOFP	31/03/2017 £'000	30/05/2017 £'000
Non-Current Assets		
Property, Plant and Equipment	28,037	27,963
Intangible Assets	222	213
NCA Trade and Other Receivables	1,426	1,426
Other Financial Assets	897	897
Total Non-Current Assets	**30,581**	**30,499**
Current Assets		
Inventories	88	78
Trade and Other Receivables	5,146	6,049
Cash and Cash Equivalents	6,964	6,059
Non-Current Assets Held For Sale	0	0
Total Current Assets	**12,198**	**12,186**
Total Assets	**42,780**	**42,685**
Current Liabilities		
Trade and Other Payables	(7,472)	(7,535)
Provisions	(333)	(314)
Borrowings	(457)	(633)
Total Current Liabilities	**(8,262)**	**(8,482)**
Net Current Assets / (Liabilities)	**3,937**	**3,704**
Total Assets less Current Liabilities	**34,518**	**34,203**
Non Current Liabilities		
Provisions	(474)	(474)
Borrowings	(12,189)	(11,937)
Total Non-Current Liabilities	**(12,663)**	**(12,411)**
Total Assets Employed	**21,855**	**21,793**
Financed by Taxpayers' Equity		
Public Dividend Capital	7,648	7,648
Retained Earnings reserve	3,987	3,924
Revaluation Reserve	9,323	9,323
Other Reserves	897	897
Total Taxpayers' Equity	**21,855**	**21,793**

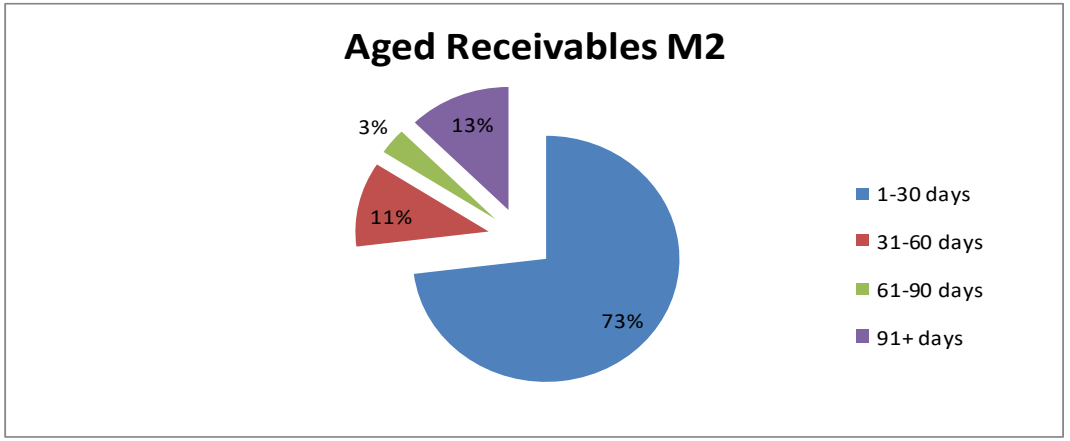
Current receivables are £6,049k

- £4,027k is based on accruals (not yet invoiced) and relates in the main to STF and income accruals paid at the end of each quarter.
- £2,022k in awaiting payment on invoice. (£1,477k within terms)

£545k is overdue by 31 Days or more and therefore subject to routine credit control processes;

- £10k has been escalated to management /solicitors;
- £14k has been formally disputed through the M12 Agreement of Balances process;
- £521k has not been formally disputed and full payment is anticipated.

Table 6.1 Aged Receivables/Payables	1-30 Days £'000	31-60 Days £'000	61-90 Days £'000	91+ Days £'000	Total £'000
Receivables Non NHS	424	56	7	36	523
Receivables NHS	1,053	169	62	215	1,499
Payables Non NHS	1,164	121	28	16	1,329
Payables NHS	745	2	7	1	755

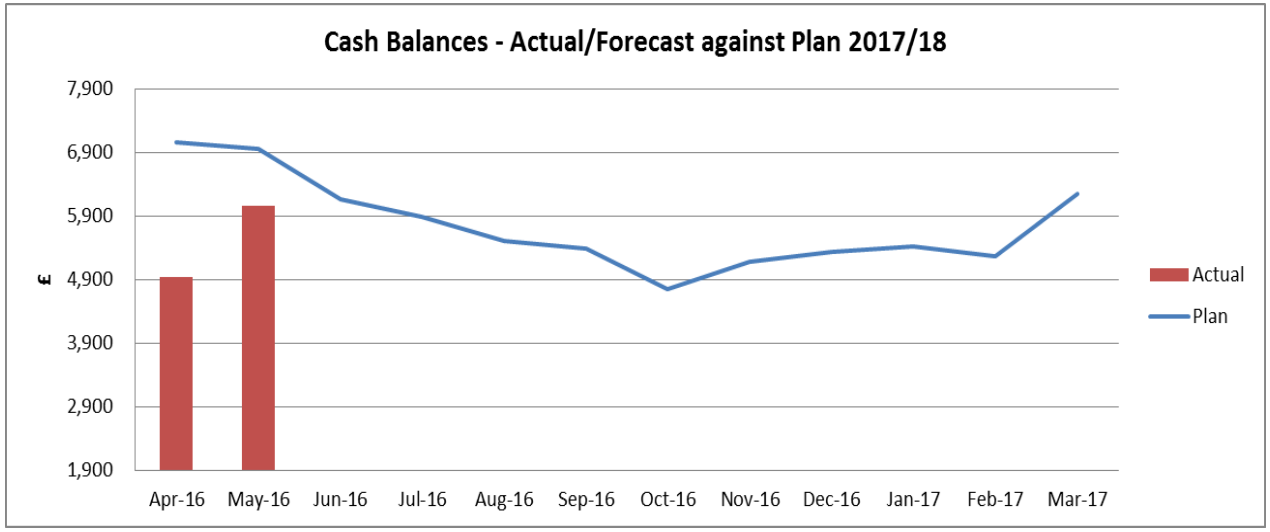


7. Cash Flow Statement

The Trust's cash position was £6.964m at 31st March 2017. The cash balance at 31st May 2017 has decreased to **£6.059m** due to an increase in the value of receivables and a reduction in the payables. The Trust cash position at 31st May 2017 is **£905k lower than planned.**

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

Table 7: Statement of Cash Flows	**Apr-16 £'000**	**May-16 £'000**
Net Inflows/(Outflow) from Operating Activities	(2,674)	1,184
Net Inflows/(Outflow) from Investing Activities	692	(31)
Net Inflows/(Outflow) from Financing Activities	(38)	(38)
Net Increase/(Decrease)	**(2,019)**	**1,115**
Opening Cash & Cash Equivalents	**6,964**	**4,945**
Closing Cash & Cash Equivalents	**4,945**	**6,059**
Plan	7,064	6,964
Variance	**2,119**	**905**



Summary of Outstanding Income		
Receivables	**£'000**	**RAG**
Invoices		
NHS Digital	313	
Stoke CCGs	307	
NHSE	221	
Health Education WM	315	
Staffs & SoT Council	355	
Accruals		
STF	604	
TOTAL	**2,115**	

8. Capital Expenditure

The Trust's permitted capital expenditure agreed within the 2017/18 plan is £2.979m. Table 8 below shows the planned capital expenditure for 2017/18 as submitted to NHSI.

		Year to Date			Forecast		
Capital Expenditure	**Annual Plan £'000**	**Plan £'000**	**Actual £'000**	**Variance £'000**	**Plan £'000**	**Actual £'000**	**Variance £'000**
Place of Safety	660	0	3	3	660	660	0
Temporary Place of Safety	83	0	0	0	83	83	0
Psychiatric Intensive Care Unit	2,153	0	(7)	(7)	2,153	1,993	(160)
E-rostering	102	21	22	1	102	102	0
Information Technology	235	8	1	(7)	235	235	0
Environmental Improvements (backlog)	120	20	25	5	120	120	0
Reduced Ligature Risks	217	0	7	7	217	217	0
Equipment	50	0	0	0	50	50	0
Ward 4	30	0	0	0	30	30	0
Lymebrook MHRC	36	0	0	0	36	36	0
Contingency	6	0	0	0	6	6	0
Total Gross Capital Expenditure	**3,692**	**49**	**51**	**2**	**3,692**	**3,532**	**(160)**
Bucknall Hospital (Part)	(713)	(713)	(713)	0	(713)	(713)	0
Total Capital Receipts	**(713)**	**(713)**	**(713)**	**0**	**(713)**	**(713)**	**0**
Total Charge Against CRL	**2,979**	**(664)**	**(662)**	**2**	**2,979**	**2,819**	**(160)**

- The **Operating Plan** as reported to NHSi forecast there would be a total charge against the CRL of £15k by month 2, including £713k Capital Receipts for the sale of Bucknall Hospital and £728k Capital Expenditure.
- **Actual Capital Expenditure** as at month 2 is £51k.
- The £7k negative expenditure on PICU Year to date is due to VAT recovery on PICU invoices paid in March.

9. Use of Resource Metrics

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

Table 9: Use of Resource	Year to Date £'000	RAG Rating
Liquidity Ratio (days)		
Working Capital Balance	3,626	
Annual Operating Expenses	13,188	
Liquidity Ratio days	17	
Liquidity Ratio Metric	**1**	
Capital Servicing Capacity (times)		
Revenue Available for Debt Service	380	
Annual Debt Service	384	
Capital Servicing Capacity (times)	1.0	
Capital Servicing Capacity Metric	**4**	
I&E Margin		
Normalised Surplus/(Deficit)	(63)	
Total Income	13,567	
I&E Margin	(0.00)	
I&E Margin Rating	**4**	
I&E Margin Variance from Plan		
I&E Margin Variance	0.20	
I&E Margin Variance From Plan	**1**	
Agency Spend		
Providers Cap	555	
Agency Spend	631	
Agency %	14	
Agency Spend Metric	**2**	
Use of Resource	**3**	

Table 9.1: Use of Resource Framework Parameters				
Rating	**1**	**2**	**3**	**4**
Liquidity Ratio (days)	0	(7)	(14)	<(14)
Capital Servicing Capacity (times)	2.50	1.75	1.25	<1.25
I&E Margin	1	0	(1)	<=(1)
I&E Margin Variance	0.01	0.00	(0.01)	<=(0.01)
Agency Spend	0	25	50	>50

The Capital Servicing Capacity and I&E margin risk ratings are both level 4 due to the YTD planned deficit.

In later months where there is a planned surplus, due to delivery of CIP's, both ratings will improve.

10. Better Payment Practice Code

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

At month 2, the Trust has under-performed against this target for the number of invoices, having paid 86% of the total number of invoices (88% for 2016/17), and paid 89% based on the value of invoices (95% for 2016/17).

In order to meet its statutory obligation, to operate within its External Financing Limit (EFL), the trust reduced payment runs in M12, maintaining cash balances. Performance in Month 2 is reflective of a number of breaches, triggered upon payment of an invoice which exceeds the 30 day target.

Table 10 below shows the Trust's BPPC performance split between NHS and non-NHS suppliers.

	2016/17			2017/18 YTD		
Table 10: Better Payment Practice Code	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**
Number of Invoices						
Total Paid	508	13,183	13,691	130	2,128	2,258
Total Paid within Target	459	11,610	12,069	116	1,815	1,931
% Number of Invoices Paid	90%	88%	88%	89%	85%	86%
% Target	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**-4.6%**	**-6.9%**	**-6.8%**	**-5.8%**	**-9.7%**	**-9.5%**
Value of Invoices						
Total Value Paid (£000s)	6,860	29,380	36,240	1,280	4,075	5,355
Total Value Paid within Target (£000s)	6,385	27,914	34,299	1,202	3,584	4,786
% Value of Invoices Paid	93%	95%	95%	94%	88%	89%
% Target	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**-1.9%**	**0.0%**	**-0.4%**	**-1.1%**	**-7.0%**	**-5.6%**

11. Recommendations

The Trust Board is asked to:

Note:

- The reported deficit of **£63k against a planned deficit of £101k**. This is a favourable variance to plan of £38k.
- The M2 CIP achievement:
    - YTD achievement of £45k (16%); **an adverse variance of £234k**;
    - 2017/18 forecast CIP delivery of £2,161k (68%) based on schemes identified so far; an adverse variance of £1,036k to plan;
    - The recurrent forecast delivery at month 2 of £2,434 representing a **recurrent variance to plan of £763k**.
- The cash position of the Trust as at 31st May 2017 with a **balance of £6,059k**; £905k worse than plan.
- Year to date Capital expenditure for 2017/18 is £51k compared to a plan of £728k;
- Use of resource rating of **3**.

Approve

- The month 2 position reported to NHSI

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO TRUST BOARD

Enclosure No: 13

Date of Meeting:	13th July 2017		
Title of Report:	PCD Summary		
Presented by:	Lorien Barber, Non-Executive Director and PCD Chair		
Author:	Paul Draycott, Executive Director of Leadership & Workforce		
Executive Lead Name:	Paul Draycott	Approved by Exec	☒

Executive Summary:		Purpose of report	
		Approval	☒
		Information	☐
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☒ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement. ☒ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve. ☒ 4. Encourage, inspire and implement research & innovation at all levels. ☐ 5. Maximise and use our resources intelligently and efficiently ☒ 6. Attract and inspire the best people to work here ☒ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	A number of risks are monitored and reviewed through the Committee. The current risks identified and mitigation plans in place are: Risk 868 – There is a risk that the Trust will breach its Agency cap for the use of temporary staffing with a consequence of increased spend and reputational harm due to reduced segmentation by NHSi relating to temporary staffing Risk 901 - There is a risk that the Trust does not have an inclusive and diverse workforce impacting on our ability to support the needs of diverse communities and ability to attract and retain staff Risk 12 – There is a risk that there is insufficient staff to deliver appropriate care to patients because of staffing vacancies and increased referrals. This has a consequence of potential failure to achieve performance targets, inability to deliver service user expectations and increase pressure upon existing staff.		
Resource Implications: Funding Source:	n/a		

Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	The Committee plays a huge role in actions and assurance related to Diversity and inclusion and the oversight of the Public Sector Equality Duty under the Equalities Act. This duty requires the Trust to • Eliminate unlawful discrimination • Advance equality of opportunity • Foster good relations PCD received a suite of document to show how we are measuring against protected characteristics and the plans we are developing to address gaps. There are implications and these will be shared with the Board in more detail at the next Board meeting and following sessions planned at Board Development and Leadership Academy. There were also items reviewed at the Committee that supported these aims. Policies have been reviewed with Stonewall to ensure that they are gender none specific; the staff stories were in support of learning where someone has a long term health issue; risks include diversity and inclusion and what the trust is doing to support; and Staff Engagement is also supporting diversity and inclusivity.
Recommendations:	The Board are asked to approve the policies identified and received the summary for assurance.

People & Culture Development Committee
Summary to Trust Board
Monday 3rd July 2017, 9.30 – 11.45am

The meeting was chaired by Miss Barber.

1. Consent Agenda Proposal

The Committee agreed to trial a consent agenda at the next meeting on September 4th.

2. Policies

The following policies were approved by the Committee and the Trust Board on are requested to approve the following:

- Pay Progression Policy
- On Call Policy
- Expenses Policy
- Acting Down Policy
- Producing Clinical Information for Service Users
- Media Policy

The following policy was agreed an extension until October 31st 2017 and the Board are asked to support that extension:

- Remediation Policy

3. Staff Story

Two related staff stories were presented to the Committee. The Trust has a proactive policy of recruiting service users, and at the point of recruitment their mental health history was made known. The staff members initially worked effectively in their appointed clinical roles, but due to the complex nature of mental health their health fluctuated several times which triggered their management.

The staff members were removed away from their clinical roles and redeployed into administration positions in the hope that the adjustments would support them to stay in employment at the Trust. In hindsight the move has exacerbated their conditions and has been less easy on their anxieties than anticipated.

The learning outcomes highlight the need for a greater degree of honesty in work care plans; the real understanding the impact of offering alternative employment; future pay progression opportunities and the fact that there may be others within the Trust experiencing similar issues that have not yet triggered active management and the need to use expertise in house more effectively such as Step On.

The staff members concerned are now healthy but have experienced a long often complex journey to reach this point. These concerns also need to be considered as part of the sickness policy review.

4. Go Engage – Towards Outstanding Engagement

The initial results of the quarterly Pulse Check staff engagement survey (May 2017) were presented to the Committee. The report records the responses provided from 261 staff to the new 'Towards Outstanding Engagement Pulse Survey'.

The survey consists of 47 questions and is conducted on a quarterly basis. The main aim of the survey is to periodically review levels and trends of staff engagement across the organisation and identify the factors that may be enabling or inhibiting staff engagement. By frequently obtaining and acting up on this cultural data, the Trust will be able to continuously improve staff experience, involvement and well-being.

The survey excludes the data of 15 of our teams who are currently taking their own pulse surveys as part of Cohort One of the "Towards Outstanding Engagement" programme. Their data will be compared to the trust-wide data as they embark on a 6 month engagement improvement journey in their teams.

The main headline is that the Trust currently indicate experiences a reasonably positive level of engagement with an overall score of 3.96 out of 5. This overall figure will now form the benchmark in which we can then track staff engagement levels going forward.

The results will also be presented to the Board to update the Board on progress.

5. Diversity & Inclusion Report including Workforce Race Equality Standard (WRES)

The suite of documents summarised the progress made in developing and embedding the Trust's culture of diversity and inclusion through 2016-17 and sets out our plans to further this in 2017-18 and beyond.

Following the successful Symphony for Hidden Voices conference held on Friday June 30th further actions have been identified and will be added to the action plan e.g. community inclusion and broader engagement.

There are also planned Board Development and Leadership Academy sessions for end of July and beginning of August that will inform our planning too.

6. Workforce Directorate Performance & Rectification Plans

Updates by exception were received by the Committee. It was noted that there was a slight increase in sickness for April, but that this had since improved.

Overall Trust Rectification Plans were reviewed for Clinical Supervision (May 78%), Statutory/Mandatory training (May 83%), PDRs (83%), Annual Appraisal (April 82.3%) Vacancy Rate (5%) and Agency. The submitted plans provided trajectories for improvement and actions identified. It was also noted that improvements were required in some of the Directorate plans to offer real assurance.

7. Board Assurance Framework (BAF)

The BAF was not reviewed by the Committee as this is currently undergoing updates.

8. Performance Report Month 1

It was noted that there had been a small increase in agency spend (mainly attributed to ROSE), but a significant decrease in core agency spend. Rectification plans are in place for the Directorates and will be continue to be monitored.

It was also noted that the new Learning Management System providing on-line training (Moodal) will now improve the data quality in real time.

9. HR Disciplinaries/Grievances/Management of Change

There are no live Management of Change processes, and the Committee will receive a quarterly update on grievances and disiplinaries.

10. Workforce & OD Risks

The Committee reviewed the Workforce & OD Risks and agreed for the following risks to remain at a residual risk of 12:

Risk 868 – There is a risk that the Trust will breach its Agency cap for the use of temporary staffing with a consequence of increased spend and reputational harm due to reduced segmentation by NHSi
relating to temporary staffing
Risk 901 - There is a risk that the Trust does not have an inclusive and diverse workforce impacting on our ability to support the needs of diverse communities and ability to attract and retain staff
Risk 12 – There is a risk that there is insufficient staff to deliver appropriate care to patients because of staffing vacancies and increased referrals. This has a consequence of potential failure to achieve performance targets, inability to deliver service user expectations and increase pressure upon existing staff.

11. PCD Reporting Groups

The Committee received the JNCC minutes from the meeting held on May 22nd for information.

12. Any Other Business

Mrs Smith asked for any ideas for the Health & Wellbeing Strategy to be forwarded to her.

The Trust was to be congratulated for their recent submissions to the Healthcare People Management Association (HPMA) Awards in London where the Organisational Development Award was won with their Compassionate Leadership Scheme, and the Workforce Team were finalists for the “Feel Good Friday” initiative in the Social Partnership Forum Award for partnership working between employers and trade unions, a considerable achievement as over 240 nominations were submitted in this category.

13. Date & Time of Next Meeting

Monday 4th September 2017 at 9.30 am, Boardroom, Trust HQ, Lawton House, Trentham

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REPORT TO TRUST BOARD

Enclosure No:14

Date of Meeting:	13th July 2017		
Title of Report:	Fit and Proper Persons Requirements: Chairman's Annual Declaration		
Presented by:	David Rogers, Chair		
Author:	Paul Draycott, Executive Director of Leadership & Workforce		
Executive Lead Name:	Paul Draycott	Approved by Exec	☐

Executive Summary:	Purpose of report	
The report is to provide assurance that all Board members meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that all individuals holding the role of Executive Director (or equivalent) and Non-Executive Director meet the requirements of the Fit and Proper Persons Test (Regulation 5).	Approval	☐
	Information	☐
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement. ☐ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve. ☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently ☒ 6. Attract and inspire the best people to work here ☒ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	This is a requirement under CQC registration		
Resource Implications: Funding Source:	n/a		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	Under the requirements the Trust has a duty to ensure that all reasonable adjustments are considered when considering whether someone is fit for the role.		
Recommendations:	That the Board note the declaration that all Board members meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that all individuals holding the role of Executive Director (or equivalent) and Non-Executive Director meet the requirements of the Fit and Proper Persons Test (Regulation 5).		

Fit and Proper Persons Requirements: Chairman's Annual Declaration

Introduction

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires all health bodies to ensure that all individuals holding the role of Executive Director (or equivalent) and Non-Executive Director meet the requirements of the Fit and Proper Persons Test (Regulation 5).

The Fit and Proper Persons Test applies to Directors (both Executive and Non-Executive, whether existing, interim or permanent and whether voting or non-voting) and individuals *"performing the functions of, or functions equivalent or similar to the functions of a director"* of which we have none.

Detail of the requirements

The act states that a provider must not appoint or have in place an individual as a director who:

- is not of good character;
- does not have the necessary qualifications, competence, skills and experience;
- is not physically and mentally fit (after adjustments) to perform their duties.

It also says that directors cannot have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity.

These requirements play a major part in ensuring the accountability of Directors of NHS bodies and outline the requirements for robust recruitment and employment processes for Board level appointments.

Declaration

As Chairman of North Staffordshire Combined Healthcare NHS Trust, I confirm that all Executive and Non-Executive Directors (both permanent and interim) meet the requirements of the Fit & Proper Persons Test. My declaration has been informed by:

- The annual Fit & Proper Persons Test self-declarations completed by all Executive and Non-Executive Directors;
- Annual checks against all individuals and for new Directors. These include checks on
    - Employment history
    - Qualifications
    - Criminal records
    - Professional registration (if appropriate)
    - Checks to confirm that they are not disqualified Directors, no bankruptcy or insolvency
- The outcome of the annual appraisals of all Executive and Non-Executive Directors.

Recommendation

That the Board note the declaration that all Board members meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that all individuals holding the role of Executive Director (or equivalent) and Non-Executive Director meet the requirements of the Fit and Proper Persons Test (Regulation 5).

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REPORT TO TRUST BOARD

ENCLOSURE 15

Date of Meeting:	13 July 2017		
Title of Report:	The Trust's Approach to Partnerships		
Presented by:	Andrew Hughes, Joint Director of Strategy and Development		
Author:	Andrew Hughes, Joint Director of Strategy and Development Andy Oakes, Head of Partnerships and Social Care Lead Karen Day, Business Development Manager		
Executive Lead Name:	Andrew Hughes, Joint Director of Strategy and Development	Approved by Exec	☒

Executive Summary:	Purpose of report	
To provide the Trust Board with a briefing on the Trust's approach to partnership working and to describe next steps to deliver a Partnership Plan.	Approval	☒
	Information	☐
	Discussion	☒
	Assurance	☐
Seen at: SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐	
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☐ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☐ 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐	
Risk / legal implications: Risk Register Ref	None specifically identified.	
Resource Implications: Funding Source:	None specifically identified Directorate of Strategy and Development	
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	None specifically identified	
Recommendations:	• RECEIVE the paper and to DEBATE the issues that it raises. • UNDERSTAND where partnership activity is currently focused. • APPROVE next steps to develop a Partnership Plan.	

THE TRUST'S APPROACH TO PARTNERSHIP WORKING

1. INTRODUCTION AND PURPOSE

Partnership is fundamental to delivery of our values, aspirations and business and has long been a characteristic of mental health and learning disability services nationally.

We have a strong and long-standing reputation for working in our local communities to develop both formal and informal partnerships at both operational and strategic levels - but 'partnership working' is not something in which we have directly invested or something that we regularly audit and consider.

The Trust's work on the Staffordshire STP generally and the proposals to develop a North MCP specifically has highlighted the importance of partnership working as a critical requirement for the provision of sustainable, person centred care. We need an ever stronger focus on working together across systems and organisations.

This paper has been prepared by the Directorate of Strategy and Development as a stock take of partnership working. It is a first step towards production of a Partnership Plan. The paper:

- Describes the reasons why the Trust has and needs to continue to focus on partnerships.
- Identifies the different types of and reasons for partnership.
- Highlights the resource and effort required to establish and maintain partnerships.
- Schedules the partners with which the Trust currently works [as a first cut this list may not be exhaustive but it will be maintained by the Directorate].
- Identifies what other partnerships the Trust may need to develop.

The Trust Board is asked to:

- **RECEIVE** the paper and to **DEBATE** the issues that it raises.
- **UNDERSTAND** where partnership activity is currently focused.
- **APPROVE** next steps to develop a Partnership Plan.

2. PARTNERSHIP MATTERS

Unprecedented need and stagnant budgets are now the mainstay of the NHS and there is growing realisation that cross-sector, inter-organisational working is the only way to address health and wellbeing.

In many areas of our business, partnership working is the norm without necessarily ever having been documented or resourced. Mental health and learning disabilities services have long been ahead of the curve in recognising that service users want care organised around them to achieve the things they prize: independence, control and a meaningful quality of life.

We have different types of partnership:

- Partners with whom we **provide services**.
- Partners with whom we **co-produce and design services**.
- Partners upon whom we rely for **facilities from which to deliver services**.
- Partners with whom we **do business**.

We are often the principal (or, in tendering terms 'prime' or 'lead') partner but this is not always the case. Sometimes we agree to operate as a junior member of a consortium, either because there is a more appropriately qualified or experienced organisation that can take the lead or because the tender documentation specifically stipulates a preference for a third sector lead.

Recent examples of this approach include our relationship with Mitie for the delivery of care and custody health services within HMPs Whatton and Gartree and the West Midlands-wide bid for new care models money for CAMHS, led by Birmingham Women and Children's NHS Foundation Trust.

Nor are all partnerships formally documented and established. While some are governed by Partnership Agreements (e.g., North Staffordshire GP Federation) or formal Contract (e.g., the business partners for the delivery of substance misuse services) others are bound together more by custom and practice and shared values.

For example, our community teams often develop very localised partnerships, such as small local group meetings held weekly to address specific needs. While it is not the intention of this paper to track those relationships, focussing rather as it is does on critical partnerships that affect whole system delivery, the Committee should note that such arrangements are the bedrock of good and outstanding services.

Perhaps our most important partner also operates on an informal basis. Service users and carers provide the expertise and experience that influence, inform and drive our day to day delivery. The Service User and Carer Council have provided a statement that demonstrates the significant importance that they place on this partnership, which is provided at **Appendix One**.

All partnerships, formal or otherwise, are typically easy to establish but then inevitably require an inordinate amount of effort to maintain and sustain. This does not happen by chance. Our senior leaders continually strive to communicate and strengthen relationships, often in the face of significant service or financial challenges. The breakdown of these relationships within partnerships would have a significant impact on both reputation and our capacity and capability to deliver safe, effective and sustainable services.

An example of the commitment required is the Substance Misuse Directorate. The unscheduled and urgent response to Stoke-on-Trent City Council's Public Health Commissioners' request to take on services dropped by Lifeline has exhausted 80% of time in hours and many more hours late into the evening and at weekends. New partnerships have had to be formed with BAC O'Connor and Addaction, organisations which, up until 8 weeks ago, were the service's direct competitors.

At the same time the Directorate has been working with the business development team to prepare for the imminent invitation to tender for community services for East Cheshire. We are joining an existing partner (ADS) to respond to this tender but the discussions have been challenging as we have sought to explore why we have been unsuccessful in recent bids.

Finally, at the same time, the Directorate is working with Mitie to implement a new service in HMPs Whatton and Gartree. Mitie is a new partner and prison services are a new area of business - challenges on two fronts.

All of this is in addition to the day job of maintaining existing services and relationships – and the infrastructure for this work within the Directorate is really limited to the Head of Directorate and Clinical Directorate.

While this is an extreme and unique set of circumstances there is every reason to assume that an increasing range of services will be tendered in the years to come, particularly as the STP and associated Capped Expenditure Process move from planning to implementation. Substance Misuse Services are in the vanguard of a way of working and approach to partnership that could well become the norm.

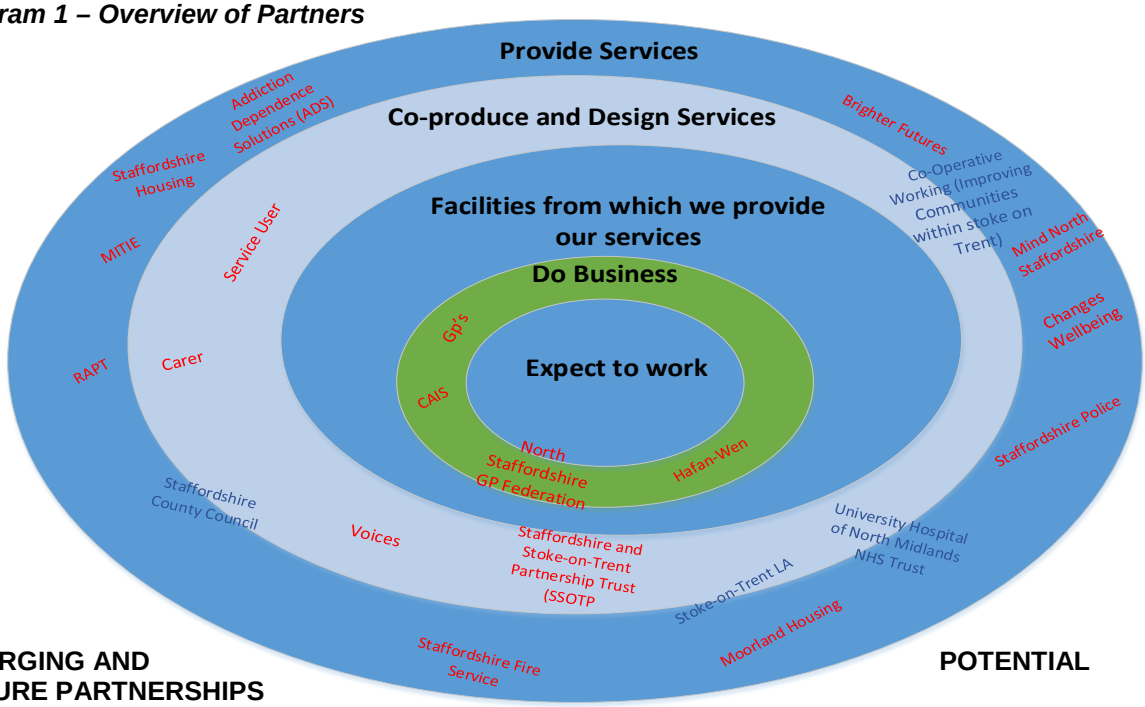
3. OUR EXISTING PARTNERSHIPS

Various criteria are used (on an informal, undocumented basis) to assess the relevance or suitability of potential or existing partners:

- Does the partner support delivery of our strategy and business objectives?
- Does the partner share our Values and Objectives?
- Does the partner bring core skills, experience and impact that will enable us to improve care, safety, experience and outcomes (and to respond to the service specification where appropriate)?
- Does the partnership offer broader commercial and business opportunities?
- Does the partnership sustain our established reputation for innovation?

Appendix Two schedules the existing known partnerships by type. Diagram 1 below provides an overview of the more detailed schedule in the appendix.

Diagram 1 – Overview of Partners



4. EMERGING AND POTENTIAL FUTURE PARTNERSHIPS

The North Staffordshire and Stoke-on-Trent Multispecialty Community Provider (MCP)

Our formal agreements with the North Staffordshire GP Federation are a significant influence on the direction and construct of the future MCP models. We have been instrumental in convening the Alliance Provider Board, bringing together established partners in SSOTP, UHNM, the City Council, Healthwatch and the voluntary sector.

Development of the MCP is central to our strategic future. It is an excellent example of the effort required to bring together existing partnerships into a consolidated partnership body. The work has consumed approximately 80% of the capacity of the Strategy and Development Directorate, and this does not reflect the involvement of other corporate and operational teams who are already supporting pilots in some of the proposed care hub areas. We foresee that activity and involvement in this partnership will considerably ramp up over the next few months and beyond.

Cooperative Working

We are key partners in the development of the Cooperative Working Model across Stoke-on-Trent.

Cooperative Working is collaboration between key stake holders who provide services within the city, including including the City Council, The Fire Service, The Police Service, and significant involvement from third sector providers.

The focus of Cooperative Working is agreed principles and values. It encourages organisations to embrace systems thinking and find ways to reduce the need to refer on to other services by pulling services around the person. The Cooperative Working Board aims to influence the transformation agenda within services.
Partnership working is at its core and the Board, which is chaired by an Third Sector Organisation CEO, has had access to the allocation of a £5m Transformation Grant of which approximately £1m remains.

Again this has a direct impact in time within the Directorate of Strategy and Development, equating to *circa* 20% time for one person.

Commercial Partners

A significant gap in our thinking continues to be around how we develop commercial partnerships and this will be a clear priority in the coming year.

We can demonstrate some areas we are attempting to forge forward with this work as follows:

- The Bid for East Cheshire Substance Misuse Service with the lead partner ADS is third sector charitably funded organisation who are exploring how to provide "sustainable legacies" within local communities. What we mean by sustainable legacies is where ever possible we intend to support peer groups during their recovery journey to take advantage of any commercial or social enterprise opportunities as they arise examples of these are deliver gardening services and restore furniture.
- Keele University and North Staffordshire YMCA are interested in developing new versions of our It's a Goal project tailored for their customers with a view to then marketing these projects to other universities and organisations.
- The established and nationally recognised quality service provided by Growthpoint operates on a partial social enterprise whereby commercial contracts fund some our service users who deliver the service. We could explore locally any commercial or social enterprise opportunities to support this group to become a commercial entity in their own right.

5. PARTNERING IN THE FUTURE

As partnerships are a critical element of winning and delivering our business, it is appropriate that the Business Development Committee should have oversight of the partnership agenda.

The matrix at **Appendix Two** needs to evolve and to be developed jointly with partners and operational services to reflect the depth, extent, range and relative priority of our partnerships.

In the next six months Going forward the Strategic and Development Directorate will:

- Recognise that operational staff develop and maintain partnerships in an informal manner to meet the needs of the local community and our service users. Although not wanting to stifle this work we want to develop a register so that NSCHT has a record of all partners however small thus providing an element of governance within the organisation. More importantly sharing knowledge across directorates to see if there is any cross directorate opportunities we are missing.
- Consider next focus and have a strategic plan for developing future partners and priority actions, which are monitored throughout the year. For consideration are the following:

    - Working with MCP partners to influence the direction and development of new care models at both a strategic level and operationally at scale in locality areas.

    - Further development of the partnership with Stoke-on-Trent LA to ensure maintenance of the S75 arrangements, supporting the future MCP model.

    - Cooperative Working provides the opportunity for increased cooperation and partnership work with organisations outside mainstream mental health provision that impact significantly on mental health services.

    - From a service user perspective the services provided by joint working in these areas significantly improves their recovery and is often a preventative intervention which means that they do not require acute or secondary services.

    - We need to formalise existing partnerships with third sector partners by developing Memoranda of Understanding or Partnership Agreements taking our arrangements to the next level.

RECOMMENDATIONS

The Business Development Committee is asked to:

- **RECEIVE** the paper and to **DEBATE** the issues that it raises.
- **UNDERSTAND** where partnership activity is currently focused.
- **APPROVE** next steps to develop a Partnership Plan.

APPENDIX ONE

Partners, Service User and Carer Council for Andy Oakes June 2017

Working with Partners from the third sector and other providers has been evident within the trust for many years.

This has in the past been endorsed and encouraged by both service user and carer organisations.

This commitment has been shown in the development of the Service User and Carer Council and representation this has provided at board and operational level.

Service users and care involvement in the delivery and development of services provided by the trust is essential if we are to ensure the openness, clarity and willingness to be a listening and learning organisation. This reflects the Trusts declared values and principles, which service users and cares were involved in developing, but above all is the only way that we can continue to truly provide services which are responsive to the needs of the people who use them.

Partnership working between trust members and members of the Service User and Carer Council is essential if each is to take ownership of decisions made. The Service User and Carer Council reflects this with its membership, which includes representation from Service User's and Carer's, third sector organisations and Trust staff from executive to directorate level. All have equal say and responsibility to ensure that service delivery is enhanced by working together with a common goal of exemplary services. If all feel a sense of ownership, the focus will be on progressing forward not just reflective practice.

Quote from Service User and Carer Council member

"*As a Service User I have been struck by the Trust's commitment to genuinely encourage Service Users and Carers to be actively involved at all levels. This includes the opportunity for the Chair of the SUCC to have a seat on the Trust Board, non-voting, but in every other way treated the same as all other Trust Board Members. While impacting on shaping the services we use by sharing our lived experiences, we also start to work towards reducing the stigma attached to those of us with Mental Health Issues"*

'Working in partnership = consideration for all'

APPENDIX TWO

Name	Directorate Involvement	Who Manages Relationships	Who Operational Manages Service
Co-producing and design services:			
Service Users and Carers	All	• Service User Groups and Carer Council • Citizens Jury • Directorate Service User and Carer Forums	Directorate of Nursing and Quality All Directorates
Voices	All	Directorate of Strategy and Development	All Directorates
SSOTP	All	• Alliance Board	Directorate of Strategy and Development
Do business:			
GP's and GP Federation	All	• Alliance Board • MCP Development	Directorate of Strategy and Development Adult Mental Health Community and NOAP Directorates
Primary Care	All	• Alliance Board	Directorate of Strategy and Development
Addaction	Substance Misuse	Head of Service and Clinical Director Directorate of Strategy and Development	Head of Service and Clinical Director
BAC O'Conner	Substance Misuse	Head of Service and Clinical Director Directorate of Strategy and Development	Head of Service and Clinical Director
Cais and Hafan Wen	Substance Misuse	Head of Service and Clinical Director Directorate of Strategy and Development	Head of Service and Clinical Director
Keele University	Psychology	Directorate of Strategy and Development OD Directorate	Clinical Directorates
Future Partners:			
Staffordshire Housing	All	Directorate of Strategy and Development	
YMCA	Young People and Adult Mental Health	Directorate of Strategy and Development	
Aspire Housing	All Directorates	Directorate of Strategy and Development	
Addullum Housing	Substance Misuse / Potential for Adult Mental Health Community	Head of Service and Clinical Director Directorate of Strategy and Development	Head of Service and Clinical Director
Provide services:			
ADS	Substance Misuse	Head of Service and Clinical Director Directorate of Strategy and Development	Head of Service and Clinical Director
Mitie	Substance Misuse (Prison Service)	Head of Service and Clinical Director Directorate of Strategy and Development	Head of Service and Clinical Director

Name	Directorate Involvement	Who Manages Relationships	Who Operational Manages Service
Brighter Futures	Adult Mental Health Community Substance Misuse	Directorate of Strategy and Development	Head of Service for Substance Misuse. Service Manager for Adult Mental Health Community (Resettlement)
Mind North Staffordshire	All (delivering Healthy Minds Stoke)	Directorate of Strategy and Development	Service Manager for Healthy Minds
Changes Wellbeing	All	Directorate of Strategy and Development	Service Manager /Clinical Lead for Healthy Minds Head of Service for Substance Misuse
Staffordshire Police	All	Directorate of Strategy and Development (Co-operative Working) Executive Directors	Service Manager Criminal Justice Team
Moorlands Housing	Adult Community Mental Health	Service Manager (Resettlement)	Service Manager (Resettlement)
Staffordshire Fire and Rescue		Directorate of Strategy and Development (Co-operative Working) Executive Directors	Co-Operative Working.
Rapt	Substance Misuse (Prison)	Head of Service and Clinical Director Directorate of Strategy and Development	Head of Service and Clinical Director
Stoke-on-Trent Local Authority	All	Directorate of Strategy and Development (Social Care input)	Section 75 Directorate Heads of Services
Co-operative Working	All	Directorate of Strategy and Development.	Service Manager (Resettlement) Pilot Meir Care Hub.
Stoke City Football Club	Adult Mental Health Community	Directorate of Strategy and Development	Service Manager (Resettlement).

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REPORT TO Trust Board

ENCLOSURE 16

Date of Meeting:	13th July 2017		
Title of Report:	Annual Organisation Audit (Medical Appraisal & Revalidation)		
Presented by:			
Author:	Robert Walley (Medical Staffing Manager)		
Executive Lead Name:	Dr Olubukola Adeyemo	Approved by Exec	☐

Executive Summary:		Purpose of report	
This is the fifth annual board report since the introduction of medical appraisal and revalidation in 2012. The Trust has, in 2016/17, achieved a 100% appraisal and revalidation rate.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☐
Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☒ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☒ 4. Encourage, inspire and implement research & innovation at all levels.☒ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	n/a		
Resource Implications: Funding Source:	n/a		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	n/a		
Recommendations:	Audit report for information only.		

Quality Assurance for Responsible Officers and Revalidation

Annual Board Report 2016-7

Contents

1. Executive summary

This is the fifth annual board report since the introduction of medical appraisal and revalidation in 2012. The Trust has, in 2016/17, achieved a 100% appraisal and revalidation rate.

An independent audit into the quality of the appraisal data finished in March 2017. The final report made recommendations around the administration process of recording appraisal data. These recommendations were accepted and implemented by the end of April 2017.

The transition from the Equiniti software to Allocate software has taken place. Equiniti remains accessible to users for previous appraisal details.

2. Purpose of the Paper

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

3. Background

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

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

4. Governance Arrangements

Appraisal and revalidation for 2016/17 has been monitored using a system which gives appraisers, appraisees and system administrator a live update of the progress on their appraisal.

Outline of Responsibilities:

Responsible Officer (RO)

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

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

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

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

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

Medical Appraisal Co-ordinator

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

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

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

Medical Appraisers

i. To undertake appraisals within each appraisal period – generally appraisers are expected to undertake a minimum of 2 and a maximum of 5 medical appraisals annually.

ii. To participate in appraisal training and maintenance of their appraisal skills and current knowledge of the medical appraisal process and discuss their performance and skills as an appraiser in their own medical appraisal. This includes seeking and reflecting on feedback from appraisees.

iii. To participate in medical appraisal review meetings as required by the RO.

5. Medical Appraisal

a. Appraisal and Revalidation Performance Data

Number of doctors: **38**

Number of completed appraisals: **38**

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

b. Appraisers

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

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

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

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

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

c. Quality Assurance

The March 2017 audit report made recommendations that:

1) Any gaps resulting from the transfer of systems from Equiniti to Allocate must be resolved immediately
2) The medical appraisal coordinator's spreadsheet must be enhanced
3) The RO should consider using a checklist when validating documents
4) Evidence of training for appraisers should be recorded on file
5) An annual internal spot-check will take place to review the appraisal process and documentation has been recorded correctly

All of the above recommendations were agreed and acted upon in April 2017.

The Trust's Performance Management team monitor compliance with national requirements and other NHS reporting requirements, as appropriate.

The quality of appraisals and revalidation is assured in relation to both assurance of the process and assurance of the appraiser work:

- Appraisees are asked by the appraiser for feedback on their experience of medical appraisal by their medical appraiser as part of the appraisal process.

- Appraisees are invited periodically (ideally annually) to participate in a short anonymous survey of medical appraisal experience within the Trust. Appraiser performance will be reviewed by analysis of feedback from these questionnaires.

- Appraisers are asked to take part in a self-assessment for their role as an appraiser on an annual basis and to discuss this in their own appraisal and annual RO- appraiser review meeting.

d. Access, Security and Confidentiality

Appraisal folders are accessible only by the appraisee and, once submitted, the appraiser. Folders are stored on a secure system by password protection. No one else, other than a restricted number of system administrators, can access this information.

6. Revalidation Recommendations

All eligible doctors in the Trust received a positive recommendation. There were no delays, deferrals or non-engagement notifications.

7. Recruitment and engagement background checks

All permanent and temporary (including agency) medical staff are subject to the NHS pre-employment check standards.

8. Monitoring Performance

The annual job plan review and appraisal process ensures that performance standards are maintained and reviewed annually.

9. Responding to Concerns and Remediation

In the event of a complaint about the conduct or performance of a doctor in their role as medical appraiser, every effort should be made to address and resolve these informally

between the parties to the appraisal. Where difficulties cannot be resolved informally, the doctor should pursue their complaint under the Trust's Grievance Procedure.

Any complaints about the Trust's appraisal process itself should be referred to the responsible officer (RO) or medical appraisal coordinator.

No complaints have been made in the current reporting period.

10. Risks and Issues

One Specialty Doctor failed to engage in their appraisal process by 31st March deadline. The issue was escalated and dealt with at the time. The current escalation and review process will prevent this from occurring in the future.

There have been no risks or other issues reported around the appraisal and revalidation process or systems.

11. Corrective Actions, Improvement Plan and Next Steps

There are no recommended corrective actions or next steps. However, previous actions from the audit have been implemented successfully, and a clear process for communication and escalation on a monthly basis between the medical appraisal coordinator and medical appraisal lead is in place.

Please note that the Trust's responsible offer has decided to ensure that appraisals are finalised by the end on January of each year to prevent the possibility of any delays to submission by March 31st.

12. Recommendations

The Trust Board is asked to:

1. Note the contents of this end-of-year review for assurance, and

2. Support the ongoing management, governance and quality development work in relation to the Trust's medical appraisal and revalidation processes.

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REPORT TO Finance & Performance Committee

Enclosure No: 17

Date of Meeting:	13/07/2017		
Title of Report:	Finance and Performance (F&P) Committee Report to the Trust Board – 13th July 2017		
Presented by:	Tony Gadsby		
Author:	Mike Newton		
Executive Lead Name:	Suzanne Robinson	Approved by Exec	☐

Executive Summary:	Purpose of report	
This paper details the issues discussed at the Finance and Performance Committee meeting on the 6th July 2017. The meeting was quorate with minutes approved from the previous meeting on the 1st June 2017. Progress was reviewed and actions confirmed taken from previous meetings.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee X • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☐ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.X 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	N/A		
Resource Implications: Funding Source:	N/A		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	N/A		
Recommendations:	The 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 – Thursday, 13th July 2017

Finance and Performance (F&P) Committee Report to the Trust Board – 13th July 2017

This paper details the issues discussed at the Finance and Performance Committee meeting on the 6th July. The meeting was quorate with minutes approved from the previous meeting on the 1st June. Progress was reviewed and actions confirmed taken from previous meetings.

Executive Director of Finance Update

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

- The provider finance sector update, detailing a 2016/17 Q4 net deficit of £791m for the provider sector compared to £886m at Q3. The number of providers in deficit is 105 out of 238 and 210 providers have signed up to their 2017/18 control. CIP averages 4.3% across the sector for 2017/18. NHSi are to start to challenge providers on unrealised opportunities identified through benchmarking against the model hospital toolkit.

- A session has been held for "clinicians working with finance" presented by the Executive Director of Finance. This was received well by clinical colleagues who have shown strong interest in collaboratively working with finance on identified work streams.

- NSCHT Finance Team won the HFMA "Great Place to Work Award." The Finance team demonstrated a culture and development programme that enables individuals to perform at their very best, leading on innovation and best practice.

- The Committee gave assurance on the costing systems the trust employ; this was captured in a signed document from finance and education.

- The Deputy Director of Finance demonstrated the new innovative cash flow model. Following concerns raised by the DoF on cash flow, cash management and cash forecasting the BAF for 1718 contained an objective to develop a management tool. This provides both a top down and bottom up approach to cash management. The model gives improved understanding and visibility around the Trust Cash Position, greater control over cash daily management and monitors performance against statutory limits. It also allows statutory forms which feed into the annual accounts to be populated automatically and monitored monthly.

  The sophistication and detail of the cash flow model, enables the committee to give assurance around the accuracy trust cash projections. It does however raise concerns around the trust ability to operate within its statutory limits due to affordability of CIP and delivery of Cost Improvement.

Finance

The committee reviewed the Month 1 Finance position which is £63k deficit against a plan

deficit of £101k; a favourable variance to plan.

The forecast expenditure on capital is £160k below plan due to forecast underspend on PICU. The committee were assured around the financial position.

Cost Improvement Programme (CIP)

The committee received an update for CIP for month 2 and were concerned that the total CIP identified was still significantly short of the target. £2,434k is currently forecast to be recurrently delivered by M12 against the £3,197k target.

The committee were assured there was sufficient focus being placed on CIP but are unable to give assurance around the ability to deliver the full CIP target for 2017/18, which has not moved significantly since Month 1. The committee awaits the full in depth analysis of CIP to be presented at the August F&P. This remains the most significant area of concern for the committee.

Cash

Cash balances show an improvement compared to the M1 position, falling short of the Cash Target by £0.9m. The committee noted that the timing difference between cash spent on EPR and funding received from NHS Digital was a significant factor. There are issues with historical contracting arrangements where commissioning organisations pay quarterly in arrears, creating short term cash pressures.

The committee acknowledges the progress made around cash control but could not give assurance that the trust will be able to deliver against its cash plan until affordability has been reviewed and the capital plan recast in line with the BAF objective.

Other Reports and Updates

The Committee received additional assurance reports as follows:

- Agency utilisation report
- Capital spend and forecast
- Treasury and Cash Management

Performance:

- **Activity Report**

The report detailed M2 activity against plan using traditional reporting methods and clustering. The committee is not able to give assurance around activity reported, particularly around the use of care clusters, due to issues around quality of recording by operational staff.

Data quality issues as a result of EPR migration were discussed and it was noted that a commissioning colleagues had granted a 6 month grace period to resolve any reporting issues, with the trust only being required to report its constitutional targets.

An action plan was presented to improve the quality of PBR reporting. The committee

supported the mitigating actions and plans for improving activity reporting.

- **Performance Report (PQMF)**

This report provides the committee with a summary of performance to the end of Month 2 (May 2017).

CPA compliance remains an issue in respect of care plan compliance and 12 month reviews undertaken. It was noted that Lorenzo has led to some initial issues around reporting at the granular detail, which is expected to be resolved.

Delayed Transfers of Care have worsened since month 1 and remains an issue, particularly in the Older Adults Directorate, where delays are largely driven through patient choice and agreement of funding packages.

Trust vacancies rates were discussed and it was noted that this being impacted by the substantive recruitment on Ward 4 which was commissioned from June 2017. The recruitment campaign has brought success with a number of nursing vacancies recruited to. In addition a number of student nurses will start in September. This will continue to be an ongoing challenge with continuous recruitment sessions required.

- **CYP Waiting Times (PQMF)**

The Head of Directorate for CAMHS attended F&P to update on waiting times performance for CAMH's and ASD.

For ASD, it was reported that no Children are waiting over 18 weeks for an ASD assessment. Since the last F&P, performance has improved around both the 4 week and 18 weeks target.

Further improvements are expected through transformational changes within the CAMHS hub that will see quicker decision making and signposting to the right service.

The committee can give assurance that there are solid plans to deliver the improvements required and can be assured that performance has improved on waiting times in month 2, however will need evidence of sustained performance before full assurance can be given.

- **Deep Dive Analysis into Readmissions and DTOCs**

A detailed report on Delayed Transfers of Care (DTOC's) was well received. Particular issues were noted in NOAP due to patient choice and agreement of funding. The trust patient choice policy is being revisited and is anticipated to improve performance in the area.

A comprehensive report on readmissions was received providing a thorough analysis of performance, key metrics and trends. There is a notable issue around Personality Disorder Patients who are consistently readmitting, raising questions around a potential service development opportunity.

The quality of both reports was acknowledged by the committee which provided significant insight into the drivers of performance. The depth of information provoked further questions which require more investigation. Findings will be shared with the committee members.

Capital and Estates

A Capital Projects Report was presented detailing expenditure to date on the PICU project, as well as a detailed forecast, profiled over the project life, as requested at the previous committee. This is following concerns raised for the committee and the report met the requirements and gave the assurance the committee was requesting.

An updated 5 Year capital plan was presented to the committee which was approved, however due to the concerns raised around the cash limits, the committee will receive a final version as per the BAF.

Other Reports and Updates

The Committee received additional assurance reports as follows:

- Board Assurance Framework Q1:
- Annual Statement of Pay Protection
- Financial Risk Register

Recommendation

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

On Behalf of Tony Gadsby – Chair of Finance and Performance Committee

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REPORT TO: Trust Board

ENCLOSURE 18

Date of Meeting:	13 July 2017		
Title of Report:	Assurance Report from the Quality Committee meeting held on 22 June 2017		
Presented by:	Patrick Sullivan Non-Executive Director and Chair of Quality Committee		
Author:	Sandra Storey, Associate Director Medical & Clinical Effectiveness		
Executive Lead Name:	Dr Buki Adeyemo, Executive Medical Director	Approved by Exec	☒

Executive Summary:		Purpose of report	
This report provides a high level summary of the key headlines from the Quality Committee meeting held on the 22 June 2017 The full papers are available to Trust Board members, as required.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	Approved by Chair of Quality Committee and Executive Lead	Document Version No.	
Committee Approval / Review	• Summary of key points from Quality Committee 22 June 2017		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement. 2. To provide the highest quality services 3. Create a learning culture to continually improve. 4. Encourage, inspire and implement research & innovation at all levels. 5. Maximise and use our resources intelligently and efficiently. 6. Attract and inspire the best people to work here. 7. Continually improve our partnership working. The business of the Quality Committee is applicable to all strategic objectives.		
Risk / legal implications: Risk Register Ref	None identified		
Resource Implications: Funding Source:	N/A N/A		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	None identified		
Recommendations:	For assurance/information		

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Key points from the Quality Committee meeting held on 22 June 2017 for the Trust Board meeting on 13 July 2017

1 Introduction

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

2 Nurse Staffing Performance monthly report – May 2017

The Committee received the safer staffing performance report on a shift by shift basis for May 2017. Delivery of Registered Nurse staffing levels is a key requirement to ensuring that the Trust complies with National Quality Board standards. During May the Trust achieved staffing levels of 84% for registered staff and 102% for care staff on day shifts and 84% and 106% for nights respectively. Overall a 95% fill rate was achieved. Where 100% fill rate was not achieved, the Quality Committee were assured that 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.

3 Performance & Quality Management Framework Month 1 201/18

Committee members discussed performance by exception and the rectification plans in place. Month 1 was noted to have 7 targets rated as red and 2 as amber, with all other indicators within expected tolerances. Highlights were noted as follows:

- 100% of IAPT patients were treated within 4 weeks of referral.
- 93.5% of patients (excluding ASD) have been referred for treatment or intervention within 18 weeks.
- 99.4% of all service users to the IAPT service have been contacted within 3 working days of referral.

Substance misuse targets will be included from Q3 as part of the new reporting framework.

4 Reports received for Information and Assurance

4a Director of Quality Report

The Committee received the Director of Quality Report under the SPAR qualities priorities with notable items as follows:

Safe:

- **Medical examiners' scheme delayed until April 2019.** Plans to introduce a medical examiners' role and implement reforms to the death certification process has been delayed. Once in place there will be a unified system of scrutiny of all deaths not investigated by a Coroner. Medical examiners will be required to undertake an independent clinical review of all deaths that occur in England before the death can be registered. The delay is to allow more time for preparation ensuring the benefits of the new system are realised.

Personalised:

- **New guidance for commissioners on patient and public involvement.** NHS England has updated guidance on patient and public participation in health care for NHS commissioners. CCGs and NHS England are under a legal duty to have a regard to the refreshed statutory guidance. The committee was advised that this is currently being considered locally and details of action will be shared as this become available.

Accessible:

- **Mental Health patients set to benefit from pioneering new digital services.** NHS England has announced new funding for seven mental health trusts to enable these organisations to pioneer world class digital services to improve patient care. This is part of the NHS's plan to harness technology to improve services and become more efficient. Our Trust has an extensive digital by choice strategy which includes working with local health economy providers as part of the Digital workstream within the Staffordshire STP programme. Any learning, development and adopting of best practice from this new work will be communicated as appropriate, to the committee.

Recovery focused:

- **NHS Continuing Healthcare under review by the National Audit Office.** The National Audit Office has announced that it will be conducting an investigation into continuing healthcare commencing August 2017. NHS CHC is widely acknowledged as a complex area. CCGs, local authorities and practitioners alike, will be keen to hear the outcome of the review and this will be reported to the committee in due course.

4b **Clinical Audit Annual Report 2016/17**. The committee received this report summarising the organisation and achievement of the clinical audit, risk and governance functions within the Trust during 2016/17.

4c **Letter to CEO – Quality Surveillance Group (QSG) April 2017.** The QSG noted that the Trust has been reviewing the number of unexpected deaths to identify any themes for action. The QSG agreed that the surveillance rating should remain as Green – Routine, no specific concerns but watching eye on any dips in performance.

4d **Feedback from the Service User and Carer Council Open Space Event – Quality Priorities.** – The committee received a briefing in response to the priorities agreed with the Service User and Carer Council and how these are being addressed within the Trust's Improvement Programme.

4e **House of Commons Select Committee Suicide Prevention – sixth report of session 2016/17.** The committee received the interim report on suicide prevention published to help inform the Government's updated suicide prevention strategy.

5 Learning from Experience Report April/May 2017

The Committee received this report detailing the progress around monitoring patient safety during April/May 2017. It was noted that there has been an increase in the responses to the Friends and Family Test after promotion by the patient experience team. Recent engagement events have successfully recruited additional service users and carers with the aim of further improving service user and carer involvement.

6 Clinical Effectiveness Report

The committee received this assurance report on the outputs of the work of the following groups:

- Medicines Optimisation
- Mental Health Law Governance Group
- Research and Development Group
- Clinical Records and System Design Group
- Clinical Effectiveness Group

Of note were the case law updates and the implications for the Trust alongside the imminent changes to the Police and Crime Act.

7 Quality Account 2016/17 final draft

The Committee received the final draft of the Quality Account for sign off on behalf of the Trust Board. Members were assured that the project plan remains on target to ensure completion and publication by the deadline of 30 June 2017. The committee noted the positive feedback from key stakeholders such as the Stoke Overview and Scrutiny Committee, Stoke Healthwatch, Staffordshire Healthwatch and local commissioners. The external audit of the Quality Account was also positive and no comments or learning points were identified.

8 Directorate Performance Reports

Each Directorate presented in detail their performance as part of the new reporting arrangements to the committee. Committee members felt that this new style of reporting, capturing information from performance reviews, enabled a much more focussed discussion around cross cutting issues. Similar themes were compliance with supervision, statutory and mandatory training including medicine management training. Members discussed challenges with recruitment and resultant capacity and agreed issues for escalation to the risk register.

9 Risk to Quality of Services as at June 2017

Committee members considered the report for quality risks, particularly those scoring 12, which have been reported to the Committee previously and how they interrelate to Directorate risks. Members discussed the risk treatment plans in place and assurance about the actions being taken. It was agreed that safer staffing and place of safety would be added to the risk register to ensure on-going review and close monitoring.

10 Overview of the National Reporting and Learning System (NRLS)

The Committee received a paper detailing an analysis of the benchmarked data submitted by the Trust for the period 2012-2016. Pre 2012, the Trust benchmarked position reflected that the Trust was the lowest reporting mental health trust nationally. The data now reflects that during the reporting period the Trust has maintained a reporting rate within the middle 50% of reporting Trusts. The Trust will continue to utilise the data for national comparison with a report to the Senior Leadership Team and Quality Committee on a six monthly basis upon release of the organisational 6 monthly workbook.

11 Serious Incident Annual Report 2016/17

This report provided the committee with a review of the Trust's serious incident processes, details of progress made and incidents reported during the period April 2016 – March 2017. Of note was the thematic review commissioned by the Medial Director. This followed an increase in number of unexpected deaths at a particular locality with the review intended to determine any possible linking factors. While some inconsistencies in care and process, no causative factors were identified. The committee also heard about the Trust's approach to Duty of Candour and commitment to learning lessons.

12 Ward 4 Brief and Action Plan

The committee received a briefing paper relating to care and environment provision on ward 4. It was noted that this was an intensive piece of work and there is now improvement and stability following a comprehensive risk analysis and action plan. Work will be monitored and any further developments reported to the committee as appropriate.

13 Serious Incident Report Q4 2016/17

The Committee received an update on the number and type of serious incidents reported against each Directorate. Fewer deaths were reported in comparison to Q4 2015/16 and from an initial review of the incidents, no service or care delivery issues were identified. The report also included compliance with Duty of Candour and Mortality Surveillance for Q4 2016/17.

14 CAMHS Waiting Times verbal update

Committee members were provided with a verbal update and given reassurance on the progress that the service has made. Due to a concerted effort no child is waiting over 18 weeks with 75% assessed within four weeks. Challenges remain and activity will be closely monitored and actions taken accordingly to continue to improve services for children and young people.

15 Suicide Prevention Strategy and Annual Work Plan

The Trust Board approved the Trust Prevention Strategy in March 2017 subject to minor amendments to align the strategy with the Trust's quality priorities. The committee received an updated strategy aligning strategy objectives under SPAR headings. To implement the strategy an action plan has been developed and approved at the Senior Leadership Team meeting. The committee noted the commitment to this strategy and the progress with the work plan.

16 Patient Storey proposal

The Committee agreed with the proposal to implement a patient story at each committee meeting. A schedule will be introduced to rotate patient stories by Directorate. The intention is to hear about people's experiences and raise awareness of those that are either positive or negative. This will afford the opportunity for shared learning and action to improve service provision and enhance experiences for patients and staff going forward.

17 Next meeting:
Thursday 31 August 2017 2pm

On behalf of the Committee Chair, Mr Patrick Sullivan, Non-Executive Director
Sandra Storey Associate Director of Medical and Clinical Effectiveness

30 June 2017