North Staffordshire Combined Healthcare NHS Trust

MEETING OF THE TRUST BOARD

TO BE HELD IN PUBLIC
ON THURSDAY, 22nd March 2018, 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.	**DECLARATIONS OF INTERESTS RELATING TO AGENDA ITEMS**	Note
3.	**DECLARATIONS OF INTERESTS RELATING TO ANY OTHER BUSINESS**	Note
4.	**MINUTES OF THE OPEN AGENDA – 22ND FEBRUARY 2018** *To APPROVE the minutes of the meeting held on 22nd February 2018*	Approve Enclosure 2
5.	**ACTION MONITORING SCHEDULE & MATTERS ARISING FROM THE MINUTES** *To CONSIDER any matters arising from the minutes*	Note Enclosure 3
6.	**CHIEF EXECUTIVE'S REPORT** *To RECEIVE a report from the Chief Executive*	Note Enclosure 4
7.	**CHAIR'S REPORT** *To RECEIVE a verbal report from the Chair*	Note
8	**STAFF RETIREMENTS** *To EXPRESS our gratitude and recognize staff who are retiring* *To be introduced by the Chief Executive and presented by the Chair*	Verbal

9.	**CQC CELEBRATION ITEM – ADULT REHABILITATION SERVICES** To be introduced by the Chief Executive.	Verbal
10.	**REACH RECOGNITION TEAM AWARD ON EXCELLENCE** *To PRESENT the REACH Recognition Team Awards to the Substance Misuse One Recovery Team* To be introduced by the Chief Executive and presented by the Chair	Verbal
	QUESTIONS FROM MEMBERS OF THE PUBLIC	
11.	*To RECEIVE questions from members of the public*	Verbal
	TO ENHANCE SERVICE USER AND CARER INVOLVEMENT	
12.	**SERVICE USER AND CARER COUNCIL** *To RECEIVE an update from, Wendy Dutton, Chair of the Service User and Carer Council*	Assurance Enclosure 5
	ENCOURAGE, INSPIRE AND IMPLEMENT RESEARCH AND INNOVATION AT ALL LEVELS	
13.	**No items**	
	TO PROVIDE THE HIGHEST QUALITY SERVICES	
14.	**NURSE STAFFING MONTHLY REPORT - JANUARY 2018** *To RECEIVE the Nurse Staffing Monthly Report from Maria Nelligan, Executive Director of Nursing & Quality*	Assurance Enclosure 6
15.	**DIRECTOR OF INFECTION PREVENTION AND CONTROL (DIPC) Q3 OCTOBER – DECEMBER 2017 REPORT** *To RECEIVE the Director of Infection Prevention and Control (DIPC)Q3 Report from Maria Nelligan, Executive Director of Nursing & Quality*	Assurance Enclosure 7
16.	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 10** *To RECEIVE the Month 10 Performance Report from Suzanne Robinson, Director of Finance, Performance and Digital*	Approval Enclosure 8
	CREATE A LEARNING CULTURE TO CONTINUALLY IMPROVE	

17.	**STAFF SURVEY RESULTS** *To RECEIVE the Staff Survey Results from Alex Brett, Director of Workforce, Organisational Development and Communications*	Assurance Enclosure 9
	MAXIMISE AND USE OUR RESOURCES INTELLIGENTLY AND EFFICIENTLY	
18.	**FINANCE REPORT – MONTH 10 (2017/18)** *To RECEIVE for discussion the Month 10 financial position from Suzanne Robinson, Director of Finance, Performance and Digital*	Approval Enclosure 10
19.	**ASSURANCE REPORT FROM THE FINANCE, PERFORMANCE & DIGITAL COMMITTEE** *To RECEIVE the Finance, Performance & Digital Committee As surance report from the meetings held 8th March 2018 from Tony Gadsby, Chair/Non-Executive Director*	Assurance Enclosure 11
20.	**DECLARATION OF INTERESTS – FEBRUARY 2017** *To RECEIVE for information and assurance the Trust Board Register of Interests to February 2018 from Laurie Wrench, Associate Director of Governance / Trust Board Secretary*	Assurance Enclosure 12
21	**RELOCATION OF NSCHT SERVICES BRANDON CENTRE** *To RECEIVE Relocation of NSCHT Services Brandon Centre from Carol Sylvester, Acting Director of Operations*	Assurance Enclosure 13
	ATTRACT AND INSPIRE THE BEST PEOPLE TO WORK HERE	
22	**ASSURANCE REPORT FROM THE PEOPLE AND CULTURE COMMITTEE** *To RECEIVE the People, Culture and Development Committee Assurance report from the meeting held 12th March 2018 from Lorien Barber, Chair/Non-Executive Director*	Assurance Enclosure 14
23	**ASSURANCE REPORT FROM THE AUDIT COMMITTEE** *To RECEIVE the Audit Committee Assurance report from the meeting held 8th March 2018 from Gan Mahadea, Non-Executive Director*	Assurance Enclosure 15
24	**CQC ACTION PLANS & CQC DRIVING IMPROVEMENT PUBLICATION** *To RECEIVE the CQC Action Plans & CQC Driving Improvement Publication from Caroline Donovan, Chief Executive Officer*	Assurance Enclosure 16
	CONTINUALLY IMPROVE OUR PARTNERSHIP WORKING	
25	**MEIR LOCALITY PARTNERSHIP** *To RECEIVE an update on progress from Mr A Hughes, Joint Director of Strategy and Development (NSCHT/GP Federation)*	Assurance Enclosure 17

26	**SIGN UP TO THE TUC DYING TO WORK CAMPAIGN** *Mr John Ashworth MP, will be in attendance whilst the charter is signed in recognition of the Trust's commitment to the campaign.*	Verbal
	CONSENT AGENDA	
27.	**ASSURANCE REPORT FROM THE QUALITY COMMITTEE (VIRTUAL MEETING)** *To RECEIVE the Quality Committee Virtual Assurance report for the 22nd March 2018 Trust Board meeting 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 Wednesday 18th April 2018 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	

TRUST BOARD

Minutes of the open section of the North Staffordshire Combined Healthcare NHS Trust Board meeting held on Thursday, 22nd February 2018 At 10:00am in the Boardroom, Trust Headquarters, Lawton House Bellringer Road, Trentham, Stoke on Trent, ST4 8HH

Present:

Chairman:

Tony Gadsby
Non-Executive Director (Vice Chair)

Directors:

Caroline Donovan
Chief Executive

Dr Buki Adeyemo
Medical Director

Maria Nelligan
Executive Director of Nursing and Quality

Andrew Hughes
Joint Director of Strategy and Development

Lorien Barber
Non-Executive Director

Suzanne Robinson
Director of Finance, Performance and Digital

Ganeshan Mahadea
Non-Executive Director

Alex Brett
Executive Director of Workforce, Organisational Development and Communications

In attendance:

Laurie Wrench
Associate Director of Governance

Lisa Wilkinson
Acting Corporate Governance Manager (minutes)

Jenny Harvey
Staff Side Representative

Wendy Dutton
Chair of Service User and Carer Council

Joe McCrea
Associate Director of Communications

Dean Burgess
Workforce Safety Lead

Gabrielle Hoban
Service User

Members of the public:
No members of public present

REACH Individual Recognition Award
Sue Ford – Nurse Prescriber Community CAMHS

The meeting commenced at 10:01am.

29/2018	**Apologies for Absence** David Rogers Chairman, Dr Keith Tattum GP Associate Director, Joan Walley Non-Executive Director, Patrick Sullivan Non-Executive Director, Carol Sylvester Acting Director of Operations	**Action**
30/2018	**Declaration of Interest relating to agenda items** There were no declarations of interest relating to agenda items.	
31/2018	**Declarations of interest relating to any other business** There were no declarations of interest relating to any other business.	
32/2018	**Minutes of the Open Agenda – 25th January 2018** The minutes of the open session of the meeting held on 25th January 2018 were approved.	
33/2018	**Matters arising** The Board reviewed the action monitoring schedule and agreed the following:- ***830/2017 – Safer Staffing Nursing Report*** *– A report will come to March Board.* ***841/2017 – Partnership Strategic Plan*** *– Agenda item today included in the Two Year Plan discussions in Closed Board.* ***865/2017 – PCD Assurance Report Communications Strategy*** *– The strategy will come to March Board.* ***12/2018 – R & D Partnership with Keele*** *– A report will come to April Board* ***13/2018 – Nurse Staffing Monthly Report November 2018 (Mapping Exercise)*** *– A report will come to March Board.* ***14/2018 – PQMF M8 (Medical Workforce Plan)*** *– A report will come to April Board* ***14a/2018 – PQMF M8 Single Oversight Framework*** *– Agenda item today* ***17/2018 – CQC Local System Review Action Plan*** *– Actioned*	

	20/2018 – Declarations of Interest *– All declaration forms being updated and register being refreshed amended paper to come to March Trust Board.* ***21/2018 – Register of Signed and Sealed Documents*** *– There was no sign and seal document for Greenfields. Complete*	
34/2018	**Chief Executive's Report** Caroline Donovan, Chief Executive, presented this report which provides an update on the activities undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest. **CARILLION** The Trust has now received a proposal from Town Hospitals regarding an alternative supplier for facilities management services. This proposal sits outside of the national negotiations being led by PWC and we are assessing the benefits and potential risks of this alternative provision. In the meantime, all services have continued to be supplied with no disruption and staff attrition no higher than would be normally expected in the relevant staff group. The Associate Director of Estates is in daily contact with Town Hospitals Senior Director and there is a weekly meeting between relevant management teams to which local Carillion staff are invited to attend to receive information on behalf of their colleagues. **CARE QUALITY COMMISSION INSPECTION** The results of the Care Quality Commission inspection were published on Wednesday 14th February 2018. For the first time in the Trust's history every Combined Service is "Good" or "Outstanding". The Trust's overall rating is "Good". The CQC results confirm that the Trust's journey of improvement - labelled last year by the CQC as the fastest improving mental health trust in the country - has continued without let-up. The results mean that Combined Healthcare is the best rated mental health trust across the whole of the Midlands and East of England and the third highest in the country – as only 1 of 3 with every service rated at least Good and at least two Outstanding. The CQC said • "The overall culture of the trust was very patient-centred. Staff treated patients with dignity, respect and compassion and most experienced high morale and motivation for their work." • There had been significant improvement in the reduction of waiting lists in the child and adolescent mental health services and the adult community mental health services since the last CQC inspection. All teams were meeting the national waiting time standards." • "We found staff to be dedicated, kind, caring and patient focused. The local management and leadership of services were both knowledgeable and visible. Staff we talked to during inspection spoke highly of their managers and told us that a more positive and	

open culture had developed since our last inspection."

- "We were particularly impressed by the level of care offered to patients in the long stay and rehabilitation wards and the community based mental health services for older people, both of which were rated Outstanding overall."

As a Trust we are delighted that the most recent inspection rated our Community CAMHS services as “Good” and our Adult Rehab services as "Outstanding", but we are not complacent and we want our journey of improvement to continue. We will be continuing our quality strategy to deliver Safe, Personalised, Accessible and Recovery focused services based on integrated locality working across North Staffordshire and Stoke-on-Trent.

These latest inspection results come on top of our Community CAMHS Team being spotlighted in the latest edition of the CQC regional publication highlighting great practice and innovation.

As a Trust we are also proud that we have been chosen by the CQC as a mental health national exemplar and will be delighted to share our journey of improvement with other organisations.

CAMHS ACHIEVEMENTS IN THE CQC SPOTLIGHT

The achievement of CAMHS was particularly praised by CQC. CAMHS Community rating moved from Inadequate in 2015 to Good and CAMHS Wards moved from Requires Improvement to Good over the same period.

CQC’s comments included:

“There had been significant improvement since the last inspection. There were no long waiting lists and all children and young people open to the service could be tracked and monitored at any time during their pathway”

“Staff completed comprehensive, holistic mental health assessments and developed care plans that were person centred and recovery orientated. They also monitored and reviewed patients’ physical health needs in line with guidance”

“All staff displayed positive attitudes and were caring towards young people and their families. Parents of young people told us they felt involved in their care and the staff they worked with had a good understanding of the young people’s needs”

“All staff spoke positively about their managers and the service director. They felt valued and supported by senior staff and all staff were proud to have been nominated for the REACH Awards”

MOVE TO LOCALITY WORKING GATHERS PACE

The Trust is making great strides in preparing to move to new structures to align with the STP localities and enhance integrated teams enabling a smoother patient journey. Thanks are due to everyone across the Trust for

their input and really positive attitude so far towards the changes we're looking to make. Proposals will enable us to be even more responsive and effective in delivering compassionate care to our local service users, their carers and families.

The Trust is in the process of engaging with internal and external stakeholders prior to an internal consultation process.

Key considerations in making the change to locality working are:

- Ensuring the engagement of clinical staff through various forums (e.g. SUCC, JNCC). Engagement to date has been at:
    - Leadership Academy
    - SLT and SMT
    - Board Development
- Progressing at a steady pace to ensure delivery of Integrated Locality Working programme within the agreed timeline
- Consideration of CQC alignment
- Adopting a phased approach to implementation to 'smooth' change process
- Completing the impact assessment; and
- Consideration of new roles

The Trust is planning to progress in 2 phases. Phase 1 to go live on 1st July 2018 will implement the leadership structure and include the current team configurations under the new leadership structure. Phase 2 to go live on 1st October 2018 will see the reconfiguration of clinical teams to account for demography and activity. Corporate structures will be aligned by July as appropriate.

A further update will be available at the March Trust Board.

NATIONAL DIGITAL EXEMPLAR FOR CHILDREN AND YOUNG PEOPLE

On the back of the Trust's success last year in implementing the Lorenzo system, we put in a bid to NHS Digital to join a collaborative digital exemplar programme. Our bid was centred on delivering a digital transformation programme with the CYP Directorate. The trust is currently working with DXC (the suppliers of Lorenzo), NHS Digital and the Directorate to develop a business case and mobilisation plan to move towards implementation.

The Trust aims to deliver a future where young people and their families are empowered to use technology to revolutionise their care. The plan is to remodel the referral and assessment functions within the CYP service by increasing the proportion of children with the ability to self-care and self-refer into services. This self-referral approach improves recovery, and enables a person to seek prompt treatment at an early stage, and it also reduces the likelihood of lower degree problems becoming more severe.

This will be a transformation from traditional clinician referrals to a self-empowered model where children, families and professionals are able to access advice, materials and appropriate support. The Trust will be working

closely with local schools and Julia Ford, Dawn Burston and Matt Johnson have been brilliant in helping the Trust to think how technology can really change the lives of children, young people and their families.

TRUST STRENGTHENS APPROACH TO QUALITY IMPROVEMENT

The Trust has been working to strengthen its approach to quality improvement, building on valuable work carried out to date.

The latest Board Development session centred on a presentation and interactive session led by NHS Improvement on quality improvement. The NHSI team had prepared for the session by looking carefully at what the Trust have done to date and shared their positive views of the Trust.

Time was spent considering how the Trust could strengthen its strategy of "Towards Outstanding", particularly building on the Listening into Action success and continuing to improve. Staff will be asked for their thoughts and views as this progresses.

The latest session of the Leadership Academy saw Maria Nelligan and Julie Anne Murray leading an interactive session on the Trusts strategy and programme for Quality Improvement. Their session explained how there is no single definition of quality improvement. However, a number of definitions describe it as a systematic approach that uses specific techniques to improve quality.

FLU VACCINATION SUCCESS

Thank you to all staff and colleagues who have taken the opportunity to protect their loved ones, patients and colleagues by receiving the vaccine for three of the Influenza A and B strains that we know are still causing symptoms. Flu is still circulating across the region and nationally. The Trust is pleased to have exceeded its national target of 70 per cent of relevant staff taking up the vaccination.

FURTHER FINANCE AWARD SUCCESS

The Finance Team has begun 2018 where it left off in 2017, with another series of national award shortlisted nominations. The team has been chosen as a finalist in the following four awards in this year's Public Finance Innovation Awards:

- Finance Team of the Year – Health
- Achievement in Financial Reporting and Accountability
- Finance Training and Development Initiative
- Innovation in Treasury and Asset Management

Congratulations to the team, who have enjoyed plenty of awards success of late, most recently the Healthcare Financial Management Association (HFMA) Awards where it won the Havelock Training Award. The team will find out whether they have won one or more awards when they are held on 25 April – it's further fantastic news and recognition for the team.

NEW WEB, SOCIAL AND DIGITAL PILOT FOR PICU RECRUITMENT DELIVERS RESULTS

The challenge of recruitment and retention is ever present and with the impending opening of the new Psychiatric Intensive Care Unit, the Trust has been looking at all avenues and techniques for advertising the job opportunities available and attracting potential recruits.

The Trust will be continuing with its traditional recruitment channels and activities via NHS Jobs, One Stop Shops and our new TRAC system via http://jobs.combined.nhs.uk

The Trust is also piloting a new approach using the digital and social communications infrastructure the Trust has been building over the past year. The Trust has combined its website, Twitter, Facebook, YouTube and Campaign Monitor in a co-ordinated approach to raise awareness of the available jobs and log those expressing an interest. This will enable the Trust to send instant and personalised communications to everyone expressing an interest in one of the jobs.

In the first 48 hours alone of the campaign, secured expressions of interest were received from over 70 potential candidates for the various jobs on offer - Ward Manager, Deputy Manager, Registered Nurses, Occupational Therapist, HCSW and Admin Support. By the end of the pilot, over 130 expressions of interest had been received.

Carol Sylvester, Interim Director of Operations, and Ward 1 Manager Maxine Tillstone helped to boost our campaign by appearing on the Liz Ellis and John Acres breakfast show on BBC Radio Stoke - thank you both.

Moving forward, the pilot has enabled the Trust to build up a list of potential recruits who can now be approached with other employment opportunities, including going onto the bank. The pilot has been so successful; the Trust is now looking to extend the approach to other areas, beginning with student nurses.

DAVID HEWITT – NATIONAL ACHIEVEMENT

The Trust is delighted that Dave Hewitt, Chief Information Office, has been accepted on the first national leadership cohort of CIOs for the NHS Digital Academy.

The NHS Digital Academy is a virtual organisation set up to develop a new generation of excellent digital leaders who can drive the information and technology transformation of the NHS.

The Academy will provide a year long world class digital health training course to Chief Clinical Information Officers, Chief Information Officers and aspiring digital leaders from clinical, and non-clinical, backgrounds.

Commissioned by NHS England the Academy is delivered by a partnership of Imperial College London, the University of Edinburgh and Harvard Medical School

	NATIONAL UPDATE **NHS 2018/19 PLANNING GUIDANCE PUBLISHED** The 2018/19 planning guidance was published in January is a refresh of plans already prepared under the two-year NHS Operational Planning and Contracting Guidance 2017-2019. It sets out detail of how the additional funding from the November 2017 budget will be allocated and the developments in national policy with regards to system level collaboration. Jenny Harvey commented that Unison are very appreciative of the support received from the Trust for Carillion staff and asked if the Trust has any influence over who provides the contract. Andrew Hughes advised Whilst there is an obvious interest in this process from the Trust the contractual position is that the contract for FM provision sits with the SPV not the Trust. As such any award of a new or novation of an existing contract requires the SPV management company (Imagile) and their lenders (Semperian) to sign their consent. The Trust has to also sign their consent but can only withhold this for a substantive reason such as the alternative supplier being financially non-viable. **Received**	
35/2018	**Chair's Report** Tony Gadsby, Non-Executive Director provided an update in David Rogers absence. Tony wished to congratulate everyone in terms of a good CQC report and highlighted the achievement for the Trust. Tony also congratulated Finance for their recent awards success. ***Noted***	
36/2018	**Staff Retirements** There were no staff retirements ***Received***	
37/2018	**REACH Individual Recognition Award February 2018** Caroline Donovan introduced Sue Ford, Nurse Prescriber, Community CAMHS Sue fully deserves this REACH Individual Award for leading on the development of a new clinical pathway that has successfully tackled the waiting list for assessing young people for attention deficit hyperactive disorder (ADHD).	

	Sue set up and led a small project team to tackle this important issue. Team members were assigned specific roles while workshops were held for parents and carers. Assessment and school observations were carried out and their outcomes discussed. If there were no strong indicators of ADHD, parents and carers received feedback, advice and signposting to relevant services. Should there be a strong indicator for the diagnosis of ADHD, parents were contacted and invited for a neurodevelopmental assessment by Psychiatry services. Through this initiative, the number of those young people awaiting a specialist ADHD assessment reduced from 68 to zero. No young person is waiting more than 12 weeks from referral to receive treatment and Sue is working to further reduce this timescale. Sue demonstrates all the Trust values of being compassionate, approachable, responsible and excellent. She consistently goes the extra mile with children and young people at the heart of everything she does. Sue was presented with a certificate and a North Staffordshire Combined Healthcare NHS Trust Registered Nurse Badge. **Received**	
38/2018	**PATIENT STORY – EXPERIENCE OF RESTRAINT** Maria Nelligan, Executive Director of Nursing & Quality introduced Gabrielle Hoban, Service User and Dean Burgess, Workforce Safety Lead. The Board watched a video whereby Gabrielle talked about her experience of restraint. Maria highlighted the importance of listening to feedback whether the feedback is positive or negative Dean Burgess talked about how he met Gabrielle Hoban and how she shared her experience with him. As a result Dean introduced the video to the training delivered by himself and his team. MAPA is very person centred and looks at the least restrictive way of dealing with interventions. Gabrielle has been attending the MAPA training to share her experience with those taking the course. Dean provided positive feedback from staff who have attended the course. Wendy Dutton reiterated it is a difficult and personal thing to share your experiences and stories and the positive feedback shows what a difference it makes. Andrew Hughes questioned if we are excusing ourselves claiming this is a lack of training when basic humanity has to be considered. Andrew asked Gabrielle if she got a sense as a service user if services are in a different place now. Gabrielle advised that she accesses community services and has not been back to the Harplands but has friends who have relatives who	

	have had negative experiences at the Harplands. Gabrielle felt progress had been made in many respects but the Trust still needs to look for opportunities to improve. Dr Adeyemo commented that she is sad to still see incidences that do not conform and stated it is not just about training it is also humanity and understanding. Where we see that something is happening below our expectations we need to be reporting this. Caroline Donovan thanked Gabrielle and Dean. Caroline commented that she was disappointed that people feel they are not receiving the personalised care they should be. Caroline also thanked Dean for his emotive speech. Lorien Barber highlighted the need to ensure staff transfer the training into their personal experience and ensure there is opportunity for reflection for the service user.	
39/2018	**QUESTIONS FROM MEMBERS OF THE PUBLIC** There were no questions / comments from the public.	
40/2018	**SERVICE USER AND CARER COUNCIL** Wendy Dutton, Chair of the Service User Carer Council provided an update and highlighted the following. - 3 service users were welcomed and keen to view the Service User Carer Council. - **Actions from Informal workshop, November 2017** o Reviewed Care Plans on Lorenzo, feedback and suggestions are being collated and fed through work streams by Ben Boyd before coming back to the Service User Carer Council o Open Space event – Open discussion, to book venue, date for diary, members asked for suggestions regarding agenda, format and speakers - **Items covered in business meeting 31 January** o **Smoke Cessation** – 2 service users and carers supporting task and finish group o **Citizens Jury** – still waiting for a report outlining findings o **CCG** attended 2nd round 'help shaping your local healthcare services' meeting with accountable officer 22nd Jan cancelled at short notice o **RAID** interviews 4 out of 5 posts filled o **PICU** continued input and dates in the diary for interviews for a range of posts o **BAME** informal meetings continue looking at setting up 'buddy system' • Discussed **Sutherland Centre Information Pack** (AQuA) discussed	

	and further comments to be forwarded to Veronica Emlyn to feedback to the centre. Discussed opportunity to standardise information pack across centres • Discussed **Quality Priorities/improvement** for 2018/19 to further explore quality improvements in more depth at February's workshop. Lorien Barber asked if there was a specific reason for meeting with the CCG. Wendy Dutton confirmed it commenced as a general concern re: changes to service provision. Wendy advised that she has contacted everyone possible but still not able to arrange an appointment with the local councillor. Caroline Donovan offered the Trusts support. ***Received***	
41/2018	**DIGITAL EXEMPLAR – 10 MINUTE PRESENTATION** Suzanne Robinson, Executive Director of Finance, Performance & Digital introduced this item commenting that this is a huge milestone for the Trust to make a difference. Mike Barton from NHS Digital and Leo Inoue from DXC were also present for this item. Dave Hewitt, Chief Information Officer and Julia Ford, CAMHS Behavioural Psychotherapist provided a presentation. Dave Hewitt talked about the Trust's digital story so far and how the Trust has been successful in an expression of interest to become a Lorenzo Digital Exemplar delivering a digital transformation programme with the CYP Directorate. The Trust is currently working with DXC (the suppliers of Lorenzo) and NHS Digital to develop a business case and mobilisation plan to move towards implementation. The presentation explained the reasons the Trust selected Children Young People (CYP) for the Lorenzo Digital Exemplar program. The Trust aims to deliver a future where young people and their families are empowered to use technology to revolutionise their care and remodel the referral and assessment functions within our CYP service by increasing the proportion of children with the ability to self-care and self-refer into services. Dave Hewitt and Julia Ford talked about the scope, the concept and the benefits from the program. Next steps: Submission of business case to Trust Board – May 2018 Submission of business case to NHS Digital – May 2018 Moving into the implementation phase – July 2018 Andrew Hughes asked if children would be able to access the portal themselves. Julia Ford advised that the hope is for children, parents and	

	carers to be able to access the service via apps. This portal could form part of the work being undertaken in schools. We are also hoping to involve the Youth Council and be guided by them. Teachers have expressed their interest in the program. It enables people to openly talk about mental health in schools. Dave Hewitt advised going forward members many stakeholders would be involved. Caroline Donovan asked if this could be rolled out across services. Dave Hewitt confirmed the concept moves across and could be applied to any of the Directorates or other NHS Trusts and is transferable across multiple services. Lorien Barber asked if we would be upskilling staff and giving them confidence to embrace this as a lot of the staff might struggle with digital, Parents may need help also. Dave Hewitt confirmed there is an element of training and work will be undertaken with staff and teachers. Maria Nelligan asked if the Darwin Centre had been involved. Dave Hewitt confirmed invites have been extended to the Darwin. Maria Nelligan asked if additional IT equipment would be required. Dave Hewitt confirmed there may be an element of hardware requirement but the system has been designed to be completely platform independent. Maria Nelligan asked what difference this system would make to practitioners. Julia Ford stated that as a practitioner you would be more informed with on screen chats, improving and increasing treatment opportunities by the time the child attends an appointment clinical staff. Dr Adeyemo stated that we need to be mindful of the description used in terms of benefits within the paper i.e. 'Inappropriate referral', every referral is appropriate it just needs to be signposted accurately. Dr Adeyemo also asked for the process to be multi-disciplinary. Gan Mahadea stated this was a brilliant concept but shared his concern that we could see a sudden increase in referrals and are we prepared to deal with this. Dave Hewitt advised this had been considered and as 68% of referrals into the Hub get signposted out a third party sectors discussions are taking place with partners to look at how this will be managed. ***Received***	
42/2018	**NURSE STAFFING MONTHLY REPORT – DECEMBER 2017** Maria Nelligan, Executive Director of Nursing & Quality presented the report and highlighted the following: This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during December 2017 in line with the National Quality Board requirements. The performance relating to fill	

	rate (actual numbers of staff deployed vs numbers planned) during December 2017 was 82% for registered staff and 95% for care staff on day shifts and 84% and 101% respectively on night shifts. Overall a 91% fill rate was achieved. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover and Ward manager supporting clinical duties. The data reflects that Ward Managers are staffing their wards to meet increasing patient needs as necessary. Safe staffing reporting indicated challenges in staffing wards during December 2017. Vacancies across all wards have contributed to this coupled with the increase in sickness due to flu like illness seen locally and nationally. Additionally the use of temporary staffing to support Ward 4 has reduced the availability of temporary staff to backfill other wards. A significant number of RN vacancies have been filled by newly qualified RNs during October 2017; these nurses are going through a period of preceptorship. The Board should note the further challenges associated with the temporary increase of beds on Ward 4 in the response to the winter pressure in the health economy. There were 5 incidents reported by in-patient wards during December 2017 relating to patient safety and nurse staffing issues. The following actions have been taken to strengthen RN staffing: • 18 RNs commenced preceptorship in October 2017 • A further 26 third year Keele nursing students have accepted a conditional offer to commence with Trust in Oct 2018 • Shift patterns have been altered in response to staff feedback (with further NOAP consultation ending 22 Feb 2018) • Recruitment opportunities for RNs continue to be advertised (including bank) • Increased the presence of Duty Senior Nurses (DSN), Nurse Practitioners and WM on wards • The Trust has joined the NHSI MH recruitment and retention programme • Recruitment campaign launched for PICU Caroline Donovan highlighted that the Edward Myers Centre has the highest overall fill rate of 97% and yet the report states we are cancelling no direct care activity Caroline asked Maria Nelligan to look into the reasoning behind this. Lorien Barber enquired as to how long we would be involved with the NHSI MH recruitment and retention programme, Maria Nelligan confirmed this would be three years. Kerry Smith is the Lead Operational contact and Maria Nelligan the Sponsor. ***Received***	**MN**

43/2018	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 9** Suzanne Robinson, Executive Director of Finance, Performance and Digital, presented the report highlighting key points. Performance highlights: • Emergency readmissions continue to reduce to 3.9% in December 2017 (4.1% in November 2017.) This has continued to reduce over the last 6 months. • 96% of all service users on CPA received their review within 12 months (against a target of 95%). • 100% of patients assessed within 12 weeks of referral to the Memory Assessment service • The RAID waiting time target response rates have been met. • 100% of service users referred to IAPT services treated within six weeks of referral and 60% of people accessing IAPT services moved in to recovery (against a 50% target) In Month 9 there are 3 target related metrics rated as Red and 1 as Amber; all other indicators are within expected tolerances. • Agency spend 30.4% at M9 from 29.7% at M8 • Delayed Transfers of Care 10.2% at M9 from 12.5% at M8. This is positive given winter pressures. • Care Programme Approach (CPA) NHSI 90.9% at M9 from 97.4% at M8. Following a detailed review it relates to the Christmas period and accounting for bank holidays. This is expected to improve going forward. • Bed Occupancy 96.0% at M9 from 89.0% at M8. ***Received / Approved***	
44/2018	**SINGLE OVERSIGHT FRAMEWORK** Suzanne Robinson, Executive Director of Finance, Performance & Digital presented the report and highlighted the following. NHS Improvement (NHSI) published the updated Single Oversight Framework in November 2017. This briefing included in papers today summarises the changes, including the specific metric changes under each SOF theme that impact directly on Mental Health Trusts. It describes the changes to be made to the PQMF in Month 10 in response to the new metrics and clarification of measure definitions. NHSI is undertaking a programme of work to understand the productivity of community, mental health and ambulance trusts. The emerging metrics and benchmarking in these areas will be available to providers via the Model Hospital portal, in due course. These will be reported to the Board as they	

	emerge. Suzanne Robinson highlighted the changes to the mental health metrics. Mental health out of area placements - Nationally, there has been a sustained reduction in Adult Acute beds over the last 5 years although the rate of reduction has started to slow. It is of note that the Trust has the third lowest number of Adult Acute Beds per 100,000 weighted population nationally, and does not have the same level of reported resource and activity in crisis care compared to other Trusts. Data quality maturity index – the Trust is currently the 7th highest regionally (NHS England Midlands and East) 22nd nationally out of the 72 Mental Health Trusts who submit MHSDS data. Finance and uses of resources assessment - NHSI and CQC have now published the Use of Resources (UoR) assessment framework, summary of responses to the consultation on the assessment framework, and a brief guide for acute non-specialist trusts on UoR assessments. Failure to meet any of the absolute national standards for more than two months will trigger consideration of a provider's support needs. Where providers have an agreed trajectory for improvement toward any national standard, progress against this will be taken into account when determining whether they have an actual underlying support need. However, as all providers are expected to meet national standards, NHSI would consider what support may be required if performance consistently falls below this level. Andrew Hughes enquired as to the link between the single oversight framework and measuring for improvement. Suzanne Robinson advised the new framework is trying to align to other work NHSI are undertaking. This is where measurement for improvement comes in as this is more supporting and there is more awareness where targets are not being met, it is about supporting as opposed to managing. Dr Adeyemo asked if the physical health monitoring target is dependent on the CQUIN for the year or if it is fixed at 90%. Suzanne Robinson advised she would check this. ***Received***	**SR**
45/2018	**FINANCE REPORT – MONTH 9 (2017/18)** Suzanne Robinson, Executive Director of Finance, Performance and Digital, presented the report: STF is earned quarterly for trusts operating within its agreed control. The total for 2017/18 was originally £500k and is phased 15% for Q1, 20% for Q2, 30% for Q3 and for 35% Q4 plus a further £200k based on matching the increase in the forecast outturn of £1.6m (originally £1.4m). £325k is	

	reflected at month 9. The Trust Board was asked to Note: The reported YTD surplus of £943k against a planned surplus of £774k. This is a favorable variance to plan of £169k. The M9 CIP achievement: • YTD achievement of £1,195k (57%); an adverse variance of £918k; • 2017/18 forecast CIP delivery of £2,672k (84%) based on schemes identified so far; an adverse variance of £525k to plan; • The recurrent forecast delivery at month 9 of £2,962k representing a recurrent variance to plan of £235k. • A risk adjusted recurrent forecast delivery of £2,439 (76%) • The cash position of the Trust as at 31st December 2017 with a balance of £6,432k; £1,101k better than plan • Use of resource rating of 2 against a plan of 2. Trust Board were asked to approve: • The month 9 position • The forecast Agency Ceiling breach of £515K Jenny Harvey highlighted the expectancy of an offer for an Agenda for Change settlement to be agreed soon, Jenny noted this has to be fully funded centrally. Suzanne advised a report would come to Trust Board in March re: the budget for 18/19 which will include planning for pay increases. ***Received / Approved***	
46/2018	**ASSURANCE REPORT FROM THE FINANCE, PERFORMANCE & DIGITAL COMMITTEE** Tony Gadsby Chair of the Finance, Performance and Digital Committee / Non-Executive Director presented the report for assurance from the meeting that took place on 8th February 2018. Q3 Quarterly Deep Dive, outlining the key risks for delivering the 2017/18 control and sensitivity forecasts modelling different scenarios. The most likely forecast is a £1.8m surplus, as agreed with NHSi. Mitigations in year are mostly non-recurrent and therefore not financially sustainable in absence of recurrent CIP delivery. The Committee were assured that there was sufficient focus being placed on Cost Improvement but are unable to give assurance around the ability to deliver the target for 2017/18. The committee also noted a significant risk; that CIP plans were not yet worked up for 2018/19. The Committee were presented with the Agency utilisation report at M9 which showed a forecast breach of the Agency ceiling by £515k, mainly due to Medics and ROSE. The committee acknowledged the national shortage of medical locums but were assured that the trust was doing	

	everything possible to recruit substantive posts. It was also noted that expenditure on ROSE agency was non recurrent. The Committee noted the significant reduction since April 2016 and was confident the Trust would deliver against the 2018/19 ceiling, which has now reduced from £2.068m to £1.887m in the updated 2018/19 plan. It was also noted that the percentage Agency nursing as a % of total nurse pay was exceptionally low at 1%. There has been an improvement in the PBR report, particularly for admitted cluster days as a direct result of the impact of data quality improvements made to date. Cluster 99 continues to be over reported due to data quality issues, although the upwards trajectory has levelled out. A Task and Finish Group has been established and the committee received updated action plan and a breakdown of the issues around compliance and data recording by Directorates. Whilst improvements have clearly been made around data quality, the Committee is still not able to give any assurance around the activity reported due to issues with the quality of recording by operational staff. Compliance is no longer an issue for CPA 12 month reviews undertaken, with performance improving in month 9 to the point there is no longer a requirement to report an exception. This is following embedding of clear guidance for staff around quick reference guides. The committee approved 6 month extensions on the following policies: • Access to Health and Employee Records • Information Governance Policy • Information Governance Strategy ***Ratified /Received***	
47/2018	**ASSURANCE REPORT FROM THE QUALITY COMMITTEE** Lorien Barber, Non-Executive provided an update in the absence of Patrick Sullivan, Chair of the Quality Committee / Non-Executive Director and presented the report for assurance from the meeting that took place on 8th February 2018 Junior Doctor Staffing. In May 2017, it was identified that NSCHT would have a high number of Junior Doctor vacancies. The paper highlighted the reasons for these vacancies, the expected impact of these vacancies and what the Trust has done to minimise the disruption caused by them. CQC Core Services Action Plan. The actions contained in the plan are in response to a Core Services visit conducted by the CQC during 6 October 2018. The actions address the issues highlighted by CQC.	

	Review of Quality Committee Effectiveness. At the last CQC Well-Led Inspection, the Trust also had a developmental Well Led Review undertaken with AQuA. Each Committee of the Board has been allocated a KLoE under the new 8 Well Led KLoEs to lead on. Observed strengths were noted as well as observed development opportunities for which an action plan will be devised prior to submission to Audit Committee. DIPC Report Q3 – 2017/18. The report assures the Board in relation to the IPC arrangements within the Trust and gives an overview of the Influenza situation, our external reporting responsibilities, confirmed Influenza activity and Influenza vaccine update including the CQUIN requirements. Q3 report on Safeguarding Activity. The detailed report provides information to the Committee on current case reviews, themes and trends in safeguarding and pertinent issues from the Trust`s Safeguarding Team. Policy Report - the recommendations supported by the Committee for ratification of policies by the Trust Board (approval for 3 years otherwise stated) as follows:- • RO2 Bed Rails Policy • 1.74 Environment Ligature Risk Assessment • Staffordshire & Stoke-on-Trent - supporting Patients Choices to Avoid Long Hospital Stays Operational Policy - Multi-Agency • IC4a Hand Hygiene Policy • IC4b Personal Protective Equipment Policy • IC5 Isolation Policy • IC7 Innoculation Policy • OC8 Cleaning & Disinfection Policy • IC9 Food Safety Policy • IC10 Management of Pulmonary Tuberculosis Policy • IC121 MRSA Policy • OC12 Outbreak Policy • IC13 Linen & Laundry Policy • IC17 Specimen Management Policy Pan Staffordshire Mental Health Act Related Policies:- • Section 135 Policy • Section 136 Policy • Mental Health Act Transportation Policy The Board ratified the above policies. Learning from Experience Report December 2017 The Committee received a verbal bi-monthly Learning from Experience report detailing emerging issues, including learning and action taken following the feedback from Trust services. The following points were noted: • There is a slight increase in incidents compared to previous months	

	and the monthly average this year, however they are all either of minor harm or no harm. • Slight increase in self-harm, however there has been a reduction in staffing issues due to recruitment during October 2017. • 10 complaints received and investigated. • Received 566 compliments. Using FFT to ensure that all compliments or otherwise is captured. 91% of people would recommend receiving treatment at the trust. • 4 compliments and one negative feedback received through NHS Choices. Quality Account Project Timeline All organisations are required to develop and publish a Quality Account which if designed well will assure Commissioners, patients and the public that Trust Boards are regularly scrutinising each and every one of their service. The draft Project Plan has been agreed at Quality Committee for onward submission to the Trust Board where delegated authority will be requested to be given to the Quality Committee to take forward accordingly. ***Ratified / Received***	
48/2018	**TO RECEIVE A VERBAL UPDATE ON PROGRESS FROM ANDREW HUGHES, JOINT DIRECTOR OF STRATEGY, DEVELOPMENT AND ESTATES (NSCHT / GP FEDERATION)** Andrew Hughes provided an update as detailed below: • Discussions will take place during the closed session of the Board this afternoon around one and two year plans and potential next steps with Carillion. • The Alliance Board goes from strength to strength; a memorandum of understanding has been drafted around the Alliance and the support they provide. • The Carillion issue has reinforced our partnership working with the PFI partnership in a positive way. The success of the PICU scheme is a result of the support we are receiving from our PFI partners. Andrew Hughes advised a paper will come to the March Board meeting regarding the Trusts partnership working.	**AH**
49/2018	**ANY OTHER BUSINESS** No items to discuss	
50/2018	**Date and time of next meeting** The next public meeting of the North Staffordshire Combined Healthcare	

	Trust Board will be held on Thursday, 22nd March 2018 at 10:00am, in the Boardroom, Lawton House, Trust HQ.	
51/2018	*** Motion to Exclude the Public** The Board approved a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted.	

The meeting closed at 12.20pm

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
05-Oct-17	830/2017	Safer Staffing Nursing Report 25.01.18 : The 6 monthly report was put on hold due to the management of change of the shift patterns being consulted upon - the next 6 monthly report is now due therefore an annual report is being produced which will come to Trust Board 22nd March 2018.	Maria Nelligan	18-Apr-18	Finance information to be included. Deferred to April 2018
09-Nov-17	865/2017	PCD Assurance Report - Updated Communications Strategic Plan will be presented to PCD and Trust Board in January 2018. 25.01.18 - Some changes to be made to be approved at PCD and presented at March Trust Board.	Joe McCrea	18-Apr-18	Agenda item deferred to April 2018
25-Jan-18	12/2018	R & D Partnership with Keele - Update on Stategic Engagement to come to April Trust Board.	Dr Adeyemo	18-Apr-18	
25-Jan-18	13/2018	Nurse Staffing Monthly Report November 2018 - Alex Brett to undertake an execise to map reasons for staff leaving and calculate the length of time staff remain with the Trust. Report to come to March Trust Board.	Alex Brett	22-Mar-18	Agenda item
25-Jan-18	14/2018	PQMF M8 - Deep dive into medical workforce - plan required to come to Trust Board.	Dr Adeyemo	18-Apr-18	
25-Jan-18	20/2018	Declarations of Interest - Laurie Wrench to look into whether Executive Reviewers and new appointment of STP DoF should be declared. Total refresh of register to be undertaken. 22.02.18 - All declaration forms being updated and register being refreshed amended paper to come to March Trust Board	Laurie Wrench	22-Mar-18	Agenda item
22-Feb-18	42/2018	Nurse Staffing Monthly Report - December 2017 - Caroline Donovan highlighted that the Edward Myers Centre has the highest overall fill rate of 97% and yet the report states we are cancelling no direct care activity Caroline asked Maria Nelligan to look into the reasoning behind this.	Maria Nelligan	22-Mar-18	
22-Feb-18	44/2018	Single Oversight Framework Dr Adeyemo asked if the physical health monitoring target is dependent on the CQUIN for the year or if it is fixed at 90%. Suzanne Robinson advised she would check this.	Suzanne Robinson	22-Mar-18	

Board Action Monitoring Schedule (Open Section)

Meeting Date	Minute No	Action Description	Responsible Officer	Target Date	Progress / Comment
22-Feb-18	48/2018	Verbal Update of Progress from Joint Director of Strategy - Andrew Hughes advised a paper will come to the March Board meeting regarding the Trusts partnership working.	Andrew Hughes	22-Mar-18	Agenda item

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REPORT TO TRUST BOARD

Enclosure No:

Date of Meeting:	22 March 2018		
Title of Report:	CEO Board Report		
Presented by:	Caroline Donovan, Chief Executive		
Author:	Caroline Donovan, Chief Executive		
Executive Lead Name:	Caroline Donovan, Chief Executive	Approved by Exec	☐

Executive Summary:		Purpose of report	
This report updates the Board on activities undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest.		Approval	☐
		Information	☒
		Discussion	☒
		Assurance	☐
Seen at:	SLT ☐ Execs ☐ 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:	1. To receive report for information		

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Chief Executive's Report to the Trust Board
22 March 2018

PURPOSE OF THE REPORT

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

LOCAL UPDATE

1. COMBINED HEALTHCARE'S JOURNEY OF IMPROVEMENT FEATURED AS AN EXEMPLAR IN NEW CQC REPORT

We are delighted to have been among just a handful of organisations to feature in a new CQC report showcasing how mental health trusts have led by example in raising standards.

The CQC's 'Driving Improvement' report focusses on a select few mental health trusts that, like North Staffordshire Combined Healthcare, have achieved significant improvement in their CQC ratings.

Combined's ongoing journey of improvement has seen the Trust transform itself in the past two years – from being rated as 'Requires Improvement' in September 2015 to 'Good' in 2017; with every service being rated as 'Good' or 'Outstanding' – which gives confidence that all our services are at a good standard for our service users and carers.

The report states that "the trusts featured in this publication show how good leadership can drive significant improvements, in some cases in a relatively short time. We want to encourage others to look at and learn from these case studies to help them in their own improvement work".

In order to produce the report, the CQC interviewed people throughout the Trust, from Chair David Rogers and Chief Executive Caroline Donovan to other Executives, managers and frontline staff. They also spoke with a number of partners and stakeholders about how they are working with Combined to improve services.

Driving Improvement chronicles the story of how Combined Healthcare has transformed itself, starting with the development of the SPAR quality priorities of Safe, Personalised, Accessible and Recovery-focussed care and Proud to CARE values of a Compassionate, Approachable, Responsible and Excellent workforce.

The developing culture of the organisation, with an emphasis on supporting staff and enabling clinicians to lead has been highlighted by the CQC, as has its improved governance. The Trust's Raising our Service Excellence (ROSE) electronic patient record and Valuemakers initiative were both featured in the report as examples of real improvement.

In addition, the CQC praised the Trust's excellent partnership working supporting the coordination and integration of its services across the local health and care system – highlighting the ongoing partnership between Combined and the North Staffordshire GP Federation.

The full report is available to view at www.cqc.org.uk/sites/default/files/20180315c_drivingimprovementmh_report.pdf.

2. NHS STAFF SURVEY – OUR JOURNEY OF IMPROVEMENT CONTINUES

Thank you to everyone who completed the recent annual NHS Staff Survey. The results are in and they confirm that our journey of improvement Towards Outstanding continues. Coming hot on the heels of the CQC rating every one of our services as 'Good' or 'Outstanding', it's welcome further evidence that our journey of improvement is also being felt and recognised by our staff.

The survey helps us to gauge how our staff are feeling, what they think about working in the Trust and the services and care we provide to our local communities. It also allows us to compare ourselves against other NHS trusts.

It's particularly encouraging to see an improved score in "a place you would recommend to work or receive treatment" in comparison to other trusts. That's great news and a sign our staff recognise positive change in our Trust.

Other areas of improvement include:

- 21 out of 28 categories we were average or better than average, with 10 categories ranking better than average.
- 91% of staff believe the organisation provides equal opportunities for career progression or promotion
- Scoring highly on staff believing that we act on service user feedback effectively
- A low percentage of staff said they experienced bullying, harassment or abuse in the last 12 months, supplemented by a higher than average score for supporting staff health and wellbeing.

There are no significant reductions in our scores compared with last year, but we aren't complacent. Areas that we will continue to work on improving include:

- Staff being able to contribute toward improvements at work
- Staff agreeing that their role makes a difference to service users and staff feeling confident in reporting unsafe clinical practice
- Improving the experience of our Black, Asian and Minority Ethnic (BAME) staff.

A particular priority will be creating real and lasting change in workforce race equality and supporting a culture of continual improvement that all staff can engage in. The Trust is also implementing a Towards Outstanding Engagement programme which aims to improve the skills within teams – in particular, helping improve staff engagement and effective team working.

To view the survey results in full, please click here. Directorates and the Trust Board will be discussing the results and formulating plans of where we can improve even further.

3. COMBINED SERVICES AND INITIATIVES SHORTLISTED FOR HSJ VALUE AWARDS

We are delighted that four of our services and programmes have been selected as finalist in the 2018 HSJ Value Awards.

Our innovative Valuemakers programme has been shortlisted in the Improving Value through Innovative Financial Management or Procurement category.

In the Mental Health category our CAMHS in Schools team has been shortlisted, as has the Meir Partnership Care Hub service we provide with Stoke-on-Trent City Council and a number of other partners.

We have also been shortlisted in the Pharmacy and Medicine's Optimisation for Medication Reduction in a Learning Disability Service.

The award ceremony will be on Thursday 7 June in Manchester.

4. CONTINUING TO ENGAGE AS WE MOVE TOWARDS LOCALITY WORKING

Our plans to introduce new integrated locality-based structures within Combined Healthcare continue apace. We've held a series of engagement forums with staff groups and our stakeholders, while members of the Executive team have been out and about meeting Trust teams to seek their views on the proposals.

The driving principle of this new way of working is to strengthen how our wider community teams work across primary care, social care and community services.

The plan is to have a two-phased approach, moving to four directorates (Stoke, North Staffordshire, Specialist Services and Urgent Care & Acute Services). Phase 1 is due to go live on 1 July and will implement the leadership structure and include the current team configurations under the new leadership structure, while phase 2 will go live on 1 October and will involve the reconfiguration of clinical teams to account for demography and activity.

These new proposals, we feel, will enable us to be even more responsive and effective in delivering compassionate care to our local service users, their carers and families.

We will be holding further engagement forums over the course of the next six-eight weeks and will continue to involve frontline staff and teams across the Trust.

We want to continue the conversations with everyone as we move to this new way of working, including finalising a new web microsite we will be introducing to enable everyone to keep fully informed about our plans and progress, ask questions of us and see answers to questions asked by others. All staff are encouraged to get involved in the conversations about this exciting development in how we deliver our services.

5. STOKE-ON-TRENT CQC LOCAL SYSTEM REVIEW WORKSHOP

During September 2017, the Care Quality Commission (CQC) undertook a Local System Review of the Stoke-on-Trent health and care system. The Review considered system performance along a number of 'pressure points' on a typical pathway of care with a focus on older people aged over 65.

At a local summit in November senior leaders from the five organisations – Combined Healthcare, Stoke-on-Trent City Council, Stoke-on-Trent Clinical Commissioning Group, University Hospitals of North Midlands NHS Trust and Staffordshire and Stoke-on-Trent Partnership NHS Trust – committed to work together to develop an Improvement Plan in response to the Review Report.

A half day workshop has been arranged to further progress the Local System Improvement Plan and we will be joined on the day by Ed Moses, Deputy Director, Social Care Oversight, Department of Health and Social Care.

The workshop is an opportunity to share the Improvement Plan more widely, including with operational and clinical staff and identify approaches that will help strengthen the actions identified within the plan.

6. NOMINATIONS OPEN FOR REACH AWARDS ON 26 MARCH

The Recognising Excellence and Achievement in Combined Healthcare (REACH) Awards are an annual celebration of our staff and teams who go above and beyond in delivering excellent services. To mark the NHS 70 celebrations, this year's REACH will take place on Thursday 5 July at the Stoke-on-Trent Moat House. Nominations will open on Monday 26 March and we are hoping to beat last year's record-breaking total of 290 nominations. This year's awards 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
6. Developing People Award
7. Partnership Award
8. Service User and Carer Council Award (decided by the Service User and Carer Council)
9. Unsung Hero Award
10. Proud to CARE Award
11. Team of the Year Award
12. Chairman's Award (decided by the Chair)

For more information about the awards, including how to nominate, please visit our REACH website www.reachawards.org/nscht.

7. RESEARCH RECRUITMENT BOOSTER

One of our key strategic objectives is to 'Encourage, inspire and implement research and innovation at all levels'. Our Research Team have been working hard with our staff and teams to boost research throughout the Trust and have launched a new campaign in the lead up to Easter to increase the number of patients, staff and carers participating in the mental health and dementia research studies we are involved with.

Teams have been increasing the exposure of our research studies by displaying literature and speaking to their service users to see if they would be interested in taking part.

To find out more about our research studies, and to take part, you can contact the Research Team via email at R&D@combined.nhs.uk or by calling 01782 441773.

8. PLANNING

We have been completing a refresh of our One and Two Year Plans. They demonstrate the additional investment we have received from commissioners to underpin our new Psychiatric Intensive Care Unit, liaison psychiatry and outreach services.

Each directorate has developed its own One Year Operating Plan, which feed in to the overarching Trust Plan and describe the continuing journey towards outstanding at a service level.

9. CARILLION UPDATE

We have now agreed with Town Hospitals Ltd, the provider of our Harplands PFI, that Serco will take over responsibility for delivery of Facilities Management services from Carillion. A transition plan has been developed that assumes a start date of 1 May 2018. We remain incredibly grateful for the care and professionalism that our staff have continued to show during this time of uncertainty.

10. CONTRACT AGREEMENT

We are one of the first providers in the STP to agree our 2018/19 contract with lead commissioners – this took place on 1 March. The 2018/19 contract includes a 4.3% increase for new services against the mental health investment standard of 2.82%. This secures additional investment into a number of key services including IAPT and RAID, as well as our new Psychiatric Intensive Care Unit (PICU) and allows us to develop some of the outreach services which supported Royal Stoke University Hospital during the winter period on an ongoing basis. This is a really important step in ensuring our service users receive services out of hospital and closer to home.

11. STAFF OVERCOME 'BEAST FROM THE EAST' TO CONTINUE DELIVERING GREAT SERVICES

I was hugely proud of the way our staff once again rose to the challenge as they overcame the snow, blizzards and severe cold weather brought about by the so-called 'Beast from the East'. Our teams made sure that patients got the care and support they need by coming in to do extra shifts or changing their working patterns to support each other, with some colleagues even coming in on their day off, staying with colleagues to enable them to get to work or walking in to work if they couldn't drive. Other people also helped transport staff to work. I want to take this opportunity to thank each and every one of them who went the extra mile.

12. MEDICAL WORKFORCE WORKSHOP

The first of a series of events to engage with our medical staff on key issues and ensure they are at the forefront of leading and developing the Trust as we continue to move forward was hosted by our Medical Director Dr Buki Adeyemo. Our Chairman David Rogers held a question and answer session and Consultant Psychiatrist Dr Chris Link presented a service improvement project that had positively benefited patients on Ward 3 at Harplands. The afternoon focussed on developing our Medical Strategy. I will be attending the next session to work with colleagues on how we progress going forward.

13. SYSTEM TRANSFORMATION PLAN

The Chairman and I met with all Chairs and CEOs with the Staffordshire and Stoke-on-Trent STP independent Chair Sir Neil McKay and Director Simon Whitehouse this month. The focus of the discussion was how we could work together across our respective organisations even better. The Alliance Boards are a key enabler of this. Increasingly, we will see the three Alliance Boards being a key integrator of organisations working together to deliver innovation and improved services for the communities we serve.

NATIONAL UPDATE

14. NHS TO LAUNCH NATIONAL SCHEME TO TREAT VETERANS' MENTAL HEALTH

The Veterans' Mental Health Complex Treatment Service was designed after former military personnel and their families across England were asked by the NHS how services could be improved. The new service, backed by £3.2m of funding, will help those who have the most complex needs, including substance misuse and trauma.

The initiative would also aim to help veterans access services closer to home, rather than requiring them to travel, as well as helping them access information about employment, accommodation, finances and relationships. However, some veterans have raised concerns that the money will take funds away from existing charity schemes and have a developed business case for commissioners to support future funding opportunities.

www.telegraph.co.uk/news/2018/03/04/nhs-launch-national-scheme-treat-veterans-mental-health/

REPORT TO: OPEN TRUST BOARD

Enclosure No 5:

Date of Meeting:	22 March 2018		
Title of Report:	Service User & Carer Council Report		
Presented by:	Wendy Dutton, Chair, Service User & Carer Council		
Author:	Wendy Dutton, Chair, Service User & Carer Council		
Executive Lead Name:	Maria Nelligan, Executive Director of Nursing & Quality	Approved by Exec	☒

Executive Summary:		Purpose of report	
This report has been prepared to provide an update of the Service User & Carer Council since the last meeting held on 22 February 2018.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐	Date:	
	Execs ☐	Date:	
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 identified		
Resource Implications: Funding Source:	None identified		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	The Service User & Carer Council supported the principle of increasing representation across the Protected Characteristics when reviewing the Diversity and Inclusion Strategy. They also committed to supporting inclusive services and workforce in their review of the Strategy.		
Recommendations:	The Trust Board receives the update for information and assurance.		

Version	Name/group	Date issued

North Staffordshire Combined Healthcare NHS Trust

SERVICE USER AND CARER COUNCIL UPDATE
FOR TRUST BOARD ON 22 2018

1. Acute Care Pathway Presentation by Dr Chris Link, Consultant Psychiatrist and Laura Jones, Ward Manager

Presentation included background influencing this change. Points discussed:-

- Not a 72 hour admission - emphasis 72 hour assessment
- 72 hour assessment adapted to the needs of the individual
- Robust assessment sensitive to impact on service user
- Daily review multi-disciplinary team
- Cares/support actively engaged

There is an acknowledgement that there will be additional pressure on community teams, therefore if/when this is rolled out this needs to be taken into consideration, suggestions as follows:-

Written brief outline of a 72 hour assessment with possibly some service user/carer comments for use, not only on in-patient areas, also in community settings. This will allow productive conversations and also avoid confusion:-

- How are carer`s involved as not always easy if someone is really poorly or other commitments make it difficult to be involved.
- Assessment is made in as many ways as possible based on patient and carer need. To accommodate this need, this could be a `phone call and changing the time of the multi-disciplinary team meeting.
- Concern regarding service users feeling overwhelmed by an intense assessment.

2 REACH Awards

Discussion took place on what would make the `Council` award different from any of the others. The award winner will be chosen by the Service User & Carer Council members and nominations will only be accepted from service users and carers. The agreed criteria is as follows:-

Service Users of Carer`s can nominate anyone, e.g. who has made a positive improvement to their lives. Information requested as follows:-

Who you are nominating
Where they are
Why are you nominating them
OR
How did they make a positive improvement in your life

3 Items covered in Educational/Workshop on 28 February 2018

- **New name for RAID** - now called Mental Health Liaison Team
- **CYP wait for treatment -** Concerns discussed, Sue Tams will update asap.
- **Advocacy Services** - will be provided by a different organisation from April 2018. Su Carson, Healthwatch Staffordshire will update at the Service User & Carer Council meeting on 28 March 2018.

3.1 Service User & Carer Council members continued involvement with the Trust as follows:

- Induction
- Interviews including PICU and Student Nurses
- Smoke Cessation
- Business meetings and others

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North Staffordshire
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NHS Trust

REPORT TO OPEN TRUST BOARD

Enclosure No: 6

Date of Meeting:	22nd March 2018		
Title of Report:	January 2018 Monthly Safer Staffing Report		
Presented by:	Maria Nelligan, Executive Director of Nursing & Quality		
Author:	Julie Anne Murray, Deputy Director of Nursing, AHP & Quality		
Executive Lead Name:	Maria Nelligan, Executive Director of Nursing & Quality	Approved by Exec	☒

Executive Summary:		Purpose of report	
This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during January 2018 in line with the National Quality Board requirements. The performance relating to fill rate (actual numbers of staff deployed vs numbers planned) during 2018 was 85% for registered staff and 100% or care staff on day shifts and 87% and 105% respectively on night shifts. Overall a 94% fill rate was achieved. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover and Ward manager supporting clinical duties. The data reflects that Ward Managers are staffing their wards to meet increasing patient needs as necessary.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐	Date:	
	Execs ☒	Date:06.03.18	
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		

Version	Name/group	Date issued
1	Maria Nelligan	05 March 2018
2	Execs	06 March 2018

1 Introduction

This report details the ward daily staffing levels during the month of January 2018 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 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 6 monthly review covering January to June 2017 was originally planned to be reported to November Board. However, due to the management of change (MoC) relating to shift patterns, it was agreed at October 2017 Quality Committee to delay the report in order to capture the outcome of the MoC. Due to the timeline of the MoC, the 2 six monthly reports (January-June and July-December 2017) will be amalgamated into a comprehensive annual report for 2017. This will be presented to March 2018 Board.

3 Trust Performance

During January 2018 the Trust achieved a staffing fill rate of 85% for registered staff and 100% for care staff on day shifts and 87% and 105% respectively on night shifts. Taking skill mix adjustments into account an overall fill-rate of 94% fill was achieved. Where 100% fill rate was not achieved, staffing safety was maintained on in-patient wards by nurses working additional unplanned hours, cross cover, Ward Managers (WMs) and the multi-disciplinary team (MDT) supporting clinical duties and the prioritising of direct and non-direct care activities. Established, planned (clinically required) and actual hours alongside details of vacancies, bed occupancy and actions taken to maintain safer staffing are provided in Appendix 2. A summary from WMs of issues, patient safety, patient experience, staff experience and mitigating actions is set out below.

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

4 Impact

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

4.1 Impact on Patient Safety

There were 10 incidents reported by in-patient wards during January 2018 relating to patient safety and nurse staffing issues. Breakdown by ward is summarised as follows:

Ward	Incident Reports
Ward 1	• One incident where an agency RN did not report for duty; the DSN had to cover the ward and the Access team supported the bleep. • One incident where it was challenging to maintain observation levels due to the 136 suite being occupied • One incident where a member of staff was moved to IOU due to an admission arriving when there was no IUO cover due to short notice sickness
Ward 2	• Two incidents where preceptorship nurse was in charge of the ward • One incident where it was challenging to maintain observation levels due to staffing levels • One incident where it was challenging to maintain observation levels due to escorting a service user to A&E
Ward 4	• One incident where it was challenging to maintain observation levels due to staffing levels
Ward 7	• One incident where an agency RN did not report for duty; the DSN had to cover the ward and the Access team supported the bleep
EMU	• One incident where a member of staff was moved from IOU to support Ward 1; no IOU referrals received during this time

Additionally, across the in-patient areas there were 131 occasions where there was only one RN on duty (excluding where the planned staffing is for one RN).

4.2 Impact on Patient Experience

Staff prioritise patient experience and direct patient care. During January 2018 it was reported that 12 activities were cancelled or shortened (and not rearranged) due to nurse staffing levels. All of these cancellations were on Darwin where staffing levels have been challenging.

4.3 Impact on Staff Experience

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

- 108 staff breaks were cancelled (equivalent to approximately 2% of breaks)
- 15 staff breaks were shortened equivalent to approximately >1% of breaks)
- 35 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 231 RN shifts were covered by HCSW where RN temporary staffing was unavailable. A total of 18 HCSW shifts were covered by RN staff where HCSW temporary staffing was unavailable. Additionally, as outlined in section 4.3, staff

breaks have been shortened or not taken (time is given in lieu) and wards have cross covered to support safe staffing levels.

4.5 RN Staffing Trend

Although there has been recruitment of RNs over the last 12 months, including 18 RNs commencing preceptorship in October 2017, this increase in demand for staffing has also resulted in the RN fill rate trend line showing only a slight increasing trend. (Figure 1).

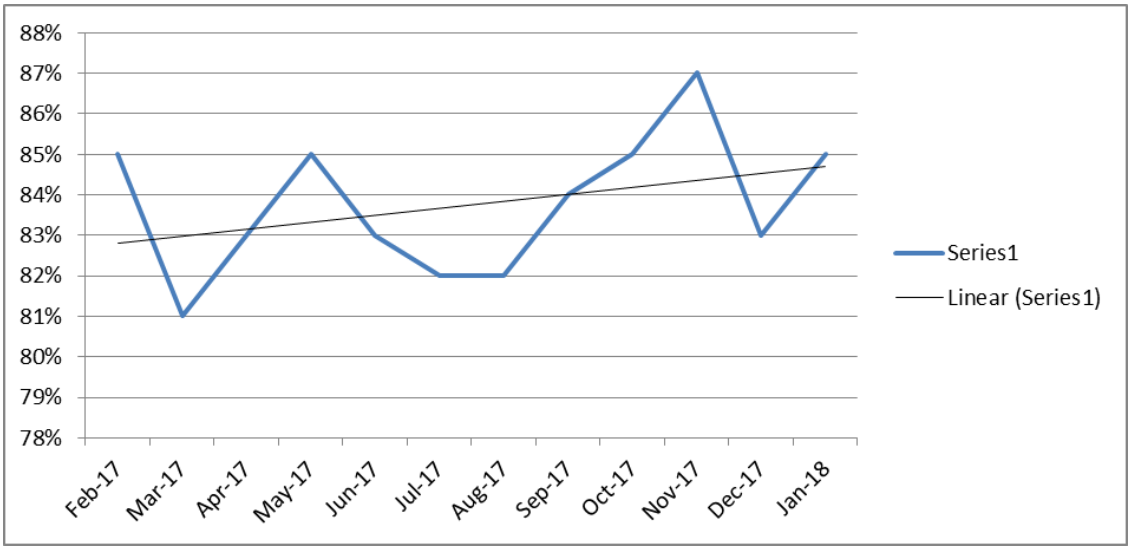

Figure 1 Twelve month RN fill rate trend line

This increasing trend is continuing to be built upon and the following actions have been taken to strengthen RN staffing:

- 18 RNs commenced preceptorship in October 2017
- A further 26 third year Keele nursing students have accepted a conditional offer to commence with Trust in Oct 2018
- Shift patterns have been altered in response to staff feedback
- Recruitment opportunities for RNs continue to be advertised (including bank)
- Increased the presence of Duty Senior Nurses (DSN), Nurse Practitioners and WM on wards
- The Trust has joined the NHSI MH recruitment and retention programme
- Recruitment campaign launched for PICU

5. Summary

Safe staffing reporting indicated challenges in staffing wards during January 2018. Vacancies across all wards have contributed to this coupled with the increase in sickness due to flu like illness seen locally and nationally. Additionally the use of temporary staffing to support Ward 4 has reduced the availability of temporary staff to backfill other wards. A significant number of RN vacancies have been filled by newly qualified RNs during October 2017; these nurses are going through a period of preceptorship. The Board should note the further challenges associated with the temporary increase of beds on Ward 4 in the response to the winter pressure in the health economy. During 2018 it is anticipated that challenges will also be experienced with the planned opening of PICU, therefore the 2017 annual nurse staffing review will

make recommendations in relation to this. The Trust continues to employ alternate strategies with the support of the HR and communication teams to attract RNs during this national shortage.

The trust have joined the NHSI Retention Support Programme. A project team is being identified to deliver this programme and a visit from NHSI is arranged for March 2018.

6. Recommendations

The Trust Board is asked to:-

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

Appendix 1 January 2018 Safer Staffing

Jan-18	DAY						NIGHT						DAY		NIGHT		Overall						
Ward name	Registered nurses			Care staff			Registered nurses			Care staff			Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Overall RN	Overall HCSW	Overall	Safe staffing was maintained by:	RN Vacancies	HCSW Vacancies	Bed occupancy	Movement
	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											
Ward 1	1560	1215	1182	1395	1215	1216	665	683	341	665	683	1023	97%	100%	50%	150%	80%	118%	99%	Nursing working additional unplanned hours and altering skill mix.Cross cover provided to other wards	1.40	2.41	93%	↑↑
Ward 2	1395	1215	902	1395	1215	1375	665	683	441	665	683	914	74%	113%	65%	134%	64%	120%	92%	Altering skill mix.	6.20	1.21	99%	↑
Ward 3	1568	1460	1154	1395	1287	1405	665	683	584	665	771	881	79%	109%	86%	114%	81%	111%	96%	Nursing working additional unplanned hours and altering skill mix. Cross cover provided to other wards.	1.80	1.44	85%	↓
Ward 4	1568	1568	1375	1395	1965	1792	290	664	601	698	1062	938	88%	91%	90%	88%	72%	90%	81%	Altering skill mix	6.80	3.40	93%	
Ward 5	1110	1574	1055	930	1688	1791	290	318	318	871	1163	1154	67%	106%	100%	99%	72%	103%	88%	Altering skill mix	2.30	-0.20	106%	↑
Ward 6	1103	1208	1118	1860	1928	1888	281	329	364	872	1319	1295	93%	98%	111%	98%	96%	98%	97%	Nursing working additional unplanned hours and altering skill mix.	2.30	3.35	99%	↓
Ward 7	1103	1127	728	1395	1287	1493	290	332	343	581	996	985	65%	116%	103%	99%	73%	108%	93%	Nursing working additional unplanned hours and altering skill mix.	0.80	0.00	101%	
A&T	1563	1288	1349	1395	1166	1080	333	342	342	1000	1256	1245	105%	93%	100%	99%	103%	94%	99%	care activity. Cross cover provided to other wards.	2.63	4.31	90%	↓
Edward Myers	1095	1089	1006	930	858	807	291	332	334	581	664	638	92%	94%	101%	96%	94%	95%	95%	Nursing working additional unplanned hours and altering skill mix.	1.90	2.14	87%	↓
Darwin Centre	1335	1256	1047	1163	1170	1168	324	340	351	667	748	737	83%	100%	103%	99%	88%	99%	94%	Nursing working additional unplanned hours, cancelling non-direct care activities and altering skill mix.	0.85	0.20	94%	↑
Summers View	1009	853	785	930	923	730	332	332	332	665	621	632	92%	79%	100%	102%	94%	88%	91%	The MDT supporting the nursing team.	0.00	0.40	88%	↑
Florence House	544	566	540	930	900	900	332	332	332	332	332	332	95%	100%	100%	100%	97%	100%	99%	The MDT supporting the nursing team.	0.00	1.53	99%	↓
Trust total	**14950**	**14416**	**12238**	**15113**	**15600**	**15645**	**4759**	**5369**	**4683**	**8261**	**10297**	**10772**	**85%**	**100%**	**87%**	**105%**	**85%**	**102%**	**94%**		**26.98**	**20.19**		

Appendix 2 Staffing Issues

- There have been challenges and limited success in recruiting band 5 adult RNs to Ward 4 therefore the team are seeking to recruit RNs from other fields who have physical health experience, this will be supported by an education programme. An Advanced Nurse Practitioner has been recruited and will commence in April 2018.

- There are currently 27 WTE RN vacancies reported within in-patient wards. Of these, 16.6 WTE are in the recruitment process. We continue to advertise for the remainder.

- There are currently 20 WTE HCSW vacancies reported within in-patient wards. Of these, 16.4 are in the recruitment process.

- Ward 2 and 4 have the highest RN vacancies of 6.2 and 6.8 WTE respectively; 4.6 WTE of these have been recruited to. The remaining posts have been advertised externally and have been included within the recruitment events with limited success. Therefore we are reviewing skill mix and shift patterns.

- Ward teams are supported by Modern Matrons and a 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 and are based on wards as opposed to Nursing Office from September.

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

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

REPORT TO: OPEN TRUST BOARD

Enclosure No: 7

Date of Meeting:	22 March 2018		
Title of Report:	Director of Infection Prevention & Control (DIPC) Q3 - October - December 2017) report		
Presented by:	Maria Nelligan, Executive Director of Nursing & Quality/Director of Infection, Prevention & Control (DIPC)		
Author:	Amanda Miskell, Consultant Nurse Physical Health/Deputy Director of Infection, Prevention & Control (DIPC)		
Executive Lead Name:	Maria Nelligan, Executive Director of Nursing & Quality	Approved by Exec	☒

Executive Summary:		Purpose of report	
To provide the Board with assurance in relation to the IPC arrangements within the Trust. The report will also give an overview of the influenza situation, our external reporting responsibilities, confirmed Influenza activity and Influenza vaccine uptake, including the CQUIN requirements.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐	Date:	
	Execs ☐	Date:	
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:	None		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	There is no direct impact on protected characteristics in relation to the completion of this report.		
Recommendations:	For Assurance and Information		

Version	Name/group	Date issued
V1	IPC Group	16/01/2018
V2	Director of Nursing & Quality (DIPC)	16/01/2018
V3	Quality Committee	08/02/2018
V3	Trust Board	22/03/2018

1. Purpose of the report

This report is in line with the requirements set out in Winning Ways (DH, 2003) and the Health Act (2006) for the Director of Infection Prevention and Control (DIPC) to appraise the Board on a quarterly basis on the arrangements and activity within Infection, Prevention and Control (IPC). The report will update and provide assurances to the Board for quarter three (Q3) on IPC activity including influenza within the organisation. The Board will also be briefed on our position in relation to Health Care Acquired Infections (HCAIs) and relevant issues.

2. Health Care Acquired Infections (HCAI)

During the Q3 period there were no HCAIs within the Trust, including incidents of MRSA Bacteraemia or C-difficile.

MRSA screening continues to be implemented with a zero positive result for this quarter. Therefore no exceptions have been reported externally.

3. Incidents

Since December 2016 we have had an agreed response and Standard Operating Procedure (SOP) with UHNM A&E department to provide assessment for HIV Post Exposure Prophylaxis (PEP). This is in line with public health guidance for healthcare workers. Unfortunately a member of NSCHT staff was informed on arrival at A&E that PEP was unavailable to staff from NSCHT. An investigation has since been carried out by the IPC team, and conversations have taken place between UHNM microbiologist, Team Prevent, and CCG colleagues. We have since been assured this service is still available and a communication from the microbiologist will be cascaded to the IPC team and A&E department at UHNM reiterating this arrangement. Public Health England (PHE) and the CCG have also been informed.

4. Influenza Activity

Nationally influenza activity peaked between weeks 50 and 52 (December 2017) and continues into 2018. Influenza like Illness (ILI) visits to GPs and A&E departments have increased significantly and continue into 2018. Inpatients at Combined have been symptomatic and those with ILI have been reported to the medical and IPC team, and those patients were reviewed and treated as required.

The NOAP wards appear to have been most affected which is expected with seasonal influenza. The number of patients seen by the IPCT increased prior to and over the Xmas week, continuing into the New Year.

Communication with colleagues across UHNM and the wider community continued to maintain an accurate daily picture across the region.

The immunisation programme for 2017/18 commenced late September 2017, and to the end of December 2017, our peer vaccinators have vaccinated nearly 900 staff. The denominator for this year has increased to over 1200 frontline staff, as a result

vaccinators have had to vaccinate more staff to meet overall compliance. The programme has included:

- Jabathons (24 hour access to the vaccine),
- Dial a jab
- We deliver to you, and
- Clinics.

Frequently asked questions, declaration forms and other relevant information, including myth busting tips, are all available via the IPC pages on SID. The communication team have also run the "12 days of Flu for Xmas" for myth busting. Alongside this our monthly draws of £100 for October, November and December have taken place, with winners including staff from pharmacy, resettlement & enablement and Ward 4. The action plan up to end of December 2017 is included as appendix 1.

5. Outbreaks

From April 2017 we report to commissioners by exception only for outbreaks or incidents of avoidable cross infection incidence.

Following identification of ILI in some patients on wards 4, 6 and 7, viral swabbing took place. Following this we had two confirmed Respiratory Syncytial Virus (RSV) on wards 4 and 6. One of the cases also had confirmed Haemophilus influenza bacteria detected, sometimes confused with Influenza. Both patients have recovered well. No cases of cross infection were observed or confirmed. Staff worked diligently and followed all IPC precautions and advice.

In addition we had four confirmed Influenza B viral swabs from patients on ward 6. These patients were symptomatic of ILI with high NEWS score. The ward was closed to admissions and the Outbreak Standard Operating Procedures followed for Respiratory outbreaks. All patients were commenced on Anti-viral medication (Tamiflu), and nursed on the ward to full recovery. Again no further cases of cross infection were observed or confirmed, and the ward resumed normal function in less than a week.

It must be noted that this is exceptional in terms of managing a respiratory outbreak with the ability to cohort or isolate effectively. The facilities team provided by Carillion, and clinical teams have been thanked and recognition of managing this situation noted. A post outbreak meeting will also take place mid-January. Thanks have also been given to our colleagues in the SSOTP IPCT who provided advice to the ward over the Bank Holiday weekend as part of the Service Level Agreement.

6. Infection Prevention & Control Group

The Infection Prevention and Control Group (IPCG) meets bi monthly, and the last meeting took place in October 2017. The chairs summary comprises:

- Terms of reference updated and approved at Quality Committee
- The IPC strategy has been updated to include Sepsis, and requires agreement at Quality Committee, and approval by Board
- Sepsis day was marked and Sepsis cards distributed across the organisation

- Environmental work plans reviewed in conjunction with Carrillion colleagues
- Waste segregation change to take place early November, and assurance visits to be carried out by the IPC team. This has been completed.
- Standardisation process continues for IPC consumables, including Personal Protective Equipment (PPE), Sharps bins, decontamination products and medical devices.
- The IPC audit programme is on track to be completed by end of Q3. Only one non-compliant area was identified. This area was supported with an action plan which is now complete and will be re-audited accordingly by the IPC team.

7. Recommendations

The Board is asked to note the DIPC Quarter 3 Report for 2017/18.

8. Appendices

Appendix 1.

Flu Action Plan v2 December 2017.xlsx

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REPORT TO Trust Board

Enclosure No:8

Date of Meeting:	22nd March 2018		
Title of Report:	Performance & Quality Management Framework: Month 10		
Presented by:	Director of Finance, Performance & Digital		
Author:	Performance & Information Team		
Executive Lead Name:	Director of Finance, Performance & Digital	Approved by Exec	☒

Executive Summary:	Purpose of report	
The report provides an overview of performance for January 2018 covering contracted Key Performance Indicators (KPIs) and reporting requirements. In addition to the performance dashboards a full database (Directorate drill-down) has been made available to Directorate Heads of Service and Clinical Directors to enable them to interrogate the supporting data and drive directorate improvement. This is summarised in the supporting PQMF dashboard.	Approval	☒
	Information	☒
	Discussion	☒
	Assurance	☐

Seen at:	SLT ☒ Execs ☒ 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	In Month 10 there are 2 target related metrics rated as Red and 1 target related metric as Amber; all other indicators are within expected tolerances. All areas of underperformance are separately risk assessed and a rectification plan is developed, overseen by the relevant sub-committee of the Trust Board.		
Resource Implications: Funding Source:	There are potential contractual penalties if the Trust is not able to meet reporting requirements or performance standards. There is an agreement with Commissioners for the Trust to use the 6 months period following the implementation of the new EPR to ensure that all reports can be made available, or to identify further actions and timescales for delivery in the Data Quality Improvement Plan. There have been significant improvements in data completeness and data quality which have mitigated the risk. There are plans to address remaining issues and to support further developments in the Data Quality Improvement Plan agreed with commissioners.		

Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	The PQMF includes monitoring of ethnicity as a key national requirement. The Trust is seeking to ensure that all Directorates are recording in a timely way the protected characteristics of all service users to enable monitoring of service access and utilisation by all groups in relation to the local population.
Recommendations:	The committee is asked to • Receive the Trust reported performance, management action and committee oversight on the Month 10 position

PERFORMANCE & QUALITY MANAGEMENT FRAMEWORK
REPORT TO TRUST BOARD

Date of meeting:	22nd March 2018
Report title:	**Performance & Quality Management Framework** **Performance Report – Month 10 2017/18**
Executive Lead:	Director of Finance, Performance & Digital
Prepared by:	Performance & Information Team
Presented by:	Director of Finance, Performance & Digital

1 Introduction to Performance Management Report

The report provides an overview of performance for January 2018 covering contracted Key Performance Indicators (KPIs) and reporting requirements.

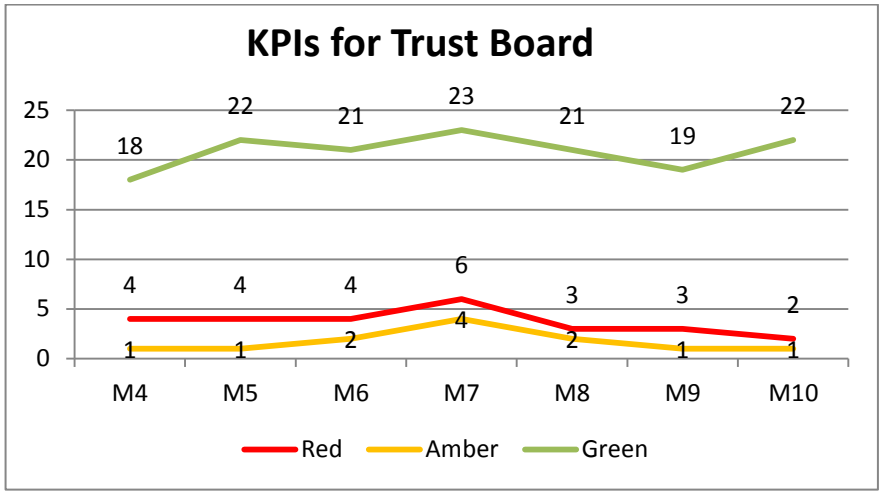
In addition to the performance dashboards a full database (directorate drill-down) has been made available to Directorate Heads of Service and Clinical Directors to enable them to interrogate the supporting data and drive directorate improvement. This is summarised in Appendix 1.

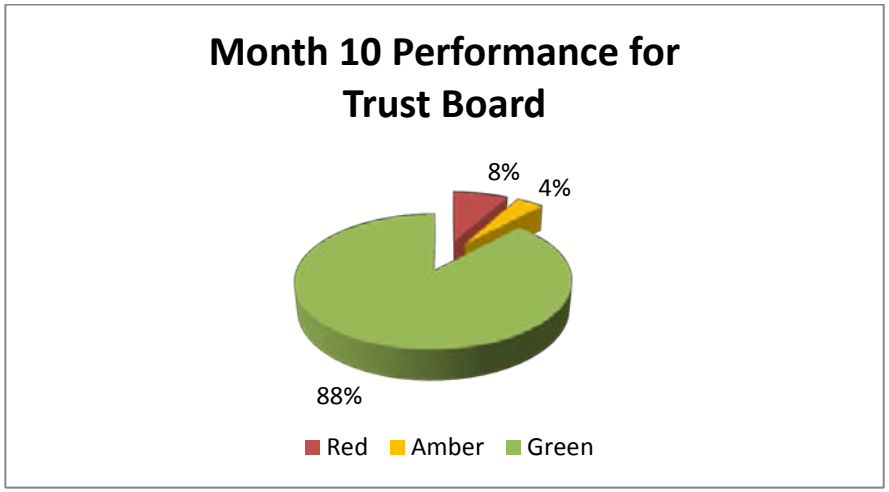
2 Executive Summary – Exception Reporting

The following performance highlights should be noted;

- 98% of service users referred to IAPT services were treated within six weeks of referral (against a 75% target) and 67.2% of people accessing IAPT services moved to recovery (against a 50% target)
- 97.5% of all service users on CPA for at least 12 months (NHSI measure) received their review within 12 months (against a 95% target)

In Month 10 there are 2 targets related metrics rated as **Red** and 1 as **Amber**; all other indicators are within expected tolerances.





3 Additional metrics

Two additional metrics have been included in the PQMF dashboard in month:

- Percentage of inpatient admissions that have been gatekept by crisis resolution/ home treatment team – in line with the updated Single Oversight Framework (SOF) guidance.
- Patient Safety Alerts not completed by deadline – in line with the updated SOF guidance.

4 Exceptions - Month 10

<table>
<tr><th>KPI Classification</th><th>Metric</th><th>Exec/Op Lead</th><th>Target</th><th>M9</th><th>M10</th><th>Trend</th><th>Commentary</th></tr>
<tr><td>National</td><td>Delayed Transfers of Care (DTOC):

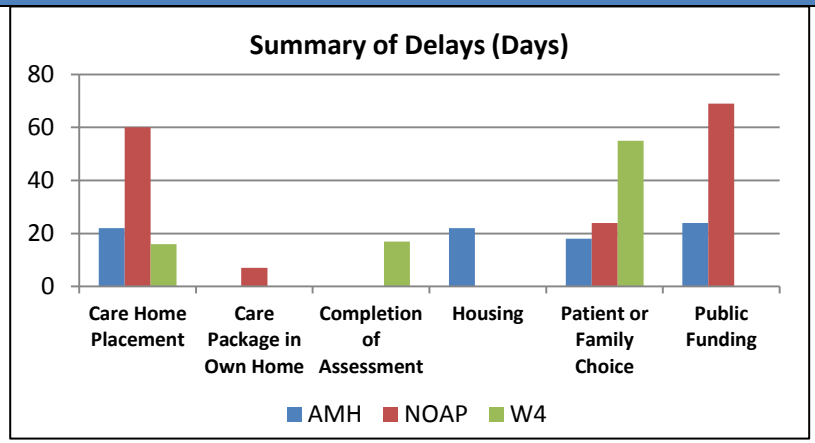
Delayed Transfers of Care</td><td>Dir of Operations</td><td>7.5%</td><td>RED
10.2%</td><td>AMBER
7.8%</td><td>↘</td><td>7.8% at M10 from 10.2% at M9

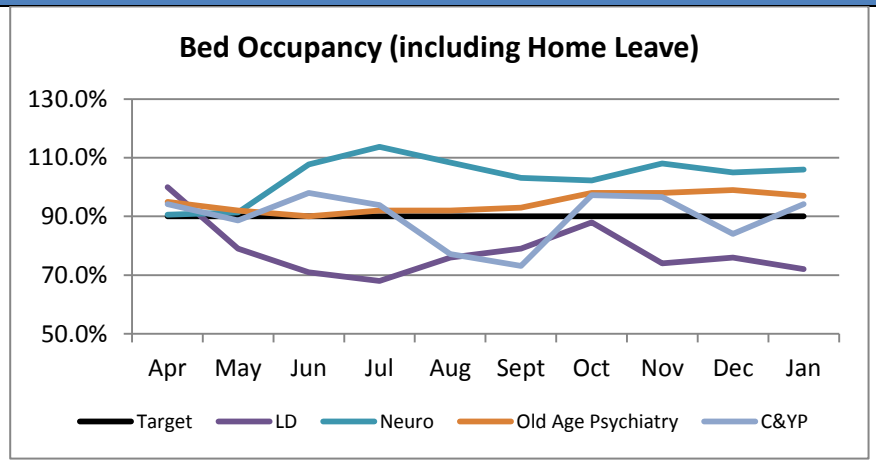
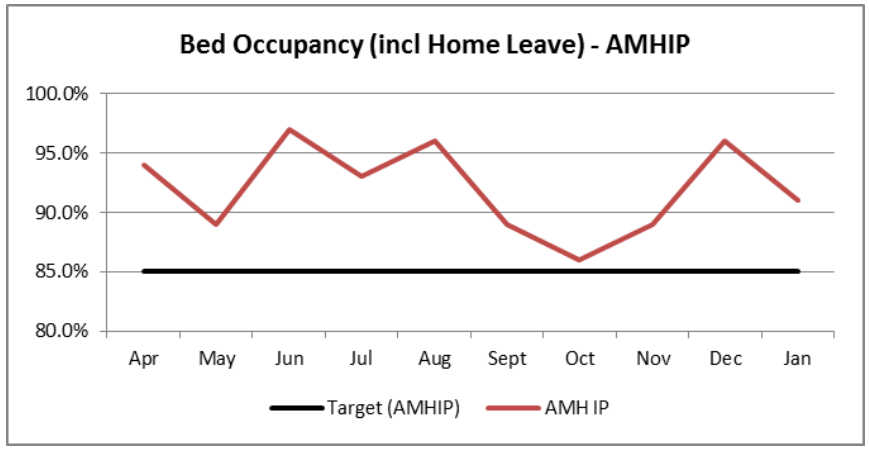
AMH IP – 4.1% at M10 from 8.2% at M9
NOAP – 10.5% at M10 from 10.3% at M9
Ward 4 – 16.3% at M10 from 20.7% at M9

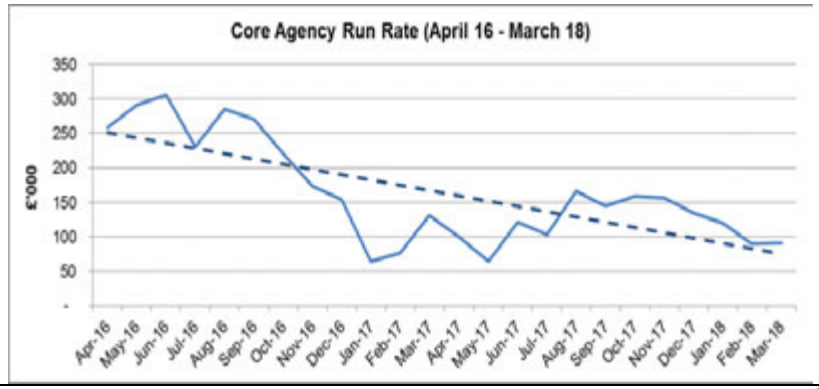
Performance has reduced from 10.2% in M9 to 7.8% in Month 10 mainly due to a significant reduction in the Adult IP directorate, where only 6 inpatients experiencing a delayed discharge in month.

Within NOAP, delays continue to be associated with access to NHS or residential funding or placements and family choice (100% of all delays). The Directorate continues to put in place actions to address the delays.

Trust
<table>
<tr><th>Reason for Delay</th><th>Total Pts</th><th>Total Days</th><th>Days as % of Total</th></tr>
<tr><td>Completion of assessment</td><td>3</td><td>17</td><td>5.1%</td></tr>
<tr><td>Public Funding</td><td>7</td><td>93</td><td>27.8%</td></tr>
<tr><td>Care Home Placement</td><td>9</td><td>98</td><td>29.4%</td></tr>
<tr><td>Care package in own home</td><td>1</td><td>7</td><td>2.1%</td></tr>
<tr><td>Patient or family choice</td><td>13</td><td>97</td><td>29.0%</td></tr>
<tr><td>Housing-patients not covered by NHS and Community Care Act</td><td>2</td><td>22</td><td>6.6%</td></tr>
<tr><td>Total</td><td>35</td><td>334</td><td>100.0%</td></tr>
</table></td></tr>
</table>

KPI Classification	Metric	Exec/Op Lead	Target	M9	M10	Trend	Commentary
							
CCG	Bed Occupancy: Bed Occupancy (including home leave) AMH Inpatient All other wards	Dir of Operations	 90.0% 85.0%	RED 96.0% 94.9%	RED 91.0% 93.8%	 ↘ ↘	AMH IP – 91.0% at M10 from 96.0% at M9 Trust excl AMH IP – 93.8% at M10 from 94.9% at M9 High bed occupancy levels are impacted by the levels of admissions and delayed transfers of care. There has been a decrease in bed occupancy in Month 10, notably in adult inpatient beds where there has also been a decrease in Delayed Transfers of Care.

KPI Classification	Metric	Exec/Op Lead	Target	M9	M10	Trend	Commentary
							 

KPI Classification	Metric	Exec/Op Lead	Target	M9	M10	Trend	Commentary
National	Agency Spend: % Year to Date Agency Spend compared to year to date agency ceiling	Dir of Workforce and Leadership	0.0%	RED 29.7%	RED 28.8%	↘	28.8% at M10 from 29.7% at M9 ROSE – 7.1% at M10 from 8.8% at M9 Ward 4 – 6.5% at M10 from 3.9% at M9 Core – 15.3% at M10 from 17.7% at M9 The cumulative YTD agency ceiling is £1,785k against actual of £2,299k - £514k worse than plan (28.8%) The main drivers of the negative variances are: • ROSE: £143k: The Trust extended the use of additional agency staff as part of the implementation of the ROSE project to ensure a safe transition. The use of agency has now ceased on this project. • Medical Locums - £306k: This reflects the national shortage of medics. The Trust is exploring a number of ways to attract and retain medical staff. The trust is forecasting that the agency ceiling will not be achieved in 2017/18. However the run rate has reduced significantly since April 2016 and therefore the trust expects to deliver the 2018/19 ceiling, when there is no Agency expenditure on ROSE. 

5 Recommendations

The Trust Board is asked to;

- Receive the Trust reported performance, management action and committee oversight on the Month 10 position

- can we swap the bed occupancy round so inpatients 90% is the first and then rename the ‘all wards’ to ‘all other wards’

Month: **January**
10
Key:-

PQMF Report to Trust Board

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

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

	Metric	Frequency	Target (2016/17) Red= 17/18 target	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
EFFECTIVE															
NHSI	Early Intervention in Psychosis - A maximum of 2 week waits for referral to treatment (Target-17/18-50%, 18/19-53%)	Monthly	50%	76.9%	81.8%	63.6%	100.0%	70.0%	50.0%	62.5%	61.5%	72.7%	70.0%		
CCG	Compliance with 18 week waits (Referral to Treatment or Intervention)	Monthly	92%	93.5%		82.4%	94.3%	95.1%	94.9%	92.5%	93.6%	94.2%	92.1%		
CCG	AMH IP	Monthly	92%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
CCG	AMH Community	Monthly	92%	89.0%		77.5%	91.9%	94.9%	95.9%	95.6%	91.6%	93.5%	89.5%		
CCG	Substance Misuse	Monthly	92%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
CCG	LD	Monthly	92%	100.0%		85.2%	100.0%	94.1%	92.3%	91.9%	90.0%	92.3%	92.1%		
CCG	NOAP	Monthly	92%	97.4%		82.3%	94.3%	94.9%	95.4%	90.5%	95.3%	95.4%	95.7%		
CCG	C&YP	Monthly	92%	100.0%		93.7%	100.0%	95.4%	90.3%	93.1%	92.2%	93.0%	85.7%		
CCG	Zero tolerance RTT waits over 52 weeks for incomplete pathways	Monthly	0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
CCG	MH Liaison Team response to A&E referrals within 1 hour	Monthly	95%	94.0%	94.0%	97.0%	96.0%	98.0%	97.0%	96.0%	95.0%	97.0%	96.0%		
CCG	Patients will be assessed within 12 weeks of referral to the Memory Assessment service	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
CCG	Number of people seen for crisis assessment within 4 hours of referral	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
National	Percentage of inpatient admissions that have been gatekept by crisis resolution/ home treatment team	Monthly	95%	100.0%	98.5%	95.9%	97.2%	97.8%	98.6%	97.5%	100.0%	100.0%	100.0%		
National/CCG	Overall safe staffing fill rate	Monthly	No Target	95.2%	95.3%	94.8%	93.4%	91.2%	90.4%	91.8%	94.3%	91.0%	94.9%		
National	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%) Target revised to 7.0% in M3	Monthly	7.5%	11.0%	8.4%	13.0%	12.7%	10.8%	8.8%	13.5%	12.5%	10.2%	7.8%		
CCG	Emergency Readmission rate (30 days). Percentage of patients readmitted within 30 days of discharge.	Monthly	7.5%	15.0%	5.2%	5.1%	5.0%	4.7%	3.0%	6.9%	4.1%	3.9%	6.6%		
NHSI	Total bed days patients have been Out of Area	Monthly	No target	0.0	0.0	160.0	295.0	259.0	22.0	1.0	28.0	150.0	68.0		
NHSI	Ratio of days Out of Area to baseline (Baseline set at M9 2017/18 figure of 150 bed days, as per SOF guidance, shown as 100%. The ratio of days each month to this baseline figure is then expressed as a percentage.)	Monthly	<100%									100.0%	45.3%		
SAFE															
CCG	Number of patients 16/17 years old admitted to Adult Psychiatric wards	Monthly	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
NHSI	Admission to adult facilities of U16s	Monthly	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
CCG	Bed Occupancy (Including Home Leave)	Monthly	85%	93.6%	89.4%	92.9%	92.6%	92.3%	90.0%	93.1%	93.3%	94.9%	93.8%		
CCG	AMH IP	Monthly	90%	94.0%	89.0%	97.0%	93.0%	96.0%	89.0%	86.0%	89.0%	96.0%	91.0%		
CCG	LD	Monthly	85%	100.0%	79.0%	71.0%	68.0%	76.0%	79.0%	88.0%	74.0%	76.0%	72.0%		
CCG	Neuro	Monthly	85%	90.6%	91.3%	107.7%	113.7%	108.4%	103.1%	102.3%	108.0%	105.0%	106.0%		
CCG	Old Age Psychiatry	Monthly	85%	95.0%	92.0%	90.0%	92.0%	92.0%	93.0%	98.0%	98.0%	99.0%	97.0%		
CCG	C&YP	Monthly	85%	94.2%	88.6%	98.0%	93.9%	77.2%	73.1%	97.2%	96.6%	84.1%	94.2%		
CCG	IAPT: The proportion of people who have depression and/or anxiety disorders who receive psychological therapies (Target: 3.75% per quarter, 1.25% p/month)	Monthly	3.75% quarterly (1.25% monthly)	1.05%	1.28%	1.21%	1.29%	1.30%	1.25%	1.5%	1.3%	0.9%	1.3%		
NHSI / CCG	IAPT : The number of people who are moving to recovery. Divided by the number of people who have completed treatment minus the number of people who have completed treatment that were not at caseness at initial assessment	Monthly	50%	67.1%	68.5%	65.1%	65.9%	69.5%	64.9%	60.8%	66.3%	60.8%	67.2%		
NHSI / CCG	Improving Access to Psychological Therapies (IAPT) Programme: the percentage of service users referred to an IAPT programme who are treated within 6 weeks of referral	Monthly	75%	99.7%	99.3%	100.0%	100.0%	100.0%	99.7%	100.0%	99.0%	100.0%	98.0%		
NHSI / CCG	Improving Access to Psychological Therapies (IAPT) Programme: the percentage of service users referred to an IAPT programme who are treated within 18 weeks of referral	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.0%		
CCG	S136 (Place of Safety) Assessments	Monthly	No Target	23.0	33.0	35.0	43.0	22.0	20.0	28.0	21.0	12.0	16.0		
National	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%	91.5%	91.8%	94.5%	92.2%	90.3%	94.1%	95.9%	97.5%		
NHSI	The proportion of those on Care Programme Approach (CPA) receiving follow-up contact within 7 days of discharge	Monthly	95%	95.7%	96.9%	94.1%	93.1%	86.7%	97.4%	92.9%	97.4%	90.9%	95.7%		
NHSI/CCG	Never Events	Monthly	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
National	Patient Safety Alerts not completed by deadline	Monthly	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
CCG	Mixed Sex Accommodation Breach	Monthly	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		

	Metric	Frequency	Target (2016/17) Reds= 17/18 target	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
CARING															
National	Inpatient Scores from Friends and Family Test – % positive	Monthly	No Target	89.0%	88.0%	83.0%	83.0%	85.9%	85.9%	93.8%	93.6%	85.9%	93.9%		
National	Staff Friends and Family Test - % recommended - care	Quarterly	No Target			60.2%			66.7%			Awaiting publication			
National	Percentage of complaints responded to in line with timescale agreed with complainant	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
National	Written complaints rate	Quarterly	No Target			2.4%			9.4%			9.3%			
CCG	Duty of Candour Each failure to notify the Relevant Person of a suspected or actual Reportable Patient Safety Incident	Monthly	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
ORGANISATIONAL HEALTH															
National	% Year to Date Agency Spend compared to Year to Date Agency Ceiling	Monthly	0%		7.0%	20.0%	10.0%	26.0%	24.0%	28.0%	30.0%	29.7%	28.8%		
National	Sickness Absence Percentage: Days lost	Monthly	4.95%	4.20%	3.95%	3.95%	4.20%	4.90%	4.88%	4.85%	4.58%	4.34%			
National	Staff Turnover (% FTE)	Monthly	>10%	0.9%	1.1%	0.6%	0.6%	1.5%	1.4%	0.7%	0.3%	1.0%	0.6%		

REPORT TO OPEN TRUST BOARD

Enclosure No:9

Date of Meeting:	22ND March 2018		
Title of Report:	2017 NHS Staff Survey Results		
Presented by:	Alex Brett, Director of Workforce, OD and Communications		
Author:	Jane Rook, Neil Clarke		
Executive Lead Name:	Alex Brett, Director of Workforce, OD and Communications	Approved by Exec	☒

Executive Summary:	Purpose of report	
This survey takes place annually and is mandated for all NHS Trusts. Our Trust is benchmarked alongside all other Mental Health Trusts. The survey covered 32 'Key Finding' measures this year plus a measure on Workforce Race Equality Scheme (WRES). Our Trust's results are benchmarked alongside all other mental health trusts. The survey results for all NHS bodies in the 2017 staff survey were made available on 7th March 2018	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 ☐ Y 3. Create a learning culture to continually improve.☐ Y 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.☐ Y 7. Continually improve our partnership working. ☐	
Risk / legal implications: Risk Register Ref	NHS staff survey results are publicly available. A considered response to continually improve and share our journey is required	
Resource Implications: Funding Source:	N/A	
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	Particular note should be made to the implications to our WRES data and recommendations/ actions to take forward	
Recommendations:	1. Discuss the findings of the staff survey 2. Support the work on strengthening our values and behaviour approach 3. Address the areas highlighted in the WRES data	

	4. Consider entirely electronic staff survey for 2018, reflective our commitment to becoming a digital exemplar

Report to Trust Board
2017 NHS Staff Survey Results – NSCHT
March 2018

1. Introduction

The 2017 NHS Staff Survey was conducted between September and December 2017.

This survey takes place annually and is mandated for all NHS Trusts. Our Trust is benchmarked alongside all other Mental Health Trusts.

The survey covered 32 'Key Finding' measures this year plus a measure on Workforce Race Equality Scheme (WRES).

Our Trust's results are benchmarked alongside all other mental health trusts. The survey results for all NHS bodies in the 2017 staff survey were made available on 7th March 2018 at http://www.nhsstaffsurveys.com.

There are nine themes within the staff survey report:

- Appraisals & support for development
- Equality & diversity
- Errors & incidents
- Health and wellbeing
- Working patterns
- Job satisfaction
- Managers
- Patient care & experience
- Violence, harassment & bullying

There are two types of Key Finding:

- Percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions
- Scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5

Responses to the individual survey questions can be found in the full report in along with details of which survey questions were used to calculate the Key Findings.

Response Rate

The response rate for North Staffordshire Combined in 2017 was 51.8%, consisting of 706 responses from a useable sample of 1363.

- The national average for all NHS Trusts was 45% in 2017
- The national average for mental health trusts was 54.0%
- North Staffordshire Combined response rate for 2017 is 52% (an increase from 51% in 2016)

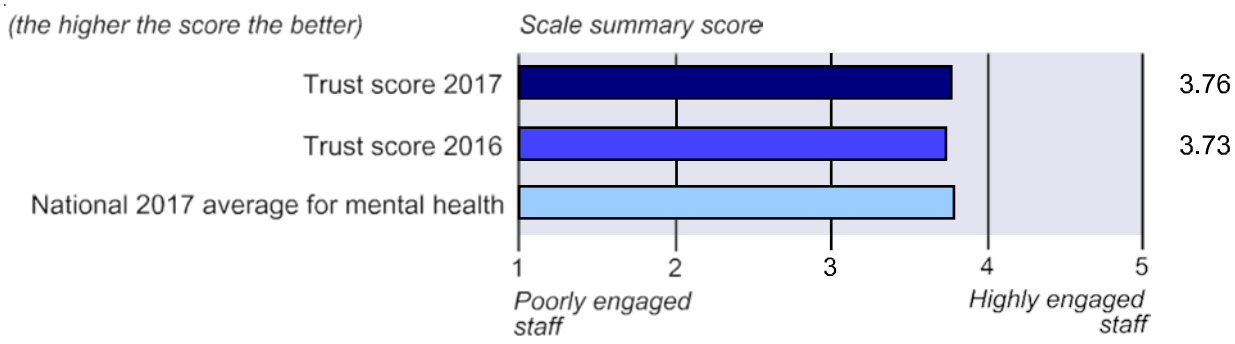
This year, the Trust chose to undertake the survey using only paper surveys.

Response rate by Directorate

Directorate	Response	Useable sample	%age response
Substance Misuse	42	63	67
Corporate	143	270	53
Neuropsychiatry and old age	137	266	52
Children and Young People	69	139	50
Learning Disabilities	56	125	45
AMH Community	169	412	41
AMH In-patients	64	162	40
TOTAL	**638**	**1374**	

2. Overall Staff Engagement Score

The below chart shows our engagement score has not changed significantly and is very close to the national mental health trust average of 3.79.



The table below shows how North Staffordshire Combined Healthcare NHS Trust compares with other mental health / learning disability trusts on each of the sub-dimensions of staff engagement, and whether there has been a significant change since the 2016 survey.

	Change since 2016 survey	Ranking, compared with all mental health
OVERALL STAFF ENGAGEMENT	• No change	• Average
KF1. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the trust's top priority, would recommend their trust to others as a place to work, and would be happy with the standard of care provided by the trust if a friend or relative needed treatment.)*	• No change	• Average
KF4. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	• No change	• Average
KF7. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	• No change	! Below (worse than) average

The table below show the overall engagement score for different staff groups. It can be seen from this table that only Registered Nurses and Allied Health Professionals are above the Trust average of 3.76 and that Additional Clinical Services score the same. More work is required with Professional Leads to analyse and understand this is greater detail.

Key Findings for different staff groups (cont)

	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Medical and Dental	Nursing and Midwifery Registered
Overall staff engagement	3.68	3.76	3.71	3.94	3.61	3.72	3.86
Number of respondents	74	135	186	29	36	25	221

The table below shows the overall engagement score for different occupational groups. It can be seen from this table that Mental Health Nurses, Occupational Therapists, other Allied Health Professionals, General Management, and Corporate services scored above the Trust average of 3.76. A query has been raised with Quality Health regarding the disparity in scores for Medical and Dental in the two tables.

Key Findings for different occupational groups

	Mental Health Nurses	Other Registered Nurses	Nursing / Healthcare Assistants	Medical / Dental	Occupational Therapy	Other Allied Health Professionals	General Management	Admin & Clerical	Central Functions / Corporate Services	Maintenance / Ancillary	Social Care Staff
Overall staff engagement	3.84	3.74	3.67	3.63	3.89	3.81	3.96	3.65	3.77	3.57	3.74
Number of respondents	197	29	60	25	25	89	12	103	47	32	41

3. Overview of staff survey results

Each one of our services was rated good or outstanding by the latest CQC visit. The results from this survey provide further evidence of our journey of improvement as also recognised by our staff.

Key Finding 1

"A place you would recommend to work or receive treatment"

In comparison to other trusts, this score has improved by 1.7% and is now close to the national average for Mental Health Trusts. This feedback demonstrates that our staff recognise positive changes taking place in the Trust on our journey *Towards Outstanding*, as a place to work and receive care.

These results are shown below;

		Your Trust in 2017	Average (median) for mental health	Your Trust in 2016
Q21a	"Care of patients / service users is my organisation's top priority"	70%	73%	70%
Q21b	"My organisation acts on concerns raised by patients / service users"	74%	75%	77%
Q21c	"I would recommend my organisation as a place to work"	53%	57%	50%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	61%	61%	61%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.62	3.67	3.56

Notable improvements show:

- 21 out of 28 categories we were average or better than average
- 10 categories ranking better than average
- 91% of staff believe the organisation provides equal opportunities for career progression or promotion
- The Trust scores highly on staff believing we act on service user feedback effectively

There are no statistically significant reductions in our scores compared with last year.

Areas that we will continue to work on improving include:

- Staff being able to contribute toward improvements at work
- Staff agreeing that their role makes a difference to service users
- Staff feeling confident in reporting unsafe clinical practice
- Improving the experience of our Black, Asian and Minority Ethnic (BAME) staff

2. Workforce Race Equality Standard (WRES) Results

As can be seen in the below WRES data chart, looking at the findings from KF25, KF26, KF21 and Q17b, our scores have remained fairly consistent, however, when looking at the breakdown of white staff in comparison to BAME staff, there is are a number of areas of focus for us to consider regarding staff from a white background in comparison to reports from staff from a BAME background.

Our work to date demonstrates the Trust has delivered against its core responsibilities in relation to the Equality Act 2010 and the associated Public Sector Equality Duty (PSED), the Workforce Race Equality Scheme (WRES), the Equality Delivery System (EDS2) and the Accessible Information Standard.

The Trust has been supported by NHS Employers and partner Trusts as a 'D&I Partner' organisation throughout 2017-18 and key areas of progress over 2017-18 have been:

- Raising the profile of race (in) equality, including launching plans to commence a Black, Asian and Minority Ethnic (BAME) Leadership Programme, led by the Trust on behalf of the Staffordshire Strategic Transformation Partnership (STP).
- Launched BAME Staff Network in November 2017
- Held 'BAME Staff big conversation' sessions with the Director of Nursing
- Embedding D&I into Trust Committee processes and Directorate decisions

We are raising expectations and awareness of Diversity and Inclusion (D&I) principles through this programme of work on Diversity and Inclusion to date but clearly we have more to do and will be a key focus for us during 18/19. Anecdotally, we believe that as a result of focusing on developing in this area, people are now feeling more able to report more confidently their own lived experience at work.

Hearing perspectives and seeking opportunities to feedback real lived experiences in an open culture within the workplace, means that we may continue to receive a spike in negative responses but this will continue to be a strategic focus for us.

WRES staff survey data 2017

			Your Trust in 2017	Average (median) for mental health	Your Trust in 2016
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	31%	32%	32%
		BME	43%	36%	37%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	16%	21%	19%
		BME	37%	26%	25%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	91%	87%	89%
		BME	64%	77%	86%
Q17b	In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	7%	6%	5%
		BME	21%	14%	17%

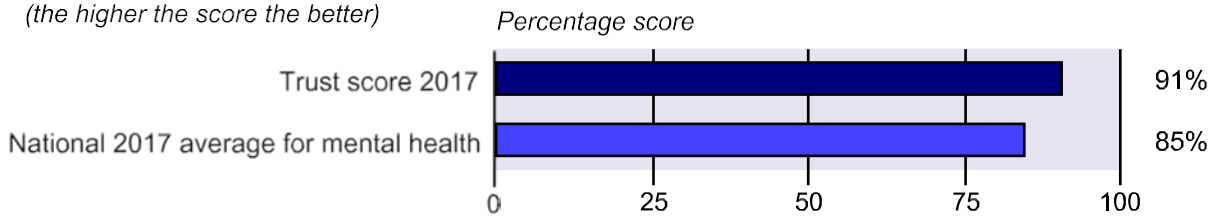
3. Summary of 2017 Key Findings for North Staffordshire Combined Healthcare NHS Trust

This page highlights the five Key Findings for which North Staffordshire Combined Healthcare NHS Trust compares most favourably with other mental health / learning disability trusts in England.

TOP FIVE RANKING SCORES

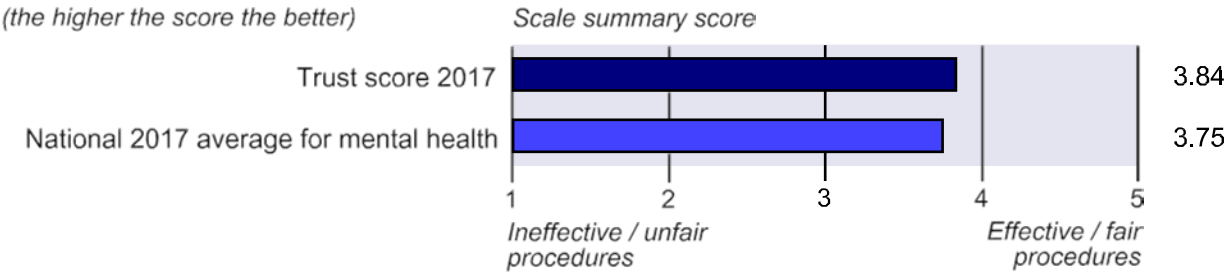
✓ **KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion**

(the higher the score the better)



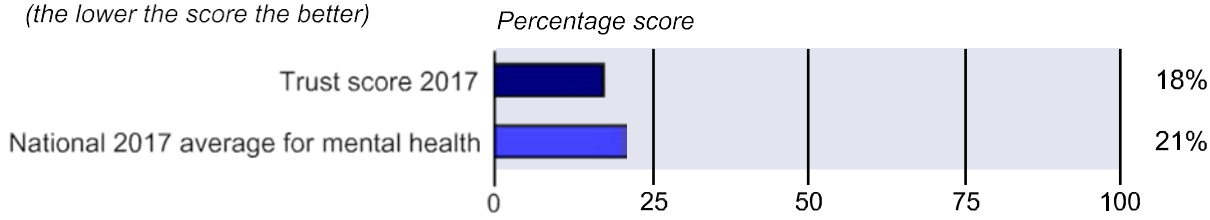
✓ **KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents**

(the higher the score the better)



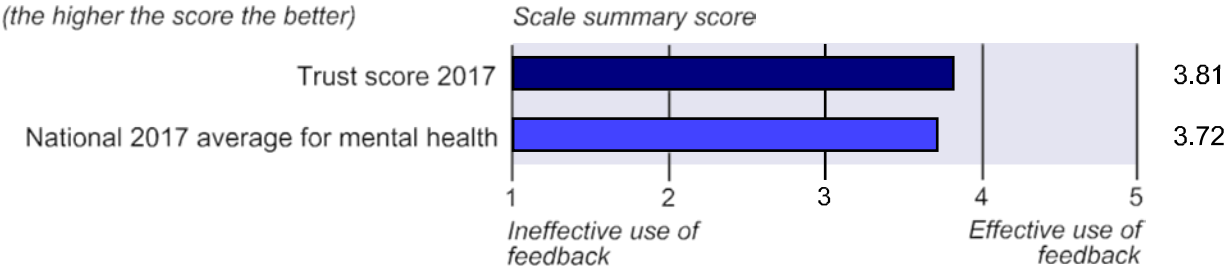
✓ **KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months**

(the lower the score the better)



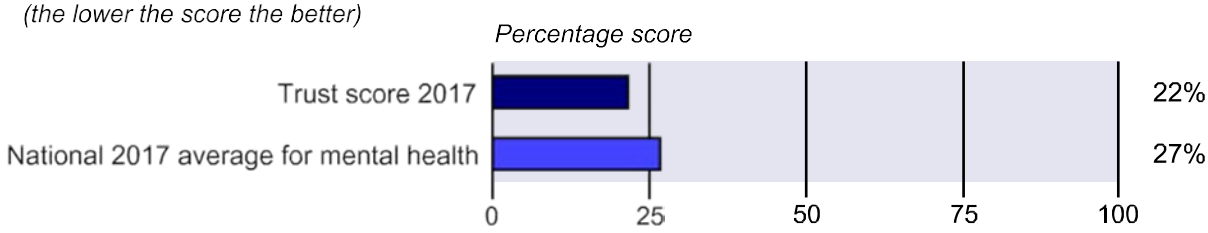
✓ **KF32. Effective use of patient / service user feedback**

(the higher the score the better)



✓ **KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month**

(the lower the score the better)

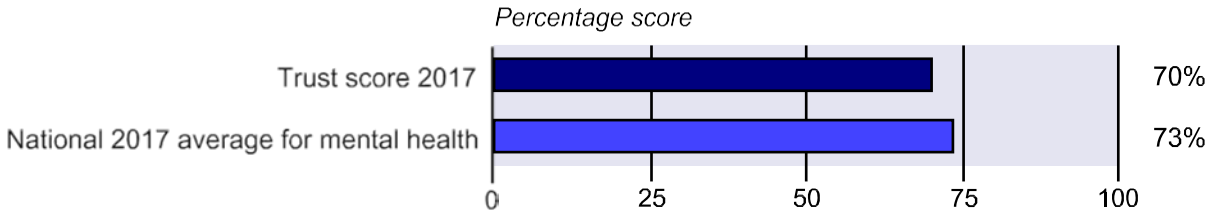


BOTTOM FIVE RANKING SCORES

! KF13. Quality of non-mandatory training, learning or development

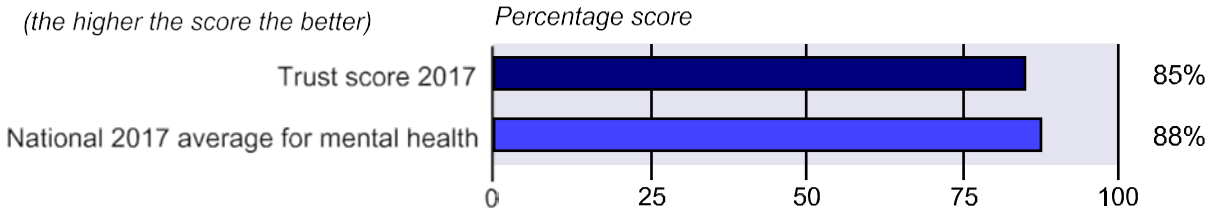
(the higher the score the better)

! KF7. Percentage of staff able to contribute towards improvements at work

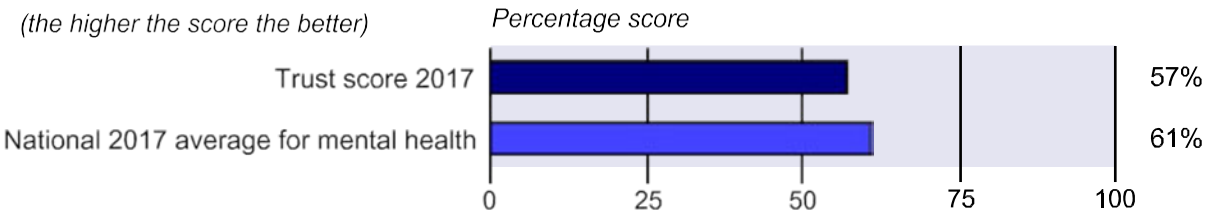


! KF3. Percentage of staff agreeing that their role makes a difference to patients / service users

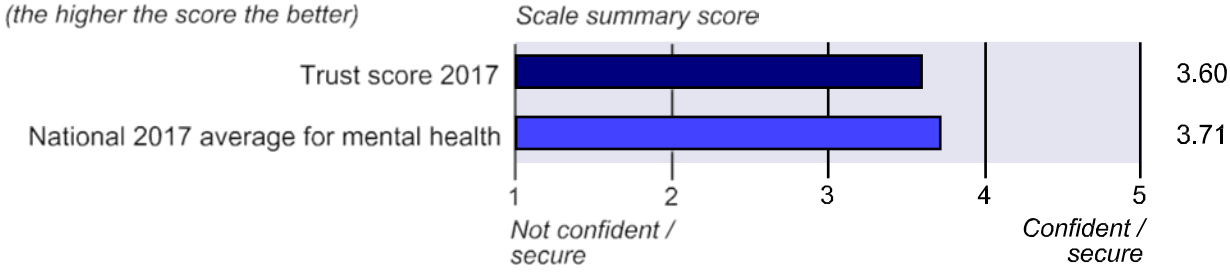
(the higher the score the better)



! KF27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse



! KF31. Staff confidence and security in reporting unsafe clinical practice



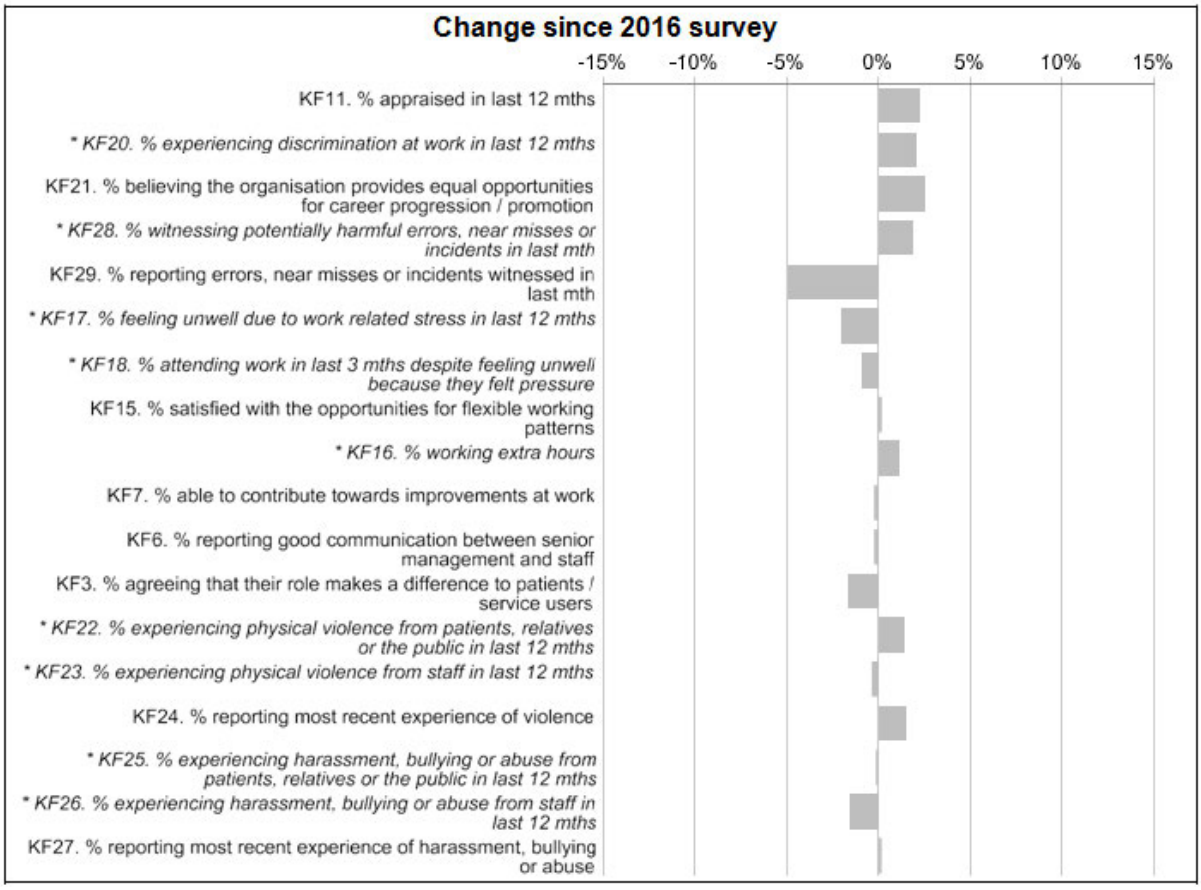
4. North Staffordshire Combined 2017 results compared to 2016

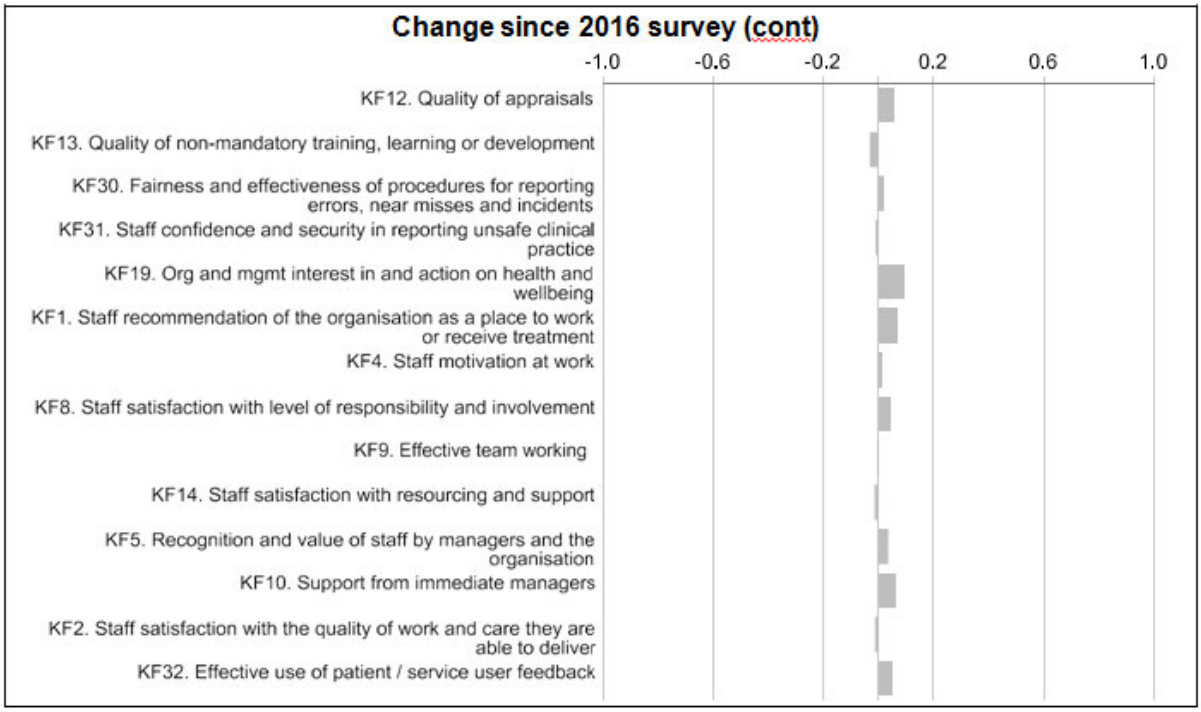
The below table indicates there has been no statistically significant change since 2016. This indicates a steady state.

KEY

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2016 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.





5. North Staffordshire Combined compared to Other Mental Health Trusts

KEY

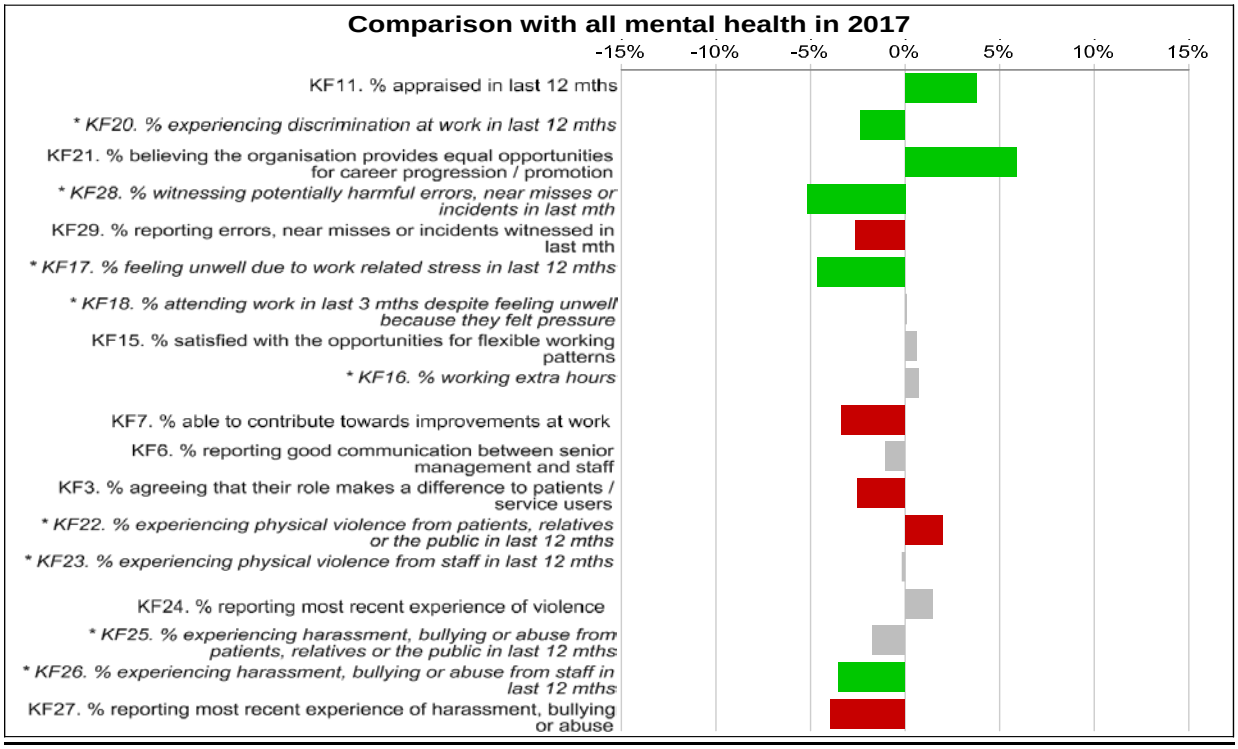
Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2016 survey.

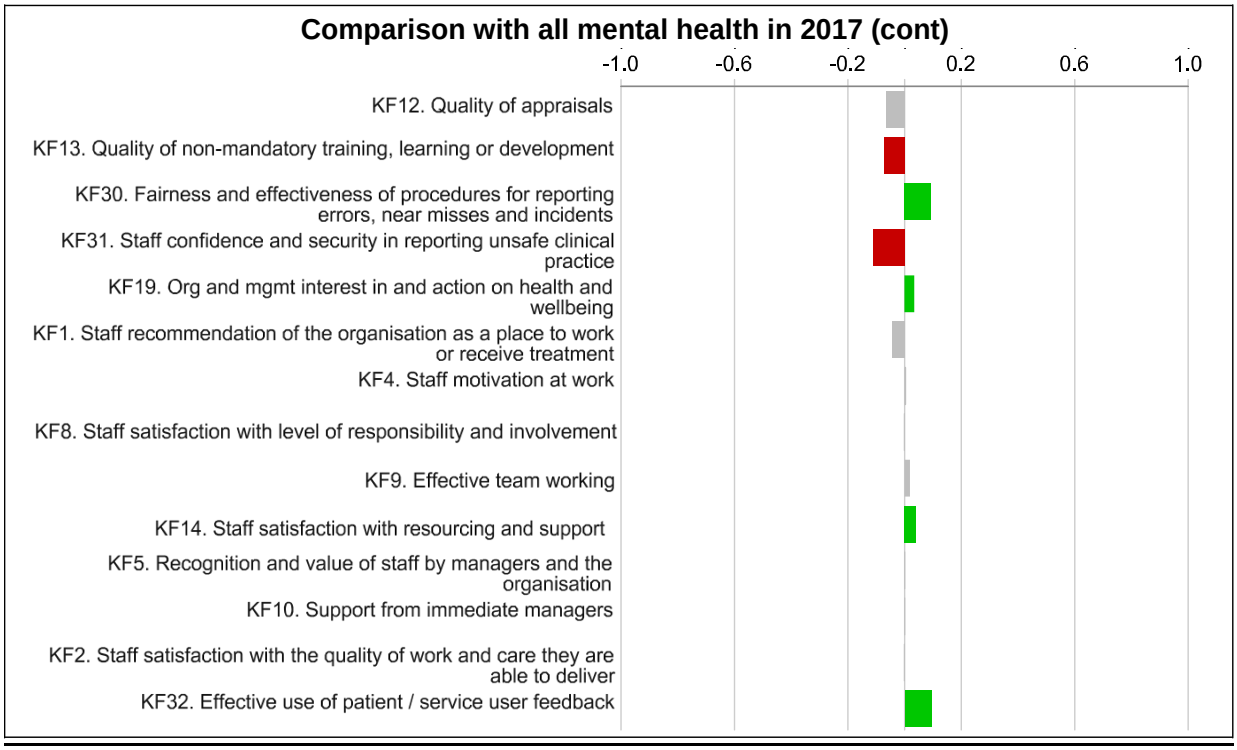
Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2016 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2016 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

The below table shows our scores as a comparison against the national average of other Mental Health Trusts.


Comparison with all mental health in 2017
-15%
-10%
-5%
0%
5%
10%
15%
KF11. % appraised in last 12 mths
* KF20. % experiencing discrimination at work in last 12 mths
KF21. % believing the organisation provides equal opportunities for career progression / promotion
* KF28. % witnessing potentially harmful errors, near misses or incidents in last mth
KF29. % reporting errors, near misses or incidents witnessed in last mth
* KF17. % feeling unwell due to work related stress in last 12 mths
* KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure
KF15. % satisfied with the opportunities for flexible working patterns
* KF16. % working extra hours
KF7. % able to contribute towards improvements at work
KF6. % reporting good communication between senior management and staff
KF3. % agreeing that their role makes a difference to patients / service users
* KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths
* KF23. % experiencing physical violence from staff in last 12 mths
KF24. % reporting most recent experience of violence
* KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths
* KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths
KF27. % reporting most recent experience of harassment, bullying or abuse


Comparison with all mental health in 2017 (cont)
-1.0
-0.6
-0.2
0.2
0.6
1.0
KF12. Quality of appraisals
KF13. Quality of non-mandatory training, learning or development
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents
KF31. Staff confidence and security in reporting unsafe clinical practice
KF19. Org and mgmt interest in and action on health and wellbeing
KF1. Staff recommendation of the organisation as a place to work or receive treatment
KF4. Staff motivation at work
KF8. Staff satisfaction with level of responsibility and involvement
KF9. Effective team working
KF14. Staff satisfaction with resourcing and support
KF5. Recognition and value of staff by managers and the organisation
KF10. Support from immediate managers
KF2. Staff satisfaction with the quality of work and care they are able to deliver
KF32. Effective use of patient / service user feedback

6. Our Actions in 2017/2018 to improve staff engagement and experience at work

- Towards Outstanding Engagement –supporting the 16 teams from cohort 1 and a 2nd cohort to be launched

- Values and Behaviours Framework– to strengthen and embed organisationally

- Quality Improvement approach defined by the Board, enabling greater engagement and empowerment of teams in improvement and building on Towards Outstanding Engagement and Listening into Action as part of this programme of work

- Recruitment and Retention – through proactive recruitment activities and working with NHSI Retention Programme

- Define our approach to Talent and leadership development as part of the Trust-wide Workforce and OD strategy

- Refresh our approach and further strengthen Being Open and Raising Concerns at work through the Freedom to Speak up Guardian

- Workforce Race Equality Standard specific actions below as follows:

    - Trust wide approach led by the Trust Board and CEO with support of Medical Director and Director of Workforce to support and redress the gap between the contrasting experiences of staff with a white or BAME background

    - D&I will continue to be a trust priority in 2018/19. We anticipate improvements in WRES scores and the staff survey next year as a result of continued activity in this area. We will also focus on our Equality Impact Assessment (EIA) highlighted recently by the CQC.

Next Steps

Actions will be developed which will be articulated in a Trust-wide and directorate action plan. This will be monitored through PCD.

Directorates are currently working on their staff survey data with the HR Business Partners. Directorates will be producing action plans which will be presented at SLT Performance for assurance.

Professional Leads will be further analysing the data to draw out actions required for Professional Groups. Work has already commenced with the Medical Workforce.

The Director of Workforce, OD and Communications will be analysing with the Executive team the comments from staff and clustering these by theme to inform the Organisational Development Approach for the coming year. This will be presented and fed in to the Board Development session in May.

Recommendations

Trust Board members are asked to:-

1. Discuss the findings of the staff survey and actions to take forward to enhance staff engagement
2. Consider the Board's role in supporting the improvements in the WRES data
3. Consider entirely electronic staff survey for 2018, reflective our commitment to becoming a digital exemplar

END OF REPORT

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO Trust Board (Public)

Enclosure No:10

Date of Meeting:	22/03/2018		
Title of Report:	Finance Position Month 10		
Presented by:	Suzanne Robinson - Executive Director of Finance, Performance and Digital		
Author:	Mike Newton – Deputy Director of Finance		
Executive Lead Name:	Suzanne Robinson - Executive Director of Finance, Performance and Digital	Approved by Exec	☒

Executive Summary:	Purpose of report	
The report summarises the finance position at month 10 (January 2018)	Approval	☒
	Information	☐
	Discussion	☒
	Assurance	☐

Seen at:	SLT ☐ Execs x 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	None applicable		
Resource Implications: Funding Source:	None directly from the report None applicable		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	There is no direct impact on the protected characteristics as part of the completion of this report.		

Recommendations:	The Trust Board is asked to: Note: • The reported YTD surplus of £1,148k against a planned surplus of £982k. This is a favourable variance to plan of £166k. • The M10 CIP achievement: o YTD achievement of £1,662k (68%); an adverse variance of £799k; o 2017/18 forecast CIP delivery of £2,588k (81%) based on schemes identified so far; an adverse variance of £609k to plan; o The recurrent forecast delivery at month 10 of £2,951k representing a recurrent variance to plan of £246k. o A risk adjusted recurrent forecast delivery of £2,475 (77%) • The cash position of the Trust as at 31st January 2018 with a balance of £5,932k; £502k better than plan • Agency forecast is currently £514k above ceiling (£2,068k) • Year to date Capital receipts for 2017/18 is £1,260k compared to a net planned capital expenditure of £1,726k; o The original operating plan submitted to NHSI in December 2016 planned net capital expenditure of £2,979k by Month 10. o Based on the NHSi plan the forecast underspend would be £708k. • Use of resource rating of 2 against a plan of 2. <u>Approve:</u> • The month 10 position reported to NHSI. • Approve the forecast Agency Ceiling breach of £461k.

North Staffordshire Combined Healthcare NHS Trust

Financial Overview as at 31st January 2018

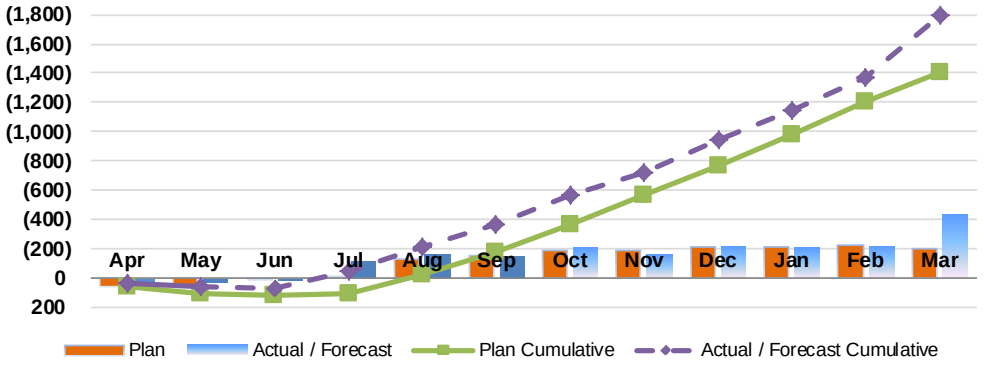
Income & Expenditure - Control Total (Surplus) / Deficit

£000	Plan	Actual	Var	%	RAG
YTD	(982)	(1,148)	(166)	(17)	G
FOT	(1,400)	(1,800)	(400)	29	G

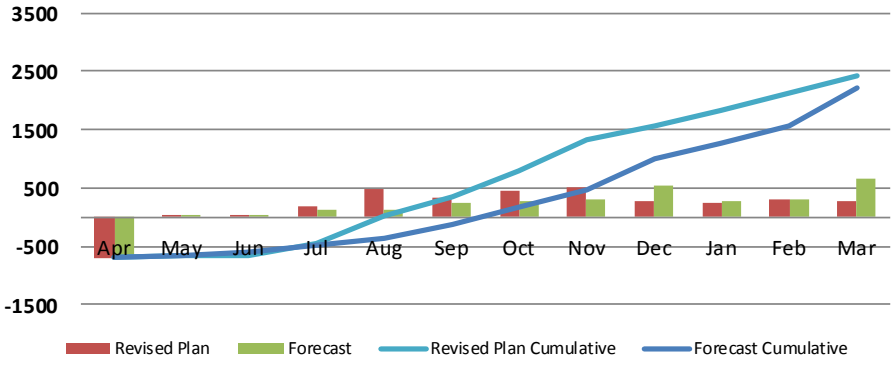
Charge to CRL

£000	Plan	Actual	Var	%	RAG
YTD	1,726	1,259	(467)	73	G
FOT	2,312	2,212	(100)	96	G

Retained (Surplus) / Deficit Run Rate 2017/18



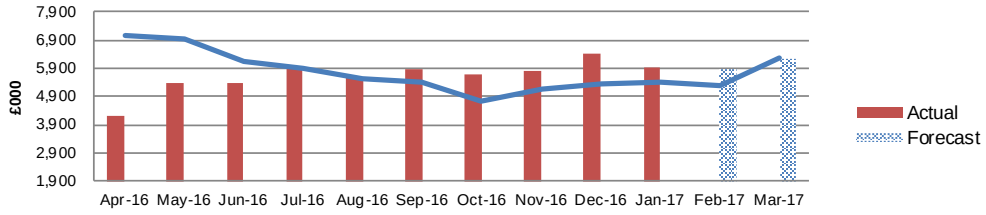
Net Capital Expenditure - Plan / Forecast 2017/18



Cash Balances

£000	Plan	Actual	Var	%	RAG
YTD	5,430	5,932	502	8	G

Cash Balances - Actual/Forecast against Plan 2017/18



Cost Improvement

£000	Plan	Actual	Var	%	Rec Var	RAG
Clinical	1,961	1,516	(445)	(23)	(542)	A
Corporate	500	146	(354)	(71)	296	G
Total	2,461	1,662	(799)	(32)	(246)	G

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

1. 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.

1.1 2017/18 Forecast Improvement

In Month 10, NSCHT Trust Board agreed to improve the 2017/18 forecast outturn position by £0.2m, increasing the trading surplus for 2017/18 to £1.1m. This would allow the Trust to attract an additional £0.2m STF funding, to deliver an overall surplus of £1.8m for 2017/18:

- Trusts that agree to improve beyond the control surplus attracts at least a pound for pound additional incentive payment
- Trusts that overachieve against control will also get a share of any remaining national STF funding at the end of the financial year. In 2016/17 NSCHT received £600k for a final outturn £47k higher than the control. This is not included in the £1.8m overall forecast surplus noted below.

	2017/18 Plan Control (£m)	Agreed Improvement (£m)	2017/18 Forecast Outturn (£m)
Trading Surplus	0.9	0.2	1.1
Sustainability and Transformation funding	0.5	0.2	0.7
Surplus / (Deficit)	**1.4**	**0.4**	**1.8**

2. Income & Expenditure (I&E) Performance

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

- During month 10, the trust had an in month trading position of £148k surplus against a plan of £150k surplus; **showing a £2k deficit**. Sustainability and Transformation funding has been assumed at £58k for month 10, bringing the overall trust control to a £206k surplus against plan of £208k; **showing £2k deficit to plan**.

- The trust has a year to date trading position of £765k surplus against a plan of £599k surplus; **a favourable variance to plan of £166k**. After Sustainability and transformation funding (£383k), the trust has a Control Total surplus of £1,148k against a planned surplus of £982k; **a favourable variance to plan of £166k**.

		Month 10			Year-to-Date			Forecast		
Table 1: Summary Performance	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
Income	(82,904)	(6,641)	(7,315)	(674)	(69,111)	(69,301)	(191)	(82,876)	(82,616)	260
Pay	62,337	4,995	4,739	(256)	52,065	50,026	(2,038)	61,815	59,275	(2,540)
Non Pay	17,004	1,279	2,199	919	14,216	16,257	2,040	17,528	19,539	2,011
EBITDA	**(3,564)**	**(366)**	**(377)**	**(11)**	**(2,830)**	**(3,018)**	**(189)**	**(3,534)**	**(3,802)**	**(269)**
Other Non-Op Costs	2,664	216	230	13	2,231	2,253	22	2,634	2,702	68
Trading Surplus	**(900)**	**(150)**	**(148)**	**2**	**(599)**	**(765)**	**(166)**	**(900)**	**(1,100)**	**(200)**
Sustainability & Transformational Funding	(500)	(58)	(58)	0	(383)	(383)	0	(500)	(700)	(200)
Control Total	**(1,400)**	**(208)**	**(206)**	**2**	**(982)**	**(1,148)**	**(166)**	**(1,400)**	**(1,800)**	**(400)**

3. Income

Table 2 below shows the trust income position by contract:

- The NHS Stoke-on-Trent CCG and NHS North Staffordshire CCG contracts are set on a block basis.
- £93k under recovery on Out of Area Treatments (OATs) due mainly to the underperformance of the sale of substance misuse beds;
- STF is earned quarterly for trusts operating within its agreed control. The total for 2017/18 was originally £500k and is phased 15% for Q1, 20% for Q2, 30% for Q3 and for 35% Q4 plus a further £200k based on matching the increase in the forecast outturn of £1.6m (originally £1.4m). **£383k is reflected at month 10.**

		Month 10			Year-to-Date			Forecast		
Table 2: Income	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
NHS Stoke-on-Trent CCG	(35,817)	(2,826)	(3,048)	(222)	(29,817)	(29,817)	(0)	(35,350)	(35,350)	(0)
NHS North Staffordshire CCG	(24,379)	(1,925)	(2,045)	(120)	(20,293)	(20,293)	(0)	(24,406)	(24,406)	(0)
Specialised Services	(3,311)	(343)	(366)	(23)	(2,644)	(2,714)	(70)	(3,311)	(3,395)	(84)
Stoke-on-Trent CC s75	(3,947)	(329)	(329)	(0)	(3,290)	(3,290)	(0)	(3,947)	(3,948)	(0)
Staffordshire CC s75	(1,056)	(88)	(88)	0	(880)	(880)	0	(1,056)	(1,056)	0
Stoke-on-Trent Public Health	(1,392)	(134)	(145)	(11)	(1,125)	(1,114)	11	(1,392)	(1,396)	(4)
Staffordshire Public Health	(613)	(51)	(51)	0	(511)	(511)	0	(613)	(613)	0
ADS/One Recovery	(1,467)	(100)	(100)	0	(1,222)	(1,222)	0	(1,467)	(1,467)	0
Associates	(756)	(63)	(54)	9	(630)	(539)	91	(756)	(649)	107
OATS	(760)	(63)	(51)	13	(633)	(540)	93	(760)	(680)	80
Total Clinical Income	**(73,498)**	**(5,921)**	**(6,276)**	**(355)**	**(61,044)**	**(60,919)**	**125**	**(73,058)**	**(72,959)**	**99**
Other Income	(9,406)	(720)	(1,040)	(319)	(8,067)	(8,383)	(316)	(9,818)	(9,657)	161
Total Income	**(82,904)**	**(6,641)**	**(7,315)**	**(674)**	**(69,111)**	**(69,301)**	**(191)**	**(82,876)**	**(82,616)**	**260**
Sustainability Transformation Funding	(500)	(58)	(58)	0	(383)	(383)	0	(500)	(700)	(200)
Total Income Incl. STF	**(83,404)**	**(6,699)**	**(7,373)**	**(674)**	**(69,494)**	**(69,684)**	**(191)**	**(83,376)**	**(83,316)**	**60**

4. Expenditure

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

Table 3: Expenditure	Annual Budget £'000	Month 10 Budget £'000	Month 10 Actual £'000	Month 10 Variance £'000	Year-to-Date Budget £'000	Year-to-Date Actual £'000	Year-to-Date Variance £'000	Forecast Budget £'000	Forecast Actual £'000	Forecast Variance £'000
Medical	7,516	620	527	(93)	6,279	5,510	(769)	7,501	6,645	(856)
Nursing	28,077	2,273	2,154	(119)	23,339	22,752	(587)	27,849	27,014	(834)
Other Clinical	14,727	1,222	1,067	(154)	12,274	10,833	(1,441)	14,467	12,852	(1,615)
Non-Clinical	10,944	902	809	(93)	9,147	8,455	(692)	10,926	10,022	(904)
Apprenticeship Levy	214	18	18	(0)	178	177	(0)	214	213	(1)
Non-NHS	858	(40)	164	204	848	2,299	1,451	858	2,529	1,670
Total Pay	**62,337**	**4,995**	**4,739**	**(256)**	**52,065**	**50,026**	**(2,038)**	**61,815**	**59,275**	**(2,540)**
Drugs & Clinical Supplies	2,299	152	174	22	1,913	1,843	(69)	2,299	2,224	(75)
Establishment Costs	1,689	145	125	(20)	1,408	1,244	(163)	1,688	1,514	(173)
Information Technology	582	68	27	(41)	508	700	192	582	751	169
Premises Costs	2,102	180	196	16	1,761	1,852	91	2,102	2,321	220
Private Finance Initiative	4,087	341	353	12	3,406	3,537	131	4,087	4,242	155
Services Received	3,288	233	286	54	2,748	2,869	120	3,288	3,454	166
Residential Payments	1,708	142	182	40	1,424	1,645	222	1,708	2,266	558
Consultancy & Prof Fees	505	68	42	(26)	450	549	99	505	642	136
Unacheived CIP	(1,203)	63	0	(63)	(799)	0	799	(609)	0	609
Other	1,946	(114)	814	927	1,399	2,017	618	1,877	2,124	247
Total Non-Pay	**17,004**	**1,279**	**2,199**	**919**	**14,216**	**16,257**	**2,040**	**17,528**	**19,539**	**2,011**
Finance Costs	1,293	108	108	0	1,078	1,078	0	1,293	1,293	0
Local Government Pension Scheme	0	0	0	0	0	0	0	0	0	0
Unwinding of Discounts	0	0	0	0	0	0	0	0	0	0
Dividends Payable on PDC	561	47	54	7	468	484	17	531	581	50
Investment Revenue	(14)	(1)	(2)	(1)	(12)	(11)	1	(14)	(14)	(0)
Fixed Asset Impairment	0	0	0	0	0	0	0	0	0	0
Depreciation (excludes IFRIC 12)	824	63	70	7	698	702	5	824	843	19
Total Non-op. Costs	**2,664**	**216**	**230**	**13**	**2,231**	**2,253**	**22**	**2,634**	**2,702**	**68**
Total Expenditure	**82,004**	**6,491**	**7,168**	**677**	**68,512**	**68,536**	**24**	**81,976**	**81,516**	**(460)**

Pay

- There is a net underspend on pay of £2,038k year to date mainly due to vacancies across the trust, particularly Other Clinical (£1,441k), Nursing (£587k) and Medical (£769k) being backfilled with agency, bank and overtime where appropriate.

- Agency expenditure is £2,299k year to date, with £790k being attributable to implementation of ROSE (40%).
  - M10 YTD agency is £514k above the agency ceiling.
  - This is mainly driven by agency expenditure for the implementation of ROSE, which is £130k above the planned spend, but within the overall project envelope and locums expenditure which is £244k above plan.

Non Pay

- Residential payments are overspent by £222k year to date. NSCHT are in discussions with the Council to resolve funding shortfalls in 2017/18 and in the 2018/19 contract.

- Consultancy and Professional Fees are overspent by £99k year to date on Trust Board, Strategy and Clinical systems. This is mainly for Consultancy Services around ROSE (£34k – funded by external recharges to NHS Digital), £38k for the Integrated Care Record, £27k on Trust Board for Aqua and £20k for Meridian.

4. Directorate Summary

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

Table 4: YTD Expenditure	Pay			Non Pay			Income			Total		
	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
AMH Community	14,418	13,303	(1,115)	3,718	3,946	228	(1,819)	(1,829)	(9)	16,316	15,420	(896)
AMH Inpatients	5,389	5,440	51	65	320	255	(130)	(121)	9	5,323	5,638	315
Children's Services	5,286	4,764	(522)	514	633	118	(531)	(525)	6	5,270	4,871	(398)
Substance Misuse	2,391	2,295	(96)	796	676	(120)	(415)	(339)	75	2,772	2,632	(140)
Learning Disabilities	4,419	4,016	(404)	264	276	12	(46)	(36)	10	4,637	4,255	(382)
Neuro & Old Age Psychiatry	9,358	9,141	(218)	637	548	(89)	(825)	(886)	(60)	9,170	8,802	(367)
Corporate	10,804	11,069	265	10,454	12,111	1,657	(65,728)	(65,948)	(220)	(44,470)	(42,767)	1,702
Total	**52,065**	**50,026**	**(2,038)**	**16,447**	**18,510**	**2,062**	**(69,494)**	**(69,684)**	**(191)**	**(982)**	**(1,148)**	**(166)**

- 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.
- Other Directorates are underspent, mainly due to the level of trust vacancies.

5. Cost Improvement Programme

The trust target for the year is £3.2m, 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 M10. The Trust wide CIP achievement is 68% at M10 compared to plan.

		YTD M10			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	834	683	(151)	1,084	846	(238)	78%	803	873
AMH Inpatients	379	292	33	(259)	379	56	(323)	15%	49	69
Children's Services	333	256	238	(18)	333	293	(40)	88%	333	333
Learning Disabilities	256	197	199	2	256	258	2	101%	260	260
NOAP	495	381	362	(20)	495	495	0	100%	470	470
Total Clinical	**2,547**	**1,961**	**1,516**	**(445)**	**2,547**	**1,948**	**(599)**	**76%**	**1,915**	**2,005**
Corporate										
CEO	26	20	7	(13)	26	13	(13)	51%	8	23
Finance, Performance & Digital	61	47	57	10	61	69	8	112%	71	71
MACE	62	48	17	(31)	62	20	(42)	33%	22	105
Operations	29	22	28	5	29	34	5	116%	35	35
Quality & Nursing	13	10	11	1	13	14	1	107%	14	14
Strategy (Core)	10	8	13	6	10	17	7	168%	20	20
Trustwide	388	299	0	(298)	388	438	50	113%	1	638
Workforce & OD	61	47	14	(33)	61	36	(25)	59%	21	40
Total Corporate	**650**	**500**	**146**	**(354)**	**650**	**640**	**(10)**	99%	**192**	**946**
Total	**3,197**	**2,461**	**1,662**	**(799)**	**3,197**	**2,588**	**(609)**	**81%**	**2,107**	**2,951**

Below 75%	
Below 90%	

Target	**3,197**
Variance	**(246)**

- The recurrent forecast as at M10 is £2.951m (92%), which represents a recurrent shortfall against the target of £246k (8%). This assumes **£844k to be recurrently** transacted before the 31st March 2018.

- The risk adjusted recurrent forecast, considering schemes not yet transacted, **is £2,475k or 77% against the £3.2m target**

6. Statement of Financial Position

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

Table 6: SOFP	31/03/2017 £'000	30/11/2017 £'000	31/12/2017 £'000	31/01/2018 £'000
Non-Current Assets				
Property, Plant and Equipment	28,037	28,621	29,185	29,371
Intangible Assets	222	252	258	263
NCA Trade and Other Receivables	1,426	1,426	608	608
Other Financial Assets	897	897	897	897
Total Non-Current Assets	**30,581**	**31,195**	**30,947**	**31,139**
Current Assets				
Inventories	88	81	84	84
Trade and Other Receivables	5,146	6,925	7,286	7,122
Cash and Cash Equivalents	6,964	5,825	6,432	5,932
Non-Current Assets Held For Sale	0	0	0	0
Total Current Assets	**12,198**	**12,832**	**13,802**	**13,138**
Total Assets	**42,780**	**44,027**	**44,750**	**44,277**
Current Liabilities				
Trade and Other Payables	(7,472)	(8,387)	(8,933)	(8,305)
Provisions	(333)	(245)	(241)	(228)
Borrowings	(457)	(633)	(633)	(633)
Total Current Liabilities	**(8,262)**	**(9,265)**	**(9,807)**	**(9,166)**
Net Current Assets / (Liabilities)	**3,937**	**3,567**	**3,995**	**3,972**
Total Assets less Current Liabilities	**34,518**	**34,762**	**34,943**	**35,110**
Non Current Liabilities				
Provisions	(474)	(474)	(474)	(474)
Borrowings	(12,189)	(11,708)	(11,670)	(11,632)
Total Non-Current Liabilities	**(12,663)**	**(12,182)**	**(12,144)**	**(12,106)**
Total Assets Employed	**21,855**	**22,580**	**22,799**	**23,004**
Financed by Taxpayers' Equity				
Public Dividend Capital	7,648	7,648	7,648	7,648
Retained Earnings reserve	3,987	4,711	4,930	5,136
Revaluation Reserve	9,323	9,323	9,323	9,323
Other Reserves	897	897	897	897
Total Taxpayers' Equity	**21,855**	**22,580**	**22,799**	**23,004**

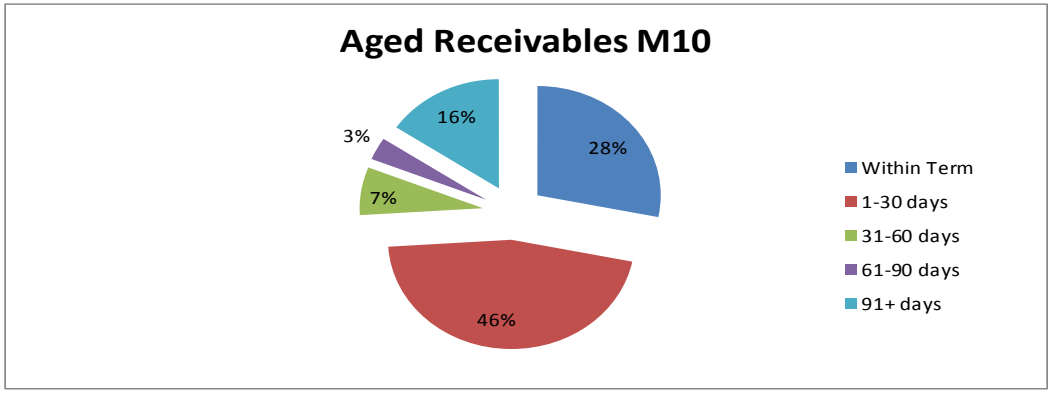
Current receivables are £7,122k, of which:

- £4,178k is based on accruals (not yet invoiced) and relates to income accruals for services invoiced retrospectively at the end of every quarter.
- £2,944k in awaiting payment on invoice. (£2,128k within terms)

£766k is overdue by 31 Days or more and therefore subject to routine credit control processes;

- £3k has been escalated to management /solicitors;
- £763k has not been formally disputed and full payment is

Table 6.1 Aged Receivables/Payables	Within Term £'000	Days Overdue 1-30 Days £'000	31-60 Days £'000	61-90 Days £'000	91+ Days £'000	Total £'000
Receivables Non NHS	193	901	128	64	191	1,477
Receivables NHS	637	446	81	34	268	1,466
Payables Non NHS	569	69	30	62	44	774
Payables NHS	498	103	90	0	10	701

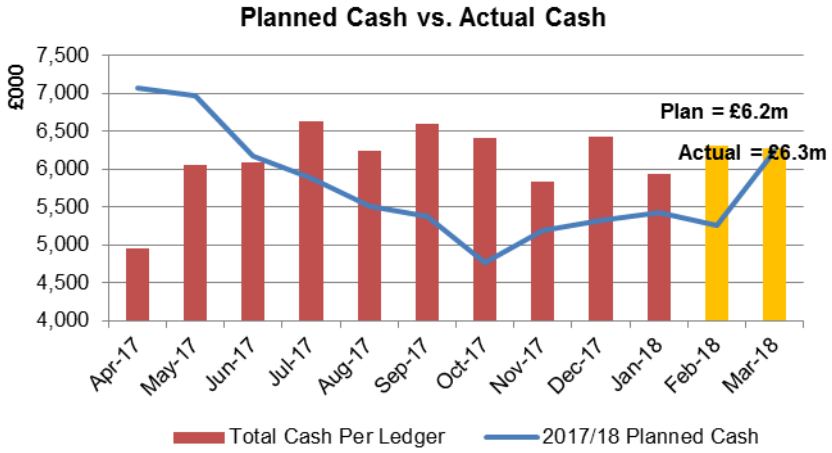


7. Cash Flow Statement

The cash balance at 31st January 2018 has decreased by £0.5m to **£5.932m** due to payments for capital projects (PICU & IT). The Trust cash position at 31st January 2018 is **£0.5m higher than planned** due to slippage in overall capital expenditure**.** The Trust anticipates to be slightly better than plan by March 2018**.**

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

Table 7: Statement of Cash Flows	Apr-17 £'000	May-17 £'000	Jun-17 £'000	Jul-17 £'000	Aug-17 £'000	Sep-17 £'000	Oct-17 £'000	Nov-17 £'000	Dec-17 £'000	Jan-18 £'000	Feb-18 £'000	Mar-18 £'000	Annual £'000
Net Inflows/(Outflow) from Operating Activities	(2,674)	1,184	116	702	(221)	635	121	479	1,201	(128)	438	1,101	**2,954**
Net Inflows/(Outflow) from Investing Activities	(21)	(31)	(45)	(120)	(134)	(237)	(279)	(311)	(554)	(334)	(453)	(673)	**(3,192)**
Net Inflows/(Outflow) from Financing Activities	(38)	(38)	(38)	(38)	(38)	(38)	(38)	(38)	(39)	(38)	(38)	(38)	**(457)**
Net Increase/(Decrease)	**(2,732)**	**1,115**	**32**	**544**	**(393)**	**360**	**(196)**	**130**	**608**	**(500)**	**(53)**	**390**	**(695)**
Opening Cash & Cash Equivalents	**6,964**	**4,232**	**5,346**	**5,379**	**5,923**	**5,530**	**5,890**	**5,694**	**5,824**	**6,432**	**5,932**	**5,879**	
Closing Cash & Cash Equivalents	**4,232**	**5,346**	**5,379**	**5,923**	**5,530**	**5,890**	**5,694**	**5,824**	**6,432**	**5,932**	**5,879**	**6,269**	
Plan	7,064	6,964	6,164	5,889	5,517	5,381	4,756	5,185	5,331	5,430	5,261	6,243	
Variance	**2,832**	**1,618**	**785**	**(34)**	**(13)**	**(509)**	**(938)**	**(639)**	**(1,101)**	**(502)**	**(618)**	**(26)**	



8. Capital Expenditure

The Trust's permitted capital expenditure agreed within the 2017/18 plan is £3,130km. Table 8 below shows the planned capital expenditure for 2017/18 as submitted to NHSI.

		Year to Date M10			Forecast		
Capital Expenditure	Original Plan £'000	Plan £'000	Actual £'000	Variance £'000	Affordability Plan £'000	Actual £'000	Variance £'000
A&T Refurbishment	400	0	0	0	0	0	0
Hazelhurst Unit Development	325	0	0	0	0	0	0
Substance Misuse Additional Beds	125	0	0	0	0	0	0
Place of Safety	0	0	9	9	100	9	(91)
Temporary Place of Safety	0	83	6	(77)	94	113	19
Psychiatric Intensive Care Unit	2,120	1,847	1,460	(387)	2,153	1,861	(292)
E-rostering	102	102	110	8	102	121	19
Information Technology	50	235	248	13	235	248	13
Environmental Improvements (backlog)	120	70	90	20	120	120	0
Reduced Ligature Risks	300	107	7	(100)	200	7	(193)
Equipment	50	0	0	0	0	0	0
Darwin	0	0	84	84	26	84	58
Ward 4	0	30	0	(30)	30	30	0
Lymebrook MHRC	0	43	38	(5)	43	43	0
NOAP Airlock	0	27	0	(27)	27	27	0
VAT Recovery on 2016/17 Schemes	0	0	(1)	(1)	0	(1)	(1)
Dementia Pods	0	0	12	12	0	20	20
BitJam	0	0	(19)	(19)	0	0	0
Fire Alarm System	0	0	0	0	0	34	34
A&T Unit BMS	0	0	0	0	0	13	13
Trust HQ BMS	0	0	0	0	0	12	12
Generator	0	0	0	0	0	24	24
Generator Enabling Works	0	0	0	0	0	38	38
Defibrillators	0	0	0	0	0	36	36
Estates Software System	0	0	0	0	0	0	0
ECT Maintenance	0	0	0	0	0	39	39
LD Beds	0	0	0	0	0	10	10
Upgrade Greenfields Reception	0	0	0	0	0	26	26
AMH Community Vehicle	0	0	0	0	0	24	24
Ward 4 Beds	0	0	32	32	0	32	32
ICT	0	0	0	0	0	119	119
Contingency	100	0	0	0	0	0	0
Total Gross Capital Expenditure	**3,692**	**2,544**	**2,078**	**(466)**	**3,130**	**3,089**	**(41)**
Bucknall Hospital (Part)	(713)	(818)	(818)	0	(818)	(818)	0
Total Capital Receipts	**(713)**	**(818)**	**(818)**	**0**	**(818)**	**(818)**	**0**
Total Charge Against CRL	**2,979**	**1,726**	**1,260**	**(466)**	**2,312**	**2,271**	**(41)**

- The **Operating Plan** as reported to NHSI forecast there would be a total charge against the CRL of £2,599k by month 10, including (£713k) Capital Receipts for the sale of Bucknall Hospital and £3,312k Capital Expenditure.
- **Actual Capital Expenditure** as at month 10 is £2,078k against an updated Capital Expenditure plan of £2,544k
- Contingency schemes have been identified to utilise the forecast shortfall in the capital expenditure in 2017/18.

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 Plan	Year to Date Actual	RAG Rating
Liquidity Ratio (days)			
Working Capital Balance (£000)		3,888	
Annual Operating Expenses (£000)		66,283	
Liquidity Ratio days		18	
Liquidity Ratio Metric	1	1	
Capital Servicing Capacity (times)			
Revenue Available for Debt Service (£000)		3,412	
Annual Debt Service (£000)		1,943	
Capital Servicing Capacity (times)		2	
Capital Servicing Capacity Metric	2	2	
I&E Margin			
Normalised Surplus/(Deficit) (£000)		1,148	
Total Income (£000)		69,684	
I&E Margin		1.65%	
I&E Margin Rating	1	1	
I&E Margin Variance from Plan			
I&E Margin Variance		0.18%	
I&E Margin Variance From Plan	1	1	
Agency Spend			
Providers Cap (£000)		1,829	
Agency Spend (£000)		2,299	
Agency %		26	
Agency Spend Metric	1	3	
Use of Resource	2	2	

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

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 10, the Trust has under-performed against this target for the number of invoices, having paid 88% of the total number of invoices, and paid 94% based on the value of invoices

Table 10 below shows the Trust's BPPC performance split between NHS and non-NHS suppliers.

	2016/17			2017/18 Month 10			2017/18 YTD		
Table 10: Better Payment Practice Code	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**
Number of Invoices									
Total Paid	508	13,183	13,691	59	822	881	550	8,865	9,415
Total Paid within Target	459	11,610	12,069	52	728	780	473	7,804	8,277
% Number of Invoices Paid	90%	88%	88%	88%	89%	89%	86%	88%	88%
% Target	95%	95%	95%	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**-4.6%**	**-6.9%**	**-6.8%**	**-6.9%**	**-6.4%**	**-6.5%**	**-9.0%**	**-7.0%**	**-7.1%**
Value of Invoices									
Total Value Paid (£000s)	6,860	29,380	36,240	639	3,378	4,017	5,873	27,380	33,253
Total Value Paid within Target (£000s)	6,385	27,914	34,299	446	3,283	3,729	5,158	26,096	31,254
% Value of Invoices Paid	93%	95%	95%	70%	97%	93%	88%	95%	94%
% Target	95%	95%	95%	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**-1.9%**	**0.0%**	**-0.4%**	**-25.2%**	**2.2%**	**-2.2%**	**-7.2%**	**0.3%**	**-1.0%**

11. Recommendations

The Trust Board is asked to:

Note:

- The reported YTD surplus of **£1,148k against a planned surplus of £982k**. This is a favourable variance to plan of £166k.

- The M10 CIP achievement:
  - YTD achievement of £1,662k (68%); **an adverse variance of £799k**;
  - 2017/18 forecast CIP delivery of £2,588k (81%) based on schemes identified so far; an adverse variance of £609k to plan;
  - The recurrent forecast delivery at month 10 of £2,951k representing a **recurrent variance to plan of £246k**.
  - A risk adjusted recurrent forecast delivery of £2,475 (77%)

- The cash position of the Trust as at 31st January 2018 with a **balance of £5,932k**; £502k better than plan

- Agency forecast is currently £514k above ceiling (£2,068k)

- Year to date Capital receipts for 2017/18 is £1,260k compared to a net planned capital expenditure of £1,726k;
  - The original operating plan submitted to NHSI in December 2016 planned net capital expenditure of £2,979k by Month 10.
  - Based on the NHSi plan the forecast underspend would be £708k.

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

Approve:

- The month 10 position reported to NHSI.

- Approve the forecast Agency Ceiling breach of £461k.

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO Public Trust Board

Enclosure No:11

Date of Meeting:	22ND March 2018		
Title of Report:	Finance & Performance Committee Assurance Report		
Presented by:	Chair of Finance & Performance Committee		
Author:	Deputy Director of Finance		
Executive Lead Name:	Suzanne Robinson	Approved by Exec	☒

Executive Summary:		Purpose of report	
This paper details the issues discussed at the Finance, Performance and Digital Committee meeting on the 8th March 2018. The meeting was quorate with minutes approved from the previous meeting on the 8th February 2018. Progress was reviewed and actions confirmed from previous meetings.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs X 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 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.X 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	Oversees the risk relevant to the Finance & Performance Committee		
Resource Implications: Funding Source:	None applicable directly from this report		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	There are no direct impact of this report on the 10 protected characteristic of the Equality Act		
Recommendations:	The Trust Board is asked to note the contents of this report and take assurance from the review and challenge evidenced in the Committee.		

North Staffordshire Combined Healthcare NHS Trust

Assurance Report to the Trust Board
Thursday, 22nd March 2018

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

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

Executive Director of Finance, Performance and Digital Update

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

- A presentation updating on the Budget and Financial Plan for 2018/19, supplemented with a detailed paper which detailed the Key Financial Statements, Cost Improvement, Use of Resources and 5 year Capital plan.

  The NHS Standard Contract was agreed on 1st March 2018 with the North Staffs and Stoke CCG totalling, broadly achieving the mental health investment standard of 2.82%. The increase in contract value included national investments, CCG local investments and 2017/18 investments made recurrent.

  The Cost Improvement Target for 2018/19 has been refreshed to reflect changes since the two year operational plan submitted in December 2016. The risk assessed forecast under delivery of recurrent Cost Improvement in 2017/18, offsets any favourable movement in planning assumptions and therefore the 2018/19 CIP remains unchanged at £2.795m.

  The trust is planning to operate within the Agency ceiling of £1.887m and achieve an overall use of resources of 1; the highest possible level.

- The Q3 update from NHS Providers outlining the finance and operational performance figures for the provider sector. Uncommitted STF funding is approximately double the amount reported during the same period last year.

Finance

- **Monthly Finance Report – Month 10**

The Finance position was presented showing a position that is £166k better than plan. This is supported non-recurrently through benefits associated with ROSE implementation.

The trust is on track to achieve a trading surplus of £1.1m, which will allow the trust to attract an additional £200k STF funding in 2017/18. This increases the overall surplus from

£1.4m to £1.8m but does not include any share of remaining national STF funding, which will be agreed in M12 2017/18.

- **Cost Improvement Programme (CIP)**

The Committee received an update for Cost Improvement for month 10 and were concerned that the total identified was still significantly short of the target. £2.951m is currently forecast to be recurrently delivered against the £3.197m target. This is a recurrent shortfall of £246k.

A risk adjusted forecast was presented, considering any schemes that are included in the forecast position but not transacted, which highlighted a c£0.5m risk in the forecast CIP position. This in the main, related to a small number of schemes.

The Committee were assured that there was sufficient focus being placed on Cost Improvement but are unable to give assurance around the ability to deliver the target for 2017/18. The committee also noted a significant risk; that CIP plans were not yet worked up for 2018/19.

Performance:

- **Activity Report**

The report detailed M10 activity against plan using traditional reporting methods and care clustering. The SLA and PbR activity reports are within contract tolerances.

There has been an improvement in the PBR report, particularly for admitted cluster days as a direct result of the impact of data quality improvements made to date. Cluster 99 continues to be over reported due to data quality issues and the committee noted concern that the trend had still not reduced.

Whilst improvements have clearly been made around data quality, the Committee is still not able to give any assurance around the activity reported due to issues with the quality of recording by operational staff.

- **Performance Report (PQMF)**

The report provides the Committee with a summary of performance to the end of Month 10 (January 2018)

The trust has introduced a new Access and Waiting time policy which requires 95% service users to receive an assessment within four weeks. The trust has not achieved this target, however the performance is expected to improve as the new standard is embedded.

Delayed Transfers of Care has improved in month for NOAP and AMH IP, which is thought to be the impact of additional beds being commissioned over winter.

Trust vacancies remain a challenge and have marginally increased for the first time in a number of months.

Other Reports and Updates

The Committee received additional assurance reports as follows:

- Agency Report M10
- Finance, Performance and Digital Risk Register 2017/18
- Business Opportunities (for information)
- FPD Monitoring Schedule (for information)
- Cycle of Business 2017/18 and 2018/19 (for information)

Recommendation

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

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

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REPORT TO OPEN TRUST BOARD

Enclosure No:12

Date of Meeting:	22ND MARCH 2018		
Title of Report:	Register of Board Members – Declarations of Interest		
Presented by:	Laurie Wrench, Associate Director of Governance		
Author:	Lisa Wilkinson, Acting Corporate Governance Manager		
Executive Lead Name:	Caroline Donovan, CEO	Approved by Exec	☐

Executive Summary:	Purpose of report	
The report provides an update as at the 31st January 2018 of current Board members interests given the change in membership since the last report of the 31st December 2017. It is the Trust Board's responsibility to ensure the Trust operates its services in an open and transparent way. In line with the Code of Conduct and Accountability for NHS Board members and the Trust's Standards of Business Conduct Policy this information is published on the website and available for public view.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

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	The register is in line with current legislation		
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:	To receive for assurance and information prior to ratification at Trust Board and uploading to the Trust external website.		

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NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST

REGISTER OF DIRECTORS' DECLARED PRIVATE INTERESTS

As at 31st January 2018

NAME OF DIRECTOR	INTEREST DECLARED
D Rogers Chairman	**Crystal Care Solutions Ltd** Chairman **Staffordshire Wildlife Trading Limited** Director **CQC** Executive Reviewer
T Gadsby Non-Executive Director	**MedicAlert Foundation, British Isles and Ireland** Chairman of Trustee Board **MedicAlert Trading, British Isles and Ireland** Director
P Sullivan Non-Executive Director	**Care Quality Commission** Mental Health Act Reviewer **Health, Education and Social Care Chamber (Mental Health)** Fee-paid Specialist Lay Member of the First-tier Tribunal **HMP/YOI Drake Hall** Member of Independent Monitoring Board
J Walley Non-Executive Director Commenced 01/12/16	**City Learning Trust** Trustee **Burslem Regeneration Trust** Chairperson **Carrick Court Freehold Company** Director
L Barber Non-Executive Director Commenced 01/12/16	**Macmillan Cancer Support with Investment Portfolio in Local Providers** Employee
K Tattum GP Associate Director	**Baddeley Green Surgery Medical Limited** Owner **North Staffordshire GP Federation** Member **Baddley Green Surgery** Senior Partner
J Harvey Staff Side Representative	**No interests declared**

C Donovan Chief Executive	**CQC** Executive Reviewer SRO System CQC Stoke plan **STP** SRO Mental Health SRO Digital SRO OD & System Leadership **HEE** LETB Mental Health Lead
Dr B Adeyemo Executive Medical Director	**Staffordshire University** Honorary Lecturer **WRES** Membership **University of Wolverhampton** Board of Governors **CQC** Executive Reviewer
A Brett Director of Leadership & Workforce (*non-voting*)	**STP System Leadership and OD Workstream** Programme Director
M Nelligan Director of Nursing & Quality	**Hospice of the Good Shepherd** Company Director **University of Chester** Honorary Senior Lecturer **CQC** Executive Reviewer
S Robinson Director of Finance and Performance	**STP Staffordshire and Stoke-on-Trent** Finance Director **CQC** Executive Reviewer
L Wrench Associate Director of Governance	**Wrench Fine Jewellery (t/a Timecraft)** Family Business
A Hughes Joint Director of Strategy & Development	**Joint Director of Strategy & Development** Joint post with North Staffordshire GP Federation **Partners in Paediatrics** Chair **Teenage Cancer Trust** Safeguarding Trustee (Non-Executive Director) **Meant Ltd**

	Owner and Director **Meant Consortium Ltd** Owner and Director **The Village Rainbow Ltd** Owner and Director **Ashbourne Retailers Association** Member **School of the Built Environment, Oxford Brookes University** Specialist Lecturer
J McCrea Associate Director of Communications	**J B McCrea Ltd (Business Partner of Mood International Ltd)** Managing Director **East Leicestershire and Rutland GP Federation** Member of the Board
G Mahadea Non-Executive Director	**General and Medical Accountants Ltd** Owner and Director
Carol Sylvester Acting Director of Operations	**No interests declared**

Guidance issued by NHS England in February 2017 regarding NHS Conflicts of Interest outline the definition for a 'conflict of interest' and this may be *Actual* or *Potential*. Interests can arise in a number of different contexts and fall into the following 4 categories:

Financial interest	Non financial professional interests	Non financial personal interests	Indirect interests
Direct financial benefit from the consequences of a decision	Non financial professional benefit	Personal benefit	Close association with someone who has an interest

7.1.2 Interests which are relevant and material (Standing Orders Policy 4.4)

(i) Interests which should be regarded as "relevant and material" are:

a) any directorship of a company;

b) any interest held by a director in any firm or company or business which, in connection with the matter, is trading with the Trust, or is likely to be considered as a potential trading partner with the Trust;

c) any interest in an organisation providing health and social care services to the health service;

d) a position of authority in a charity or voluntary organisation in the field of health and social care

REGISTER OF ACCEPTANCE OF THE CODE OF CONDUCT AND CODE OF ACCOUNTABILITY IN THE NHS

In November 2007, the Trust Board requested that a formal register of acceptance of the Code of Conduct and Code of Accountability in the NHS is established.

All Directors have provided a signed declaration of their acceptance of the Code of Conduct and Code of Accountability in the NHS to the Trust Secretary

The Code of Conduct and Code of Accountability in the NHS can be viewed on the Department of Health website at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4116281

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REPORT TO Closed Board

Enclosure No:13

Date of Meeting:	22nd March 2018		
Title of Report:	Brandon Centre Closure		
Presented by:	Carol Sylvester		
Author:	Samantha Mortimer Head of Directorate		
Executive Lead Name:	Carol Sylvester, Acting Director of Operations	Approved by Exec	☒

Executive Summary:		Purpose of report	
This report provides the detail upon the steps taken to ensure that quality care is delivered to the residents of Cheadle with the closure of the Brandon centre The report identifies actions taken, collaboration with service users and partners, key risks and challenges		Approval	☐
		Information	☒
		Discussion	☒
		Assurance	☒
Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	01
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee x☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee x☐ • 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	Public concern regarding changes to service provision		
Resource Implications: Funding Source:	Financial Efficiencies obtained of approx 50K		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	There is no direct impact on the protected characteristics as part of the completion of this report.		
Recommendations:	For information and assurance		

Relocation of NSCHT services from the Brandon Centre (Cheadle Hospital site).

Contents

1. Introduction
2. Aims and Objectives
3. Scope
4. Details
5. Challenges and Risks
6. Conclusion

1. Introduction.

The Brandon centre is a satellite service of the Ashcombe Centre providing Adult mental health service provision to the residents of Cheadle. The centre is on the site of the community hospital owned by SSOTP which last year was identified to close as part of a strategy to reduce community beds.
As a result of this potential closure In April 2017 the Adult Community Directorate were tasked with relocating the provision of NSCHT mental health services operating out of the Brandon Centre to an alternative setting.
An initial scoping exercise in 2017 started to consider options potentially available in local primary care settings or within local community centres/facilities that may have been viable options to support the relocation of mental health services from the Brandon Centre. A report on the findings of this exercise was fed back to the Trust concluding that there were limited options available at that time that would not impact upon services users' ability to access services. The directorate continued to source viable alternatives with GP colleagues, the wider primary care facilities and the voluntary sector
A Project Group was subsequently established in January 2018, led by the Service Manager for the Moorlands Community Mental Health Team and an action plan formulated with an ambition that services would no longer be operating from the Brandon Centre site by 28th February 2018.
An action plan has been developed outlining the detailed planning to support each of the 222 patients utilising the varied mental health services delivered.

2. Aim/ Key Objectives

The aim and objectives of the action plan were aligned to the Trusts quality priorities that any service relocation would be Safe, Personalised, Accessible and Recovery Focused.

The aim for NSCHCT was to develop and deliver a project plan that was as minimally disruptive to current service users as possible, that would identify at the earliest opportunity any challenges to relocation and always be mindful of the impact of any proposed changes on service users, carers and staff.

The key objectives were to relocate services from the Brandon Centre site and to use the opportunity to review and modernise the current mental health offer, from one that was predominantly centre based, to one that was more community based and recovery focused.

3. Scope

A database of all service users who would be potentially affected by any proposed changes to the Brandon Centre was developed including the groups/clinics that would be also be affected .

A total of 222 service users were identified in the scope. Many services users would attend the Brandon Centre for multiple appointments/services. Consideration was given to the

service user's home address (location in relation to Cheadle), current registered GP and transport/travel arrangements currently in place, including if carers supported attendance at appointments.

The services in operation affected by the proposed relocation included;

- Consultant Outpatient Clinics
- Medicines Management Clinics (MMC)
- Blood Clinics
- Depot Clinics
- Psychology appointments/ therapy provision
- 1-1 and individual appointments/ Care coordination appointments/ CPA's
- Groups including the Anxiety and Depression Pathway, Art and Breakfast Groups.

4. Details

A local Project Group identified all individuals affected by the changes, developed the action plan, met regularly to oversee the project, deliver on actions and address any challenges as they arose. The project group met for the final time on 5/3/2018 to sign off the project plan and deliver same to the Head of Directorate and Clinical Director for Adult Community Services.

Care coordinators across the team held responsibility for discussing the changes with service users on an individual basis so any concerns could be raised and discussed at the earliest opportunity. All individuals unable to attend a new venue or raising concerns were identified and bespoke care plans were formulated to reflect additional support or input required from the care team to retain fidelity to attendance for appointments and maintain engagement with treatment. This was to ensure that any changes did not adversely impact on those individuals.

The Consultant Psychiatrist for the service wrote individually to all service users affected by the change and encouraged them to feedback and respond if they envisaged any difficulties in the relocation of the Outpatient Clinic. He also wrote to local GP's advising them of changes and seeking support for community/GP surgery based solutions to relocation.

The Nurse Practitioner for the service contacted all the service users attending the MMC and Blood/Depot clinics and encouraged them to feedback and respond if they envisaged any difficulties in the relocation of the Clinics.

The Team Manager and Leads for the Groups met with attendees to discuss changes and identify any overarching concerns / difficulties they may have. Where questions or concerns were raised they were addressed where possible in the group setting and for individuals in 1-1 sessions with their care co-ordinators.

The Service Manager met with Dr Mark Williams (NSCHT Director for Primary Care) to discuss changes and to discuss/seek GP surgery based solutions available across the wider Staffordshire Moorlands geographical area.

The Service Manager worked with local partners Rethink to identify possible solutions for working together in the local community, shared resource and venues for groups and recovery focused pathways of care for individuals moving through NHS Mental Health services and into and out of third sector and voluntary services.

5. Challenges and Risks.

The project group and the wider Community Mental Health Team were mindful that NSCHT have been operating a mental health service out of the Brandon Centre for many years (20yrs +) and that for many service users and their carers, they will have always received their care and treatment from that site and from a centre based service. The project group and wider team understood the need to act swiftly to identify any individuals who they thought would be negatively impacted on by any proposed changes and develop individual care plans with them to mitigate any identified risks and work collaboratively around proposed solutions.

NSCHT service provision and relocation arrangements

NSCHT Services affected	**Relocation/Alternative provision**
Outpatient Clinics	Relocated to the Ashcombe Centre- service users written to directly by Moorlands Consultant without any concerns being raised as to the change in practice
	Community OP clinics taking place at Harewood Park and Church Terrace (for NSCHT service users in placement there) led by wider medical team and Nurse Practitioner. **Provided in partnership and in collaboration with private sector/ care home provider**.
MMC Clinic and Medication services	MMC clinic relocated to Ashcombe Centre- service users written to directly by Moorlands Consultant without any concerns being raised as to the change in practice Medication collections- relocated to Ashcombe or delivered to service users as part of care plan/home visit Medication collections by care home providers now realigned to the Ashcombe centre or delivery when required via OP/NP clinic. Polar Speed realigned to Ashcombe Centre
Bloods Clinic	Relocated to the Ashcombe Centre- service users written to

	directly by Moorlands Consultant without any concerns being raised as to the change in practice Clozaril service (and CPMS registration) aligned to the Ashcombe Centre
Depot Clinic	Relocated to the Ashcombe Centre Care Plan and Care Coordination re-aligned via caseload management to a CPN caseload and now delivered in the community or at a service user's home as required.
Psychology Service	Relocated to the Ashcombe Centre
Anxiety / Depression Pathway Group	Relocated to the local Conservative Club- as an alternative venue/ community setting in Cheadle- less than 0.5 mile from Brandon Centre current site **Provided (at reduced cost) to NSCHT via partnership links/contacts within the local community.**
Social Contact Groups	Relocated to Holbrook House- (on the Cheadle Hospital site where Brandon Centre is located). This is a Rethink property /service base. **Provided in partnership and in collaboration with RETHINK (Staffordshire Moorlands)**
1-1 appointments/ care co-ordination. (CPA)	Individual care plans to be formulated and reviewed by care coordinators and care team to provide services that are bespoke and aligned to service user requirements and in line with recovery focused service provision. The Ashcombe Centre, community setting, home address- all available options identified.

6. Conclusion

To date, 1 service user and 1 carer/family member (on behalf of a service user) has contacted the local team to express concern as regards the relocation of services. Both concerns have been discussed and individual's issues resolved through the teams managers and individual care co-ordinators.

Wider public involvement /engagement with the project would have been preferable. The service manager looked to attend the local Moorlands Information Group however it is our understanding that this meeting was cancelled and we are working with the Trust Patient Experience Lead as regards the future of the meeting or alternative opportunities for the team to engage with the wider public.

Moving forward we will work collaboratively with our local GP community to evolve mental health services into a provision more aligned with the local and national direction providing local services centred on a natural community, in partnership and collaboration.

A review is now underway on the Ashcombe environment to support the service need and evolving service requirements and will be reported back through the directorate.

On-going monitoring and feedback from all individuals affected by the service relocation will be via their individual care coordinator and where necessary escalated through the team's Multi-disciplinary Team meeting held weekly and/ or to team managers directly.

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REPORT TO TRUST BOARD

Enclosure No: 14

Date of Meeting:	22nd March 2018		
Title of Report:	PCD Summary		
Presented by:	Lorien Barber, Non-Executive Director		
Author:	Alex Brett, Executive Director of Workforce, OD and Communications		
Executive Lead Name:	Alex Brett	Approved by Exec	☒

Executive Summary:	Purpose of report	
A summary of the People & Culture Development Committee meeting held on Monday 5th March 2018 and chaired by Mrs Lorien Barber. It received a number of reports for assurance and approval including: • Committee Review • Director of Workforce, OD & Communications Update • Board Assurance Framework • Workforce Strategy • Staff Story • Towards Outstanding Update • Directorate Workforce Performance • Dying to Work Charter • Staff Survey Results • Gender Pay Gap • Recruitment & Retention Update • Exit Interview Update • Workforce and OD Risks • Policies for approval	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 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. 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. Risk 900 – There is a risk that the Trust does not provide inclusive services that recognise the diverse nature of our service users, therefore services may not be accessible or of sufficient quality. 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 1034 – There is a risk that staff are not effectively engaged, do not have sufficient clarity of purpose and do not realise their potential through not having an up to date PDR. This can adversely affect their ability to work efficiently and effectively and impacting upon delivery of services. Risk 1072 – There is a risk that staff may not be accessing clinical supervision on a regular basis to ensure that professional responsibilities and as a result may not feel supported in practice.
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
Recommendations:	The Board are asked to approve the policies identified and receive the summary for assurance.

Summary to Trust Board
People & Culture Development Committee
Monday 12th March 2018, 9.30 – 12.20pm

The meeting was chaired by Mrs Lorien Barber.

1. Staff Story

The Committee received a very moving staff story from a BAME staff nurse with an obvious passion to care working within the NOAP directorate. The story raised issues about how our BAME colleagues are supported as they work with patients and staff. The staff member felt there were not equal opportunities for development and training; unsupported by some colleagues and felt she had been ostracised during mealtimes. When asked if there were sufficient opportunities for BAME bank staff to join the Trust permanently, it was felt that their experiences were often discouraging them from doing so. When the staff nurse was asked what would help, the main area to address that would support a drive to change the culture was the recruitment and retention of permanent staff. Awareness training is also a valuable tool to enable staff to start to confront the issues and work together for the same purpose.

The staff member was assured that the Committee and Trust is prioritising this area of work, and would work with teams to educate them as part of the Staff Survey action plan and WRES findings.

2. Committee Review

The Committee's review is on hold pending a meeting to review the committee with the CEO and Chair. Following this meeting on April 17th which will review the findings of the AQuA Well Led Development review, the business focus, Terms of Reference and Cycle of Business which will be refreshed.

3. Director of Workforce, OD and Communications Update

The Committee was updated on the following issues:

- National campaign on nurse recruitment
- Potential pay rise for NHS staff
- Proposed review of the Clinical Excellence Awards- Consultant contract

4. Locality Working

The Committee noted that the Board had received the locality working presentation. Engagement at various Trust team meetings and forums was now ongoing on the geographical locality structure. Phase 1 will engage senior management and Phase 2 the clinical teams; the Committee will be kept updated and a paper submitted to Board in April after which time the Management of Change for the senior management group will commence.

5. Board Assurance Framework

The Committee reviewed the performance against the 2017/18 BAF at Quarter 3.

There remain some challenges on delivery at Quarter 4 for apprentices and engaging and retaining staff. Work continues to embed and strengthen the values and behaviours framework, and favourable progress has been with social media engagement.

The 2018/19 BAF is being prepared and will be reviewed at Board Development on March 14th before being circulated electronically and submitted to the April Board. Greater emphasis will be placed on the Board Assurance Framework to inform the PCD Committee agenda moving forward.

6. Workforce & OD Risks

A number of risks are monitored and reviewed through the Committee. The current risks have been identified and mitigation plans are in place for:

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. Risk to remain at 16 until a more stable period ensues.

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. Risk to remain at 12.

Risk 900 – There is a risk that the Trust does not provide inclusive services that recognise the diverse nature of our service users, therefore services may not be accessible or of sufficient quality. Risk to remain at 12.

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 to remain at 12.

Risk 1034 – There is a risk that staff are not effectively engaged, do not have sufficient clarity of purpose and do not realise their potential through not having an up to date PDR. This can adversely affect their ability to work efficiently and effectively and impacting upon delivery of services. Risk to remain at 12.

Risk 1072 – There is a risk that staff may not be accessing clinical supervision on a regular basis to ensure that professional responsibilities and as a result may not feel supported in practice. Risk to remain at 12.

It was noted that the Integrated Locality Working programme will need to be added as a separate risk.

7. Performance Reports

The Performance metrics at Month 10 were reviewed by the Committee. Agency spend and Locums remain a key area of focus, however the Workforce Team are appointing to the post of Recruitment and Resourcing Lead which will provide a more proactive approach to recruiting to medical and nursing vacancies in particular. It was noted that the vacancy rate has increased slightly. Clinical supervision compliance had improved with all teams working hard to bring this metric back in line. The Director of Nursing is also undertaking a piece of work separately and alongside this to determine what we are classing as supervision, once completed it is hoped this will improve compliance rates further.

The Committee also considered and agreed the request to reduce the metric compliance rate for PDR and Supervision to 85%, this will ensure the Trust is in line with other organisations.

8. Workforce Metrics

The Committee was updated by exception. It was noted that normal winter pressures were starting to impact on compliance but that the Trust was in a better position than last year. Statutory/Mandatory training compliance was excellent, and the work undertaken to achieve this improvement was commended. Vacancies were mitigated at 4.9%, which is an excellent benchmark position both regionally and nationally.

9. Towards Outstanding

The Committee was provided with a progress update on the 16 teams that constituted Cohort 1 of the Towards Outstanding Engagement programme. The programme has 9 enablers of engagement and looks to support change in culture at a local level.

The teams that took part are as follows:

- Access and Home Treatment
- Community Learning Disability
- Darwin Centre CYP
- Estates
- Finance
- Greenfields
- Lymebrook
- County Older Persons CMHT & County Memory Service
- Performance
- Pharmacy
- Ward 1
- Ward 6
- North Staffs Community
- North Stoke CAMHS
- North Staffs CAMHS
- Organisational Development & Learning

The engagement scores from Cohort 1 clearly show the Towards Outstanding Engagement programme has been a success and is having positive impacts on engagement. Next steps will include sharing the results at a celebration event, date to be confirmed.

Cohort 2 will be rolled out in September/October 2018 after the locality structures are in place.

10. Dying to Work Charter

The Committee was updated with regard to compliance with the Charter. The Charter will be signed off in the presence of MP Mr Jon Ashworth at Board on March 22nd. It was noted that the Charter will support the revised Supporting Attendance at Work policy.

11. Staff Survey Results

The Committee noted the 2017 Staff Survey results.

The response rate for North Staffordshire Combined in 2017 was 51.8%, consisting of 706 responses from a useable sample of 1363.

- The national average for all NHS Trusts was 45% in 2017
- The national average for mental health trusts was 54.0%

- North Staffordshire Combined response rate for 2017 is 52% (an increase from 51% in 2016)

This year, the Trust chose to undertake the survey using only paper surveys.

Notable improvements show:

- 21 out of 28 categories we were average or better than average
- 10 categories ranking better than average
- 91% of staff believe the organisation provides equal opportunities for career progression or promotion
- The Trust scores highly on staff believing we act on service user feedback effectively

There are no statistically significant reductions in our scores compared with last year.

Areas that we will continue to work on improving include:

- Staff being able to contribute toward improvements at work
- Staff agreeing that their role makes a difference to service users
- Staff feeling confident in reporting unsafe clinical practice
- Improving the experience of our Black, Asian and Minority Ethnic (BAME) staff

The Staff Survey Trust-wide action plans will continue to be monitored at PCD and Directorate actions plans through SLT.

12. Gender Pay Gap

The Committee noted that under new legislation, all employers with more than 250 employees are now required to calculate and publish their gender pay gap information each year on both the Government's website and our own. As a public sector organisation the Trust must publish our gender pay information before 30th March 2018. PCD discussed the findings of this and notes that further work needs to take place, particularly around Clinical Excellence Awards for medics.

13. Recruitment & Retention Update – Incentives Paper

The Committee noted that there remains an ongoing challenge in recruiting professionally registered Mental Health Nurses and Medical Consultant Posts within the Trust and indeed nationally. The Committee received an update on the Trust's current performance in terms of reported vacancy and turnover position; the positive steps taken over the last 12 months to improve the vacancy/recruitment process; reduce staff turnover and an overview of the future schemes planned to continue this work.

A number of non-financial schemes are being explored and actioned to encourage both recruitment of new staff and retention of our current workforce.

14. Exit Interviews

The Committee noted that in January 2018 the Trust had a reported rolling 12 month turnover of 12.98% which is marginally favourable compared to 13.8% in January 2017. In the last 12 months 194 staff has left the Trust. The top two reported highest reasons for leaving are voluntary resignations and retirements. An Exit Interview process was

implemented in 2015/16 which consists of a link being sent to leavers during their notice period to complete a questionnaire via survey monkey.

To fully understand the unknown reasons for staff leaving the Trust a more detailed review is currently being undertaken by the HR Team who are contacting all leavers for their feedback. Feedback is expected to be available by the end of March/early April and following analysis results will be reported in due course allowing further consideration on additional schemes to improve recruitment and retention within the Trust.

15. Policies

The following policies were approved by the Committee and the Trust Board are requested to approve it:

- Supporting Attendance at Work
- Induction Policy
- Roster Management Policy

The following policies were agreed by the Chair electronically and will be submitted in full to the Committee in May 2018:

- Learning & Development Policy (agreed extension until the end of April 2018)
- Smoking Policy (agreed extension until May 14th 2018)

16. Date & Time of Next Meeting

- Monday 14th May2018, at 9.30 am, Boardroom, Trust HQ, Lawton House, Trentham

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REPORT TO TRUST BOARD

Enclosure No:15

Date of Meeting:	22nd March 2018		
Title of Report:	Summary of the Audit Committee held on 8th March		
Presented by:	Gan Mahadea, Chair / Non Executive		
Author:	Laurie Wrench, Associate Director of Governance		
Executive Lead Name:	Suzanne Robinson	Approved by Exec	☒

Executive Summary:	Purpose of report	
This report provides a summary of the key headlines from the Audit Committee held on the 8th March 2018. The full papers are available as required to members.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☒ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • 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	To ensure that the committee meets its terms of reference by receiving reports of the work of its sub groups		
Resource Implications: Funding Source:	n/a n/a		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	n/a		
Recommendations:	Receive for information and assurance purposes		

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Assurance Report of the Audit Committee

8th March 2018

Board Assurance Framework – Q3

The committee received the Board Assurance Framework Q3. The BAF aligns the Trust's new strategic objective to the quality priorities and key risks. The BAF provides details of the key control and assurances to ensure delivery of the seven strategic objectives.

The committee received an update against each strategic objective and noted good progress made against most.

The deliverables rated as red are as follows and are linked into the Risk Register:

- Smoke free
- Vacancies and Recruitment
- Mental Health compliance
- Talent Management
- Agency Spend
- Our recurrent CIP

The BAF for this year includes a stretch target RAG rating to help to acknowledge assurances that are more challenging. The committees and board have oversight on the delivery of the BAF.

Risk Assurance Report

The committee received this report which provided information and assurance regarding the systems and processes used within the Trust to manage risk. The committee noted positive feedback within the inspection report relating to risk management and the Board Assurance Framework. Additionally, RSM recently completed a review of the risk management framework across the organisations and awarded a statement of substantial assurance with no further recommendations.

Audit Recommendations – Progress Report

The committee received the report detailing the Internal Audit actions and progress in terms of implementation as of March 2018.

The Audit Committee noted the following:

- 16 Actions have been successfully implemented since the last audit committee.
- 36 Actions are not yet due.

Extensions were granted for 3 audit recommendations as follows:

- Reference 2.1 - fraud extended to 31 March due to transitional period of new auditors
- Reference 3.4.1 - Home office presentation – extended to 31 March as incorrect

presentation delivered by internal audit
- Reference 1.1.1 - Ligatures - Actions are all complete – request for extension to allow review by Quality Committee

Freedom of Information Report Q3

The committee received the FOI report for Q3 and noted a slight dip in requests from Quarter 2 but noted the number of requested were still higher than the same quarter in 2016/17. The committee noted the recommendations introduced to ensure the 20 day deadline for response was achieved including an enhanced FOI section on the external website to incorporate a supportive of list of links to key documents.

Further Reports Received:

The committee received the following reports:
- Annual Governance Statement
- Quality Account Project Plan
- Well-led Review – Committee Effectiveness and KLOE Action Plan

Policy Approval

The following policy was approved for 3 years:

- Policy for the development and management of Trust-wide procedural / approved documents

The committee ask for final ratification by the Board

RSM Internal Audit Progress Report

RSM Internal Audit presented this report which included the agreed action plans in respect of the finalised reports since the last Audit Committee meeting.

In terms of delivery, 5 reports have been finalised with executive summaries and action plans as follows:

- Cost Improvement Programme (CIP) – Quality Impact Assessment and Monitoring - Partial Assurance
- Payroll - Substantial Assurance
- Information Governance Toolkit - Advisory
- Risk Management - Substantial
- Follow Up – Phase 2 - Good Progress

GDPR Readiness - Advisory. The committee noted that the Trust maintains a GDPR Action Plan, in order to track and monitor the update to the Trust's systems and policies to ensure compliance. The committee noted the particular challenge with regards to achieving 95% compliance with GDPR training. In addition the committee noted that the trust Chief Information Officer had been appointed as Data Security Officer however further consideration will be given to this appointment to ensure the role is independent and this will be reflected in a future iteration

of the action plan.

Internal Audit Plan 2018/19 (KPMG) and LCFS Audit Plan 2018/19 (KPMG)

The committee received the new audit plan from KPMG for 2018/19 and were advised that the final plan would be presented at April's Audit Committee. The committee noted that the plan spanned three years and were advised that the plan is flexible in terms of changing priorities.

In terms of the LCFS plan, there are three mandated areas:

- Employment checks
- Mandate fraud
- Pre-contract procurement

Ernst and Young External Audit Plan 2018/19

Ernst and Young presented the external audit plan for 2018/19 and highlighted the following key areas:

- Overview of the strategy and key risks
- Value for money work
- Audit materiality

Agreement of Annual Accounts Process and Timetable

The committee received the annual accounts process and timetable for information purposes

Waivers over £20k Report

Members noted the report and that there were five waivers issued in Q3 and noted the low number of waivers received.

Standing Business Items:

As per standing business items, the committee received the following:

- Summary of the Quality Committee – 21 December 2017 and 8 February 2018
- Summary of the Finance, Performance and Digital Committee – 11 January and 8 February 2018
- Summary of the People and Culture Development Committee - 15 January 2018
- Summary of the Business Development Committee – 16 November 2017 and 11 January 2018
- Minutes of the Information Governance Steering Group – 6 November 2017 and 29 January 2018
- Minutes of the Data Quality Forum – 20 November 2017, 18 December 2017 and 11 January 2018

Laurie Wrench

Associate Director of Governance on behalf of

Mr Gan Mahadea, Chair and Non-Executive Director

15th March 2018

NHS
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REPORT TO Open Trust Board

Enclosure No:16

Date of Meeting:	22.03.18		
Title of Report:	CQC - Action Plans		
Presented by:	Laurie Wrench		
Author:	Laurie Wrench		
Executive Lead Name:	Caroline Donovan	Approved by Exec	☒

Executive Summary:		Purpose of report	
The action plans in relation to the most recent CQC inspection were shared with the CQC 9th March 2018. The action plans address the 'must' and 'should' do requirements as highlighted by CQC. The action plans demonstrate considerable progress made in addressing the issues raised.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☒ Execs ☐ Date: 27.02.18	Document Version No.	1
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	Failure to implement improvements could result in risk to quality of service provision.		
Resource Implications: Funding Source:	None		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	Diversity and Inclusion is a significant consideration for the CQC when assessing the quality of services		
Recommendations:	That the Board receive the action plans for information and assurance.		

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

Corporate CQC Action Plan
Well-led Inspection October 2017

VERSION CONTROL			
Version	Date	Author	Description of Change
1	8/12/17	Zoe Grant (Quality Assurance and Improvement Manager)	Initial draft of document
2	30/1/18	Zoe Grant (Quality Assurance and Improvement Manager)	Updated following receipt of draft reports
3	30/1/18	Zoe Grant (Quality Assurance and Improvement Manager)	Added additional Trust wide actions (from core service plans)
4	5/2/18	Zoe Grant (Quality Assurance and Improvement Manager)	Meeting and updates added with Alex Brett and Buki Adeyemo
5	12/2/18	Zoe Grant (Quality Assurance and Improvement Manager)	Progress added
6	8/3/18	Zoe Grant (Quality Assurance and Improvement Manager)	Progress update

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

No.	Issue / Concern	Intended Outcome	Action to be taken	Due Date	Responsible officers		Assurance/ Evidence	RAG	Expected Completion Date
1. Trust 'MUST Do' Actions									
1.1	The trust must ensure that topical medicines are clearly labelled for the use of single patients to reduce infection risks and that opening dates of medicines are monitored. **MUST DO Requirement relates to:** *Adult Inpatient wards* *Older Persons Inpatient wards.*	The Trust will have robust system in place which ensures that labels for single patient use are routinely applied and opening dates routinely recorded.	• A review of the current process to take place to ensure that it is satisfactory. • The ISM matrix has been updated to reflect a review of any prescribed topical medicines for individual patients to ensure that nursing staff remain vigilant of the standard requirements – audit findings will be available in March 2018. • An audit tool and protocol has been developed for the pharmacy team and accepted by the Chief pharmacist. • The pharmacy team will complete an audit of all topical medicines on a weekly basis (2 weekly in specified areas) during the ward stock review. • The pharmacy team will record the audit results, ensure that any deficits from the standard are addressed and will report outcomes on a monthly basis to the Senior Operational Team meeting. • Medicines Management Training will be reviewed and updated to ensure any CQC identified issues are addressed via the training	**31/3/18**	**Exec Lead** **Buki Adeyemo**	**Operational Lead** **Louise Jackson**	Process reviewed and Audit protocol devised to be led by Pharmacy. V1 - Pharmacy led - quality assurance auc **2nd March 2018** Pharmacy Audit – 100% (W/C 19th Feb) 16th Feb - Pharmacy Audit.docx **14th February 2018** Modern Matron audit of Acute Inpatient Wards – 100% compliance.	**G**	

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

1.2	The trust must ensure that staff follow medicines management processes properly to ensure that fridge temperatures are not outside of the recommended safe range so that medicine is safe to use. **MUST DO Requirement relates to:** *Adult Community for working age adults.*	The trust will purchase a technological system which will ensures that fridge temperatures are systematically monitoring, with alerts directed to the pharmacy team when they have been detected as being out of range.	• To scope technological options with consideration to purchasing systems that automatically alerts the pharmacy when a fridge has gone out of the recommended temperature range. • Interim assurance will be provided by the Pharmacy until a new system has been purchased and in place. The team will have weekly oversight of all fridge monitoring checks; any deficits to the standards which are expected will be overseen by the pharmacy team until who will remain responsible for ensuring that appropriate action has been taken to resolve the issues. • Roll out of new system will include full review and update of the Trusts policy and protocol. • A paper regarding the Fridge temperature centralised monitoring options, along with proposed costs was presented to the Senior Operating Team meeting on 14th February 2018. Business Case ward temperature monitirin • A request to finance the system is being progressed through the Trusts Capital investment group (7th March 2018)	**31/3/18**	**Buki Adeyemo**	**Louise Jackson**	The Adult Community team are gaining assurance via the directorate's quality forum. Each service manager is responsible and reports the assurance to the quality forum – 100% compliance reported at last forum (5th March 2018). Pharmacy wide assurance obtained and latest assurance is 100% compliant as at 8th March 2018.	**G**	
1.3	The Trust must ensure that staff regularly check and record that emergency equipment is safe to use for the care and treatment of patients. **MUST DO Requirement relates to:** *Adult Community for working age adults.*	The Trust will have a robust system in place which ensures that emergency equipment is systematically monitored with any issues being addressed immediately.	• Assurance monitoring audits put into place to ensure that equipment is routinely checked.	**Complete**	**Maria Nelligan**	**Dean Burgess**	The Adult Community team have developed a protocol with service managers accountable for assurance which is reported through the directorates quality forum – 100% compliance at last forum (6th March)	**G**	
2. Trust 'Should do' Actions									

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

2.1	The trust should ensure regular formal supervision and appraisal across all staff groups. **SHOULD DO Requirement relates to:** *All core services*	The trust will consistently achieve 85% compliance in supervision and appraisal across all staff groups.	• Systems will be reviewed to ensure that all staff groups supervision and appraisal rates are reported through current reporting structures (this includes Medics and AHPs). • A review of the Trust policy is underway to ensure that there is Trust clarity regarding what constitutes Supervision.	**1st April 2018**	**Alex Brett**	**Jane Rook**	Latest Supervision compliance end Feb 2018 - 86% Latest PDR compliance end Feb 2018 – 87%	**G**	
2.2	The trust should ensure Equality Impact Assessments are routinely undertaken for all relevant decisions.	All relevant decisions will be made in line with a robust Equality Impact Assessment.	• Guidance will be available which outlines which decisions are likely to require an Equality Impact Assessment. • There will be an efficiently designed pathway in place to ensure that EIA's do not course unnecessary delays in the decision process.		**Alex Brett**	**Lesley Faux**	Review of the Trust's approach to EIA by the end of April 18. Programme of work (to embed best practice working with the Equalities Lead, NHS England) defined with key milestones: • Guidance document in production with key stakeholders to support decision making in EIA and the process for undertaking this by the end of **May 2018** • Communication and training plan will be rolled out to ensure this information reaches all key decision makers through the Trust and the opportunity for support and buddying in relation to conducting an EIA • Audit and reviewed after 3, 6 and 9 months (i.e. reports to be produced in **Sept 2018, January and April 2019**). The results of these reviews will be shared with PCD and SLT. PCD is the lead committee responsible for D&I	**G**	

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

2.3	The Trust should ensure equality representation on service user council and within its engagement networks.	The Service User Council will be adequately represented from an Equality and Inclusion perspective.	• To continue to actively encourage service user and carer involvement, which demonstrates equality and inclusion as an ongoing trust priority. • The Trust Equality and Diversity group has a representative from the Service User and Carer Council • The Trust Equality and Diversity group has the trust Patient Experience lead as a member	**Complete**	**Maria Nelligan**	**Julie Anne Murray**	The invitation to be a member of the council is open and people from all protected characteristics have equal opportunity to attend. The trust also has a young persons and carer council. We remain committed to being a values-based, diverse/inclusive organisation providing positive experiences for all people who we come into contact. Some examples are: 1. All staff attending Trust Induction are trained to say 'Hello my name is.' using BSL 2. 'New Horizons #Discover Your Future' One-Stop Recruitment Events campaign encouraging people with diverse backgrounds to consider applying to work with the Trust. 3. Stonewall Diversity Champion providing better experiences for LGBT service users and staff. 4. Stoke Pride Festival The Staffordshire Symphony of Hidden Voices is a series of activities/online places we created where seldom heard perspectives on mental health can engage with us and each other. The Symphony also included a live social 'word cloud', allowing all voices to be heard equally. We have been contacted by NHS Employers praising us as an exemplar of leading practice.	**G**	

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

2.4.	The Trust should ensure there is a process for the review of Mental Health Act manager's suitability for the role following each three year contract.	All MHA managers receive a review of their suitability to remain in the role every 3 years.	• A full discussion regarding this issue was led by the Chairman at the Associate Hospital Managers Forum in November 2017. • An agreement was reached that the Chairman and one of the NED's would meet with each of the current Associate Hospital Managers once a year. • Support and supervision proforma will be developed to maintain a written record of the session for assurance purposes	**Complete**	**Buki Adeyemo**	**Sandra Storey**	The formal process has been agreed; the Chairman or Non-Executive Director will provide sessions with each one of the Associate Hospital Members: the sessions are supportive sessions giving opportunity to discuss; concerns, development/training needs, etc. Any issues raised during a hearing are already discussed with the panel / mental health act administrator and issues from this are taken to the Associate Forum.	**G**	
2.5	The Trust should ensure robust processes are in place for the administrative receipt and scrutiny of Mental Health Act detention papers for out of hours admissions.	The process for scrutiny of Mental Health Act papers out of hours will be that same as the process in hours.	• The Mental Health Act scrutiny check list will be made available to the individuals responsible for receiving MHA papers out of hours. • A clear standard operating procedure will be developed which gives guidance of how to complete the checks to ensure that they are appropriately scrutinised.	**31.3.18**	**Buki Adeyemo**	**Sandra Storey**	The checklist has been issued to all DSN's (They are responsible for receiving papers out of hours). This checklist was already in operation within hours and managed via the MH law managers. Scrutiny checklist and guidance issued to the DSN's. Scrutiny checklist - Sections version 2.do In addition the MH Law managers will offer additional scrutiny to the papers that are accepted out of hours.	**G**	

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

2.6.	The Trust should ensure systems of assurance for embedding learning and changes in practice from serious incidents are robust.	There will be fully embedded systems which clearly demonstrate learning and assurance of actions following SI incidents.	• Lessons learned will be clearly evident within the right section of the SI investigation report. • Action plans are signed off at the CSIG meeting. • The Head of Patient Safety will seek evidence of robust assurances before action plans are signed off as completed. • There will be a quality governance process in place which gives additional scrutiny to the assurance process. • The SI condolence letters will be reviewed to ensure that relative involvement in the investigation TOR is clear to them. • The RCA form will be updated to ensure that: o There is evidence to confirm Patient / Carer involvement within the TOR of SI's with a clear explanation evident if there has been no involvement. o The lessons learning will be explicitly referenced within the report, highlighted what action is being taken to disseminate the learning.	**31/3/18**	**Buki Adeyemo**	**Julie Anne Murray**	To be presented to CSIG and ownership of associated actions to be managed via this group**.** Lessons learned discussed at CSIG 12th February 2018, the lessons learned lead will incorporate all lessons from each SI in the monthly report accessible by all trust staff. TOR and SI report structure for lessons learned discussed at CSIG on 12th February 2018 and agreed. The Head of Patient Safety will maintain an evidence database which reports the assurance obtained. All assurance will be reported through the CSIG and the head of patient safety is responsible for ensuring that assurance is robust and up to date. Letters have been reviewed and a template issued to all directorates and agreement obtained to use these going forward. The RCA documentation has been amended to reflect the required actions. There will be an annual audit carried out by the Trusts audit team as additional assurance that SI actions are fully met.	**G**	
2.7	The Trust should consider completing periodical Disclosure and Barring Service checks after recruitment of front line staff in long term employment to ensure external corroboration of staff's self-disclosure processes.	The Trust will be compliant with the DBS standards as outlined in the NHS employer's guidance.	The Trust has challenged this issue in the CQC factual accuracy response due to being compliant with the NHS employer's guidance.	**Complete**	**Alex Brett**	**Kerry Smith**	**NHS employers guidance states:** '*Employers are not legally required to obtain periodic or retrospective checks on existing members of staff who remain in the same role for the full term of their employment, although this may be required under local policy'.* The CQC have accepted that the Trust are compliant with National Guidance.	**B**	**Complete**

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

2.8	The Trust should consider improving staff and vacancy management timeliness for all professions.	The Trust will provide evidence that recruitment and vacancy management processes have improved and this improvement has been sustained since the CQC inspection.	• The Trust is implementing the TRAC system which is intended to support the reduction in recruitment times to a minimum is 12 weeks. • Comprehensive TRAC reports available via SLT performance meeting and SOT.	**1.4.18**	**Alex Brett**	**Kerry Smith**	The number of jobs reaching authorised to start in January 2018 doubled from the previous month to an average of 11.12 weeks to complete. Vacancies are reducing month on month as a result of practice recruitment exercises. The Trust is currently recruiting to a Recruitment and Resourcing lead to provide dedicated, proactive leadership and focus to the service.	**G**	

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

2.9	The Trust should consider exploring methods of engagement for professionals who feel isolated and of low morale.	The Trust will have systems and processes in place which are actively supporting engagement throughout the Trust.	• Go engage is operational with 16 teams currently in the first wave. • Outcomes from the 1st wave are shared on 21st March 2018. • 2nd wave is due to commence in April. • There is a bespoke programme of work underway with medical staff, led by the Medical Director and with support from OD. • There is a bespoke programme of work underway with AHP staff, led by the Nursing Director.	**1ST April 2018**	**Alex Brett**	**Jane Rook**	The average variance of engagement scores for teams going through cohort 1 shows an average increase of 5.7% 12 of the 16 teams saw an increase in their engagement scores Staff survey results demonstrate year on year incremental increases in engagement: from 3.73 in 2016; to 3.76 in 2017 Targeted engagement exercises with professional groups who have fell isolated such as: **Medical Staff**: Additional engagement days scheduled quarterly with the medical Director, Trust Board Chair, Chief Executive and Director of Leadership and Workforce, co-production of a Medical Strategy and launch of a clinical leadership programme. **AHPs**- through focussed work by the Director of Nursing and Quality • There is an AHP Trust wide Lead who provides professional leadership across the Trust. • There is an AHP Network who has developed the AHP strategy, this will be implemented through the network and monitored via an action plan. • The new professional structure for the Trust will include Band 7 AHP Leads in each of the new directorates to further strengthen professional leadership and engagement. • AHPs hold an annual continuing professional development conference.	**G**	

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

2.10	The Trust should consider ensuring full evaluation and the engagement of the workforce when embedding the new electronic patient record.	Workforce engagement is evidenced throughout the Lorenzo roll out and ROSE improvement plans.	• The Trust has trained 98% of the clinical EPR users within the Trust. • The Trust have 146 super users all situated within clinical teams to help to support and progress day to day challenges. • The clinical systems design group is represented by clinicians from all clinical directorates. • Processes and procedures continue to be reviewed with clinicians. • Clinical performance reports are available via Lorenzo and shared with service leads for validation.		**Suzanne Robinson**	**Dave Hewitt**	The trust has increased the number of super user sessions and has split these to cover community and inpatient services. A rolling 'ROSE on the Road' programme has been implemented to engage with users in their teams. A trust-wide engagement programme is being established to ensure we can obtain feedback from all users on key metrics and deep dive interviews with key individuals	**G**	
2.11	The Trust should consider reviewing medicines optimisation staffing in line with the pharmacy business and continuity plan to ensure sufficient staff to undertake dispensary, clinical and e-prescribing roles across the organisation.	The Trust will have robust assurance that the pharmacy is delivering the service in line with the services specifications and KPI targets are continually met.	• The Trust has challenged the accuracy in relation to these CQC findings. • Any vacant posts within the team are being recruited into. • Supervision processes for all pharmacy staff will be in place with a 90% compliance rate of supervision being received. • A review of pharmacy quality KPI's will take place to ensure that they address any areas of concern highlighted by the CQC. • Establish standards for reconciliation in line with national practice	**Complete**	**Buki Adeyemo**	**Louise Jackson**	The Trust has undertaken a benchmarking exercise which conforms that the staffing establishment within the pharmacy team is comparable to similar organisations with similar turnover. The pharmacy is currently achieving 100% compliance with KPI's. All vacant posts are recruited into. The Trust has received confirmation back from the CQC that they do not support the factual accuracy challenge. Additional leadership capacity is being obtained as a supportive measure to the pharmacy team. Medicines reconciliation reported nationally Oct 17 - 94% compliance. Meds optimisation - OCT 17 Compliance.d	**G**	
3. Additional Trust wide actions from Core service action plans									

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

3.1	The Trust requires assurance that every patient has been offered a care and risk plan and whether or not they have received this. **Concern related to Acute Inpatient wards, Harplands.** *Staff did not always record in the patient records when patients had been offered a copy of their care plan and if they accepted it.*	The trust will be assured that every patient has been offered a copy of their care and risk plan and also know how many patients have accepted a copy.	• The ability to highlight that a care and risk plan has been offered and accepted (or not) will be written into the Lorenzo system. • The outcomes will be reported monthly via the Senior Leadership performance meeting. • The Inpatient Safety Matrix will capture assurances regarding this until Lorenzo has been updated.		**Suzanne Robinson**	**Dave Hewitt**	The Inpatient Safety Matrix has been updated, Version 6 has been issued to staff and the initial audit results will be available by 12th March 2018. (When the next audit deadline is scheduled). Lorenzo now indicates if a patient has been offered a copy of their care plan and whether they accepted it or not. Care plan Copy to patient radio button.dc	**G**	

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

CQC Adult Community Action Plan

Unannounced Inspection

W/C 2nd October 2017

VERSION CONTROL			
Version	Date	Author	Description of Change
1	5.3.18	Zoe Grant (Quality Assurance and Improvement Manager)	Restructured – MUST / SHOULD / HOWEVER
2	8.3.18	Zoe Grant (Quality Assurance and Improvement Manager)	Updated assurance
3			
4			
5			
6			

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

1. MUST DO ACTION'S - Unannounced inspection 2-5th October 2018.								
No	**Issue / Concern**	**Intended Outcome**	**Action to be taken**	**Due Date**	**Responsible Officer**	**Assurance/ Evidence**	**Expected completion date**	**RAG**
1.1	The Trust MUST ensure that staff follow medicines management processes properly to ensure that fridge temperatures are not outside of the recommended safe range medicine so that medicine is safe.	Fridge temperatures will be monitored daily, in line with Trust policy. Any incidents where the fridge is out of the safe range, there will be clear evidence of the action taken and ongoing concerns will be escalated accordingly. The Trust is purchasing an automated system which will give ongoing compliance and assurance from 2018/19.	Process for fridge monitoring has been updated in line with new policy. All teams now in receipt of revised policy Monthly audit to provide assurance of actions taken in the event of temperature variance reported through the Quality Forum.	**10/1/18** **2/1/18** **31/1/18**	**Sam Mortimer (HOD)**	100% compliance reported at last directorate quality forum (6th March 2018). Pharmacy lead assurance confirms 100% compliance. A paper regarding the Fridge temperature centralised monitoring options, along with proposed costs was presented to the Senior Operating Team meeting on 14th February 2018.	**31/3/18**	**G**

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

1.2	The Trust MUST ensure that staff regularly check and record that emergency equipment is safe to use for the care and treatment of patient'.	There will be a system in place to ensure that emergency equipment is checked in line with the Trust policy, on a weekly basis.	Monthly audit to provide assurance that equipment is safe to use and variance reported through the Quality Forum.	**31/3/18**	**Sam Mortimer (HOD)**	100% compliance at last directorate quality forum (6th March)	**6/3/18**	**G**
2. SHOULD DO ACTION'S - Unannounced inspection 2-5th October 2018.								
No	**Issue / Concern**	**Intended Outcome**	**Action to be taken**	**Due Date**	**Responsible Officer**	**Assurance/ Evidence**	**Expected Completion Date**	**RAG**

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

2.1	The Trust should ensure that staff re-inform patients on a community treatment order of their rights in line with Trust Policy.	To have a consistent approach to managing the care of patients detained on a CTO. All patients to receive a standard of care in line with the Mental Health Act code of conduct including the rights being read and recorded in line with national standards.	The trusts Mental Health Law team manager has issued practice guidance to all Care co-ordinators who have patients detained under a CTO. A monthly audit will be carried out for each patient detained under a CTO to ensure that all care standards are adhered to.	**30/3/18**	**Sam Mortimer (HOD)** **Sam Mortimer (HOD)**	Clear guidance issued to all care co-ordinators of patient detained under a CTO on 12th October 2017. 100% compliance gained in Oct 2017. Audit completed of all patients detained on a CTO in February 2018 – 86% Each Care co-ordinator has been notified and will contact each patient to discuss their rights – 100% compliance expected by 30/3/18	**30/3/18**	**A**

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

2.2	The trust should ensure that staff follow medicine management processes properly and dispose of out of date medication.	There will be a system in place to ensure that there are no out of date items in the clinic room and medicines cupboard.	Medicines management lead and deputy to be nominated to carry out monthly audit. Results and assurance reported to the directorates Quality forum. A peer reviewed Community Safety Matrix to be rolled out in April 2018 with initial results excepted end of April 2018.	**30/4/18**	**Sam Mortimer (HOD)**	100% compliance reported to latest Quality forum (6th March). A further assurance check by the Quality assurance and Improvement manager ensures 100% compliance.	**30/4/18**	**G**

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

2.3	The Trust should ensure that risk assessments consistently demonstrate a detailed description of risk and how this will be managed and that staff update these regularly.	For each patient to receive a care plan and risk assessment which is person centred and fully complies with best practice guidance.	Each team completes 10 audits of risk assessments per month. Any issues which are highlighted are then discussed with the individual practitioner as part of their management supervision in order to ensure that every practitioner is fully aware of their responsibilities in line with person centred care planning. Reported monthly to directorate quality forum and Trust Performance review meetings (SLT). A peer reviewed Community Safety Matrix to be rolled out in April 2018 with initial results excepted end of April 2018.	**30/4/18**	**Sam Mortimer (HOD)**	Latest compliance with risk assessment audit: 99%	**30/4/18**	**G**

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

2.4	The Trust Should ensure that staff complete relevant audits in relation to the mental health act and mental capacity act.	There will be regular MHA audits conducted within each of the community teams and improvement actions will be overseen by the team leaders.	Initial audit completed of prescription cards. A peer reviewed Community Safety Matrix to be rolled out in April 2018 with initial results excepted end of April 2018.	**30/4/18**	**Sam Mortimer (HOD)**	CSM roll out meetings in place – Representatives from the directorate are in attendance.	**30/4/18**	**G**
2.5	The Trust should ensure that staff consistently record detailed care plans and update them regularly.	Every patient will have a personalised care plan which is sufficiently detailed with clear evidence of a regular review.	Ongoing care plan quality assurance audits on a monthly basis. A peer reviewed Community Safety Matrix to be rolled out in April 2018 with initial results excepted end of April 2018.	**30/4/18**	**Sam Mortimer (HOD)**	Latest Care plan audit result – 97%	**30/4/18**	**G**

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

CQC Adult Inpatient Action Plan

Unannounced Inspection

W/C 2nd October 2017

VERSION CONTROL			
Version	Date	Author	Description of Change
1	5/3/18	Zoe Grant (Quality Assurance and Improvement Manager)	Restructured – MUST / SHOULD
2			
3			
4			
5			
6			
7			

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

1. MUST DO Actions: Unannounced inspection 2-5th October								
No	**Issue / Concern**	**Intended Outcome**	**Action to be taken**	**Due Date**	**Responsible Officer**	**Expected Completion date:**	**Assurance/ Evidence**	**RAG**

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

1.1	The trust **must** ensure that topical medicines are clearly labelled for the use of a single patient to reduce infection risks and that opening dates of the medicines are monitored.	There will be robust system in place with measurable assurance that medicines are clearly labelled in line with Trust policy.	Pharmacy wide audit to be developed and modern matron will seek initial assurance. Ward managers will retain daily responsibility for ensuring that staff adhere to medicines management policy and the Modern Matron will provide the initial assurance.	**31.3.18** **28.2.18**	**Louise Jackson** **Jackie Clowes**	**31.3.18**	The pharmacy will take a lead, they will devise an audit which will be completed at each ward stock check, and this will be rolled out by 31st March 2018. V1 - Pharmacy led - quality assurance auc A practice note was forwarded to all teams; evidence will be provided to confirm that this has been shared with staff and discussed in the team meetings**.** Audit completed by Jackie Clowes, Matron on 12.2.18. – 100% compliance Pharmacy wide audit – 100% compliant. 16th Feb - Pharmacy Audit.docx	**B**

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

2. SHOULD DO Actions: Unannounced inspection 2-5th October								
2.1	The trust **should** ensure that the accessibility of emergency medicines for anaphylaxis use is immediately accessible when needed in an emergency.	All emergency medicines will be stored on the emergency trolley	Each ward has an emergency trolley in place which has standardised equipment readily available in an emergency.	**Complete**	**Ward Managers**	**Complete**	The Wards are fully compliant with the Trust Policy	**B**
2.2	The trust **should** ensure all staff receive and record supervision and meet their target of 85%.	All 3 wards will routinely achieve 85% compliance with the supervision target.	Support from HOD and CD put in place to improve compliance.	**30.4.18**	**Ward Managers.**	**Ongoing**	An escalation process is now in place top support managers to ensure that all staff who should receive supervision receives it. The nurse practitioner has also set up a monthly supervision group for health care support staff as a way of targeting the staff that tend to avoid supervision. Latest compliance 83.85% improvement (8th March 2018).	**A**

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

2.3	The trust **should** ensure staff record and escalate to senior staff when the fridge temperatures exceed optimum temperatures.	There will be robust assurance that all fridge monitoring actions and escalations are always actioned within line with policy.	Fridge temperatures are checked on a daily basis. Ward managers will ensure that any temperatures outside of the expected range are escalated and an incident form completed outlining what action has been taken and any additional actions to reduce the risk of this re-occurring. The Trust is purchasing an automated system which will give ongoing compliance and assurance from 2018/19.	**31.3.18**	**Jackie Clowes** **Louise Jackson.**	**31.3.18**	Assurance sort by the Modern Matron via monthly audits. Latest compliance 100% A paper regarding the fridge temperature centralised monitoring options, along with proposed costs was presented to the Senior Operating Team meeting on 14th February 2018. A request to finance the system is being progressed through the Trusts Capital investment group.	**G**

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

2.4	The trust **should** ensure all clinical items are safe to use and all out of date items are disposed of. (This relates to 3 out of date cannulas).	To have robust assurance in place that items on each emergency trolley are always in date.	A practice notice was disseminated to each team on 17th Oct 17 offering guidance about checking emergency equipment. Weekly checks of the emergency equipment, including expiry dates continue to be carried out. Assurance is obtained by the ward manager on a monthly basis.	**Complete**	**Jackie Clowes**	**28.2.18**	 Practice Note - emergency euipment Weekly audits continue and confirm that all equipment is in date. Spot check assurance sort from the Modern matron – 100% compliant (12.2.18).	**B**

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

2.5	The trust **should** consider recording when staff offer patients a copy of their care plan and whether they accept it.	Individual patient care plans will contain confirmation that that a copy of the care plan has been offered and if it was accepted by the patient.	The Lorenzo system will be updated to ensure that staff can records on the patients care plan if the patient has been offered a copy of their plan and if they accepted it or not. Guidance to be issued to all staff that this is now the expected standard. Assurance will be sort via the inpatient safety matrix.	**28.2.18**	**Ward Managers.**	**28.2.18**	Lorenzo now indicates if a patient has been offered a copy of their care plan and whether they accepted it or not. Care plan Copy to patient radio button.dc The Inpatient Safety Matrix has been updated, Version 6 has been issued to staff and the initial audit results will be available by 12th March 2018. (When the next audit deadline is scheduled).	**B**

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

2.6	The trust **should** consider recording the responsible clinician changes, and update relevant paperwork such as certificates authorising treatment. *'Ward one had had a succession of locum consultant psychiatrists. We were concern that staff did not record the change of responsible clinicians adequately in the electronic patient records in line with the guidance in chapter 36 of the Code of Practice.*	Patients will be informed and there will be a note within their clinical record if the responsible clinician changes.	There will be dedicated consultant cover on ward 1. Consultants leave is signed off by the Clinical Director once cover arrangements are in place. The ward retains a copy of leave and cover arrangements for the consultants.	**28.2.18**	**Ward Managers**	**28.2.18**	Full time dedicated consultant cover is now in place on ward one. The clinical director has reviewed the cover arrangement process – when a consultant is on leave there will be 2 named consultants covering, one will be to cover the daily needs of the patients and the other to cover emergency needs. Ward managers escalate any cover concerns to the clinical director. Ward one team have entered within Lorenzo when the consultant is on leave and who is covering the individual patient care needs. The ward also indicates this on the daily staffing board in the ward corridor.	**G**

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

CQC CAMHS Community Action Plan
Unannounced Inspection
W/C 2nd October 2017

VERSION CONTROL			
Version	Date	Author	Description of Change
1	07.03.18	Laurie Wrench (Associate Director of Governance)	Re-formatted into 'should' and 'however' and updated assurances

DRAFT

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

1. SHOULD DO Actions

No	Issue / Concern	Intended Outcome	Action to be taken	Due Date	Responsible Officer	Assurance/ Evidence	Expected completion date	RAG
1.1	Staff were unable to electronically plot height and weight on growth charts using the new electronic record system.	Growth, weight and height will be available and recorded in Lorenzo.	The directorate will ensure that staff add 'Weight and Height monitoring' as a title to the clinical note to ensure that it is easily identifiable for the patients on the eating disorder pathway. Height and weight charts will be scanned into Lorenzo	28.2.18	Ross McKenzie (Directorate Lorenzo lead)	Height and weight charts are retained within the skinny files and a record of this is also reported in the clinical notes section of the EPR system.	Complete	B
1.2	The height and weight scales were located in a corner of the corridor at Dragon Square, which could have compromised privacy and dignity.	The height and weight scales will be re – located to minimise the risk of privacy and dignity being breached.	The height and weight scales have been relocated. Clear message has been sent to all relevant staff and direction given that they need to remain within the privacy of the clinical rooms.	Complete	Service Managers	Scales are within the clinical room and all monitoring is carried out within this room. Checks of the area support that staff are following this process.	Complete	B

DRAFT

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

CQC Learning Disability Inpatient Action Plan

Unannounced Inspection

W/C 2nd October 2017

1. SHOULD DO Action - CQC inspection 2-5th October								
No	**Issue / Concern**	**Intended Outcome**	**Action to be taken**	**Due Date**	**Responsible Officer**	**Assurance/ Evidence**	**Expected Completion date**	**RAG**
1.1	The trust should ensure that the accessibility of emergency medicine for anaphylaxis use is immediately accessible when needed in an emergency.	All emergency medicines will be stored on the emergency trolley	Each ward has an emergency trolley in place which has standardised equipment readily available in an emergency.	**Complete**	**Ward Manager**	The Wards are fully compliant with the Trust Policy	**Complete**	**B**
1.2	The trust should consider involvement in national accreditation schemes as a method of quality monitoring.	The trust is AIMS accredited	The Directorate has an agreed plan to apply for accreditation through the Quality Network for Inpatient Learning Disability Services.	**April 2019**	**Head of Directorate**	LD Inpatients wards are currently in the process of registering for AIMS accreditation	**April 2019**	**G**

DRAFT

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

CQC Older Persons Inpatient Action Plan

Unannounced Inspection

W/C 2nd October 2017

VERSION CONTROL			
Version	Date	Author	Description of Change
1	5.3.18	Zoe Grant (Quality Assurance and Improvement Manager)	Re-structured into Must /Should /However actions
2	7.3.18	Laurie Wrench (Associate Director of Governance)	Assurance Updated
3			

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

1. MUST Do – CQC Inspection 2-5th October 2017								
No	**Issue / Concern**	**Intended Outcome**	**Action to be taken**	**Due Date**	**Responsible Officer**	**Assurance/ Evidence**	**Expected completion date**	**RAG**
1.1	The trust **must** ensure that topical medicines are clearly labelled for the use of a single patient to reduce infection risks and that opening dates of the medicines are monitored.	There will be robust system in place with measurable assurance that medicines are clearly labelled in line with Trust policy.	• A review of the current process to take place to ensure that it is satisfactory. • The ISM matrix has been updated to reflect a review of any prescribed topical medicines for individual patients to ensure that nursing staff remain vigilant of the standard requirements – audit findings will be available in March 2018. • An audit tool and protocol has been	**13.2.18**	**Josey Povey (Modern Matron) / Louise Jackson (Chief Pharmacist)**	Pharmacy led monthly audit. **2nd March 2018** Pharmacy Audit – 100% (W/C 19th Feb) WC 19th Feb 2018 - Pharmacy audit.docx	**16th February 2018**	**G**

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

			developed for the pharmacy team and accepted by the Chief pharmacist. • The pharmacy team will complete an audit of all topical medicines on a weekly basis (2 weekly in specified areas) during the ward stock review. • The pharmacy team will record the audit results, ensure that any deficits from the standard are addressed and will report outcomes on a monthly basis to the Senior Operational Team meeting. • Medicines Management Training will be reviewed and updated to ensure any CQC identified issues are addressed via the training					

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

2. SHOULD Do – CQC Inspection 2-5th October 2017								
2.1	The trust **should** ensure that there is appropriate decision making in place to support the transfer of patients lacking mental capacity to consent to admission to the hospital where this constitutes a more restrictive option to the place they were admitted from.	There will be a system in place to ensure that there is full compliance with the mental capacity act when transferring patients from the UHNM. The ward will have assurance that all registered nursing staff understands this process.	Referral process was reviewed immediately and amended to reflect mental capacity and Best Interest Decision to support transfer from UHNM	**14/11/17**	**Josey Povey Modern Matron**	Revised form and process in place. A review of all current inpatients records confirms that the process is embedded with 100% compliance.	**Complete**	**B**
2.2	The trust **should** ensure staff update all records at the same time to ensure consistency across paper and electronic care records.	Staff will have access to all relevant clinical information.	All paper copies of records that can be scanned onto the system are scanned within a 24hr period. Skinny files are scanned into electronic records.	**13th February 2018**	**Josey Povey Modern Matron**	Any documents that are scanned into the system are titled to indicate what they are. An audit will be undertaken to assure that records are scanned within 24 hours.	**Complete**	**B**
2.3	The trust **should** ensure that staff fully record physical observation and calculations in NEWS. Staff should record refusals in line with practice on ward 7 to	Every patient will have a NEWS assessment as indicated by their care plan as a minimum weekly. The NEWS will be	A specific audit has been designed and introduced in inpatient areas and is being monitored on a weekly basis. Ward managers review	**25/1/18**	**Josey Povey (Modern Matron)**	**13th Feb 2018** Ward 4 – 100% Ward 6 – 100% Ward 7 – 100%	**Complete**	**B**

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

	evidence attempts to perform physical observations.	completed in full with an escalation score documented and evidence of any required escalation will be recorded in the patient's electronic record.	weekly audit results and actions are taken forward via individual staff management supervision sessions.					
2.4	The trust **should** ensure complete recording of food and fluid intake to ensure these records can meaningfully inform clinical decision-making.	Every patient will receive an assessment of their nutrition and hydration needs via the Trusts MUST assessment tool. Where a monitoring need has been identified, this will be recorded on the Trusts nutrition and hydration record sheet. Any identified needs and monitoring will be clearly recorded within the individuals care plan and reviewed accordingly (minimum weekly) with a record made in the clinical notes and in the MDT notes and changes reflected in the care plan.	A specific audit has been designed and introduced in inpatient areas and is being monitored on a weekly basis. Ward managers review the weekly audit results and actions are taken forward via individual staff management supervision sessions.	**25/1/18**	**Josey Povey (Modern Matron)**	**Ward 4 –** 89% compliant **Ward 6** – 100% compliant **Ward 7** – 100% compliant.	**March 2018**	**G**
2.5	The trust **should** ensure the accessibility of emergency medicine for anaphylaxis use is immediately accessible	All emergency medicines will be stored on the emergency trolley	Each ward has an emergency trolley in place which has standardised equipment readily available in an emergency.	**Complete**	**Ward Manager**	The Wards are fully compliant with the Trust Policy	**Complete**	**B**

RAG Rating Criteria	Rating
Complete with Assurance	BLUE
On target for delivery	GREEN
Risk to delivery, plan in place	AMBER
Not deliverable by target	RED

	when needed.							
2.7	The trust **should** ensure specialist dementia training attains the level of the trust target of 90%. This is a continuing requirement not achieved since the last inspection.	All staff will receive dementia tier 2 training.	Training continues to be rolled out. All new staff to the service are allocated onto the next available training date.	**31/1/18**	**Josey Povey (Modern Matron)**	Training compliance: Ward 4 – 67% - 3 staff non- compliant and booked onto September session. Ward 6 – 93% Ward 7 – 100%	**September 2018**	**G**
2.8	The trust **should** consider review of the medical cover available on ward 4 to ensure it is consistent and skilled to support the complex physical and mental health needs of patients.	There will be dedicated medical input into ward 4 which ensures continuity of care is not hindered.	There will be substantive medical input on the ward.	**Complete**	**Josey Povey**	Consistent dedicated medical input is now available on the ward with a clear timetable of when each Dr is attending. (Daily medical attendance to the ward)	**Complete**	**B**

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO Open Trust Board

Enclosure No: 15C

Date of Meeting:	22.03.18		
Title of Report:	CQC - Driving Improvement Publication		
Presented by:	Caroline Donovan		
Author:	Laurie Wrench		
Executive Lead Name:	Caroline Donovan	Approved by Exec	☒

Executive Summary:		Purpose of report	
On 15th March, the CQC published a report that explores how seven NHS mental health trusts have been able to make significant improvements in the quality of care and improve their CQC rating. NSCHT was one of the seven trusts featured in the publication. CQC noted there were common themes that drove improvement across the featured trusts. "Strong, visible and listening leadership is vital, and good leaders engage and empower staff. Good leadership and good governance go hand in hand, and the report found that most of the trusts had made changes to their systems and processes to drive improvement."		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☐
Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	1
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		
Resource Implications: Funding Source:	None		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	Diversity and Inclusion is a significant consideration for the CQC when assessing the quality of services		
Recommendations:	That the Board receive the publication for information.		

Care Quality Commission

Driving improvement

Case studies from seven mental health trusts

MARCH 2018

Our purpose

The Care Quality Commission is the independent regulator of health and adult social care in England.
We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values

Excellence – being a high-performing organisation

Caring – treating everyone with dignity and respect

Integrity – doing the right thing

Teamwork – learning from each other to be the best we can

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Foreword

Dr Paul Lelliott
Deputy Chief Inspector of Hospitals (lead for mental health)

Professor Tim Kendall, National Clinical Director for Mental Health, NHS England and NHS Improvement, and Consultant Psychiatrist at Sheffield Health and Social Care NHS Foundation Trust

What does it take to raise standards in a mental health trust? How can a trust that requires improvement become good or outstanding?

To help answer those questions we visited seven NHS mental health trusts that had achieved significant improvements in their ratings.

At each trust, we interviewed a range of people, including chief executives, medical directors, nursing directors, other clinical and managerial staff, and front line staff. We also spoke to others who knew or worked with the trust, such as local patient or voluntary groups.

CQC's report *The state of care in mental health services 2014 to 2017*, noted that trusts cannot be outstanding without good leadership. This applies equally to the task of taking a trust from requires improvement to good. To show that everything flows from good leadership, this report gives examples of how these trusts have worked hard to strengthen their leadership through training, mentoring and development; including through working with NHS Improvement. In particular, the report emphasises the essential role of strong clinical leadership, which makes sure that medical and nursing staff are fully at one with the trust's ambitions.

Good leaders do not have to command and control. Improvement is made easier by a leadership style that is compassionate and inclusive. A finding from our state of care in mental health report, which was also evident in the trusts we have featured here, is that mental health and learning disability services can be proud of their staff. When trusts had been rated as requires improvement, inspectors had still found that the great majority of staff were caring and committed. The role of leaders is to enable their staff to fully realise their potential to provide high-quality care.

Photo credit: Sheffield Health and Social Care NHS Foundation Trust

Staff respond to leaders who are visible and approachable. Leaders really have to 'walk the talk', meeting staff, listening to them and acting on what they hear. We found that the engagement and empowerment of staff had been one of the most significant drivers of improvement in the trusts featured in this report. Front line staff often have the best ideas of how their service can improve. Efforts made to develop the skills and confidence of their people are paid back in improvements to mental health and learning disability services.

Patients and people who use services can also be a great asset in driving improvement, and we heard examples of where patients had been involved in significant areas of work. Some of these examples achieved the ultimate goal of developing services through a process of genuine coproduction.

These trusts also recognised the value in looking beyond their own boundaries. They engaged with and included the local community and local organisations. They also looked to other trusts to share learning and seek support. This willingness of mental health trusts to support one another and share good practice is a credit and testament to the NHS. The recently launched Mental Health Safety Improvement Programme, commissioned by the Secretary of State for Health and Social Care and jointly led by CQC and NHS Improvement, will promote and build on this collaboration and peer support.

All of the trusts featured in this report are ambitious. Although they have all made great improvements, none are complacent or satisfied with their current performance. This restless urge to continue to improve is an essential feature of successful organisations and is very much part of the culture of the two mental health trusts that are currently rated as outstanding.

This report follows on from our report on driving improvement in eight acute NHS trusts. As with that report, the trusts featured in this publication show how good leadership can drive significant improvements, in some cases in a relatively short time. We want to encourage others to look at and learn from these case studies to help them in their own improvement work. We are confident that the trusts themselves will be willing to share with others the lessons they have learned on their improvement journey so far.

We would like to thank everyone connected with the featured trusts for the time and help they have given us in producing this publication.

Dr Paul Lelliott
Deputy Chief Inspector of Hospitals (lead for mental health)

Professor Tim Kendall
National Clinical Director for Mental Health,
NHS England and NHS Improvement, and Consultant Psychiatrist at Sheffield Health and Social Care NHS Foundation Trust

"I see inspections as a real opportunity… In many respects the report came at the right time. It would not have been helpful to scrape a 'good'. There would not have been the energy and drive to improve. It meant we re-evaluated what we were doing."

Andy Trotter,
Chair of Oxleas NHS Foundation Trust

The trusts that we interviewed

"We could have spent time arguing about the rating, but we decided to try and fix the problems."

Chief Executive Rob Webster, South West Yorkshire Partnership NHS Foundation Trust

Photo credit: South West Yorkshire Partnership NHS Foundation Trust

We selected seven trusts on the basis that they had achieved a significant improvement in their rating. All of the trusts featured in our publication have improved by at least one rating, with the majority changing from requires improvement to good, some in impressively short timescales.

Trust rating changes

Trust	From	To
Oxleas NHS Foundation Trust	Requires improvement	Good
Somerset Partnership NHS Foundation Trust	Requires improvement	Good
Lincolnshire Partnership NHS Foundation Trust	Requires improvement	Good
South West Yorkshire Partnership NHS Foundation Trust	Requires improvement	Good
North Staffordshire Combined Healthcare NHS Trust	Requires improvement	Good
Calderstones Partnership NHS Foundation Trust	Good	Outstanding
Sheffield Health and Social Care NHS Foundation Trust	Requires improvement	Good

Source: CQC inspection reports

For each trust we interviewed a range of people including: chief executives, directors of nursing, medical and nursing directors, front line staff, non-executive directors, heads of communications, patient representatives and external stakeholders, such as Healthwatch.

We asked each interviewee the same questions:

- What was your reaction to getting a low rating?
- How did you view the hospital/trust before getting a low rating?
- How did you approach improvement?
- What support did you receive?
- What were the obstacles to improvement? How did you overcome them?
- How did you involve staff and public and patient representative groups?
- How did you make sure a focus on equality and human rights in your improvement journey?
- Did your inspection report help you to improve?
- Can you share examples of tangible improvements?
- Can you share examples of improved outcomes for patients?
- What next on the improvement journey?

A number of common themes emerged from the interviews, but as not all were given the same weight by our interviewees, we have not covered them all equally in each trust's case study.

Acknowledgements

We would like to thank everyone involved in the production of this publication. This work would not have been possible without the support and time of the seven trusts who agreed to be case studies for improvement.

We are especially grateful to the staff, patients and members of the public who took the time to give their views on the improvement journey of their trust.

Lincolnshire Partnership NHS Foundation Trust

Key themes

"My role was to make sure it was compassionately done…to me, the way we did things was as important as what we did."

Jane Wells, Director of Nursing at Oxleas NHS Foundation Trust

Photo credit: Lincolnshire Partnership NHS Foundation Trust

Reaction to the initial inspection report

Nobody likes getting a poor report and people in most of the trusts we spoke to generally expressed disappointment, but not surprise. At senior levels managers and clinicians were usually aware of problems and in some cases were underway with improvement plans, but reports gave a fresh focus on issues as well as highlighting problems that trusts may not have been aware of.

A poor rating for many was a stimulus for improvement. As Andy Trotter, Chair of Oxleas NHS Foundation Trust, put it, "I see inspections as a real opportunity…In many respects the report came at the right time. It would not have been helpful to scrape a 'good'. There would not have been the energy and drive to improve. It meant we re-evaluated what we were doing."

John Brewin, Chief Executive of Lincolnshire Partnership NHS Foundation Trust, noted that the report came at a time when it had started its improvement journey and that he viewed it "as invaluable external feedback on where we are". The trust's clinical director, Dr Jaspreet Phull, described the rating as "a springboard" to make improvements.

An acceptance of the findings is an important step in driving improvement. As South West Yorkshire Partnership NHS Foundation Trust Chief Executive Rob Webster told us, "We could have spent time arguing about the rating, but we decided to try and fix the problems."

Leadership

While trust leaders were clear that improvements had to be owned and driven by staff, all of our case studies also show strong direction from senior teams. Most of the trusts had senior leaders who were relatively new at the time of the report, with some noting that tough decisions needed to

be made to make sure the right people were in place in the organisation to lead improvement. Calderstones' Mark Hindle said the report showed him that, "some of the board and some of the people leading the organisation weren't fit for purpose in their capability or capacity and it enabled me, as chief executive, to look at those roles and change them fundamentally".

Leaders also need to tread carefully. As Jane Wells, Director of Nursing at Oxleas put it, "My role was to make sure it was compassionately done…to me, the way we did things was as important as what we did."

But even the most open an inclusive leaders need to set some red lines. In Oxleas' case there were a small number of clear principles, for example stopping mixed sex breaches, which laid the foundation for improvement; for Calderstones' medical director the 'over my dead body' moment was no more use of mechanical restraint.

Broadening the leadership base is seen as important, particularly ensuring clinicians are involved as leaders. For example, Caroline Donovan, Chief Executive of North Staffordshire Combined Healthcare NHS Trust said, "We changed so much; decisions used to be made only at the executive level, but we radically changed clinical leadership and pushed decisions down so clinicians could lead." Somerset, too, told us how it had devolved responsibility to local management and local staff, enabling them to take responsibility and contribute to change.

Trusts also saw the importance in investing in leaders to drive improvement. For example, Lincolnshire signed up to NHS improvement's Culture and Leadership programme and North Staffordshire put 140 managers through a leadership programme.

Key characteristics of effective leadership were seen to be visibility and the ability to listen to staff, having the confidence to devolve decisions and being approachable. Leaders need to be first class communicators.

Governance

Good leadership and good governance go hand in hand. Most of the trusts featured made changes to their systems and processes to drive improvement and to monitor improvement, changes to streamline decision making and changes to devolve responsibility.

It means having meaningful and achievable action plans and regular reporting on outcomes. It means boards and executives ensuring they have robust assurance that what should be done is being done. Andy Trotter, Oxleas Chair, said, "I get daily bed occupancy reports, but I will go to the wards to see what the situation is like."

And improving trusts continually ask questions of their services. For example, Somerset conducts regular monthly audits to monitor care plans. South West Yorkshire Partnership created business development units to take responsibility for areas in the action plan, then followed up with quality monitoring visits, and in North Staffordshire the trust strengthened the business case process to make finance easier to understand.

Culture

In every case, delivering improvement needs changes to the culture of the organisation. This may or may not be a big dramatic change such as developing a new vision and new values; it may be through more subtle actions to change behaviours and engage and empower staff.

A characteristic of inadequate trusts is that staff often feel they can't come forward to raise concerns or admit errors. One of the most valuable cultural changes in improving trusts is creating the environment in which staff do feel able to speak up and speak out. It helps learning and drives improvement.

Somerset's Phil Brice noted that, following the report, it was very important to foster a positive and inclusive attitude, rather than cultivating a blame culture.

Staff engagement and empowerment

All of the featured trusts recognised that one of the most important keys to improvement is engaging and empowering staff at all levels. Once staff feel they have a part to play and that they are listened to and valued, improvement gathers speed.

"Post CQC", said Dawn Argent, Healthcare Assistant at Oxleas, "a big change is that there is more involvement of junior staff, who have been part of improvement discussions."

Amy Owen, a medical secretary at Somerset told us that staff are now encouraged to put forward suggestions and are actively involved in effecting change.

Across the trusts there are a range of initiatives that bring staff together to share ideas and shape improvement. These include formal quality improvement systems to engage front line teams.

One area where several of our trusts focused was making sure all staff were engaged, for example by taking positive steps in terms of equality and diversity. North Staffordshire, for example, became a Stonewall diversity champion and an NHS Employers diversity partner, while Lincolnshire's Dr Jaspreet Phull is passionate about how a focus on equality and diversity can drive improvements.

Involving patients and people who use services

Taking the views and experiences of patients and the public into account is helping to drive improvements. For example, in Oxleas, extensive work with patients helped to review the use of sharp implements in therapeutic settings, at Calderstones patients were involved in developing alternatives to the use of restraint, and in Sheffield people who use services have helped train staff and local students. Trusts are learning from the people who are really at the heart of the work.

Outward looking

These improving trusts are increasingly working with others in the local health and care system and voluntary sector, recognising that real and lasting improvement depends on organisations working together.

North Staffordshire's chief executive Caroline Donovan says, "Most of our services are now delivered in partnership with another agency…we have tried to change the culture from criticising to being jointly accountable for improving our population's health."

Oxleas is building strong relations with other mental health trusts, sharing ideas on quality and areas of concern, while the chair and chief executive both meet regularly with other local agencies.

But it is also about engaging the local community in a variety of ways, such as South West Yorkshire's work with Barnsley Football Club on dementia awareness training and supporting people with dementia.

Relationship with CQC

Most of our trusts acknowledged an improvement in relations with CQC over time. For some, the first inspection was quite a bruising process – it was new to them and to CQC – but there were a number of comments about how regular engagement since the first inspection has helped them improve.

Two trusts were keen to have a follow-up inspection as soon as possible as they felt this would help them drive improvements and embed work that had been in its early stages at the time of the first inspection.

Being able to speak to CQC staff between inspections was seen as helpful and an open relationship encouraged the sharing of concerns and discussions about solutions.

Next on the improvement journey

Good is not enough for the featured trusts. They all see improvement as a continuous process, and this is about more than aiming for an outstanding rating. The work they have done to improve the ratings has given them sound foundations to build on, for example by setting up and embedding formal quality improvement programmes that involve staff across the trust.

Oxleas NHS Foundation Trust

February/March 2017

Rated as good

April 2016

Rated as requires improvement

Oxleas NHS Foundation Trust provides a range of health and social care services from around 125 sites in south east London and Kent, specialising in community health, mental health and learning disability services for around 28,400 people a month. The trust employs about 3,500 staff in both community and hospital settings.

Reaction to the initial inspection report

Chair Andy Trotter, who joined the trust in November 2015, said of the report and rating of requires improvement, "[It] was a shock to the organisation. But I have been subject to many inspections and take the view that they are a huge help if you handle it properly. The best way is to deal with it positively. I see inspections as a real opportunity.

"In many respects the report came at the right time. It would have been unhelpful to scrape a good. There would not have been the energy and drive to improve. It meant we re-evaluated what we were doing."

And while Chief Executive Ben Travis thought some of the judgments were harsh, he felt the report highlighted some areas, such as bed occupancy, where the trust had been too accepting of issues that it knew about but hadn't tackled.

Leadership

Andy Trotter says that it was important to get the messaging to staff right as many had been surprised by the rating. Ben Travis agrees, "We had

to take organisational responsibility. We quickly concluded we needed to take it on the chin. The report had highlighted some things that were unacceptable for patients."

Being visible and available to staff was a priority for the executive team. Keith Soper, Service Director, Forensic and Prison Services, said, "You have to win people's trust and confidence and they have to see you are good to your word. Show how you will support them if they present problems – but also be honest if things can't be done. This means being visible; going to the wards, helping with people who use services, attending the service user forum."

> **"The executive team made sure we were super visible – hands on and supportive and approachable. This did mean stopping doing some other things, but I learned to do that in order to do the right things."**
>
> **Jane Wells, Nursing Director**

Ben Travis aims to go a couple of times a week to different teams. He attends team meetings which, he says, are the best way to engage with people where they are talking about their normal agenda and it's a safe space for people to raise issues and questions with him.

> **"Post-CQC, a big change is that there is more involvement of junior staff, who have been part of improvement discussions."**
>
> **Dawn Argent, Healthcare Assistant and Patient Council Chair**

Externally, the trust is building relationships with other mental health trusts in the area, sharing ideas on quality and areas of concern. It is part of a well-established quality network that carries out peer reviews, and the trusts share reports with each other. Chair Andy Trotter meets regularly with other local agencies such as the police, while Chief Executive Ben Travis works closely with local authorities.

Governance

The executive team was clear from the start that improvement had to be owned and driven by staff, but in a framework of simple principles, which included:

- creating extra bed capacity
- stopping patient sleepovers (using the bed of a patient who is on leave for a new patient)
- stopping breaches of the guidance on eliminating mixed sex accommodation on mental health wards
- ensuring that patients would no longer wait on the ward for a bed. New metrics were developed to track progress.

These, according to Ben Travis, "were lines that we cannot cross". And knowing that there was certainty about these issues took pressure off staff

Engagement in action

Executive members post 'let's talk' videos on the intranet where they talk about topical service-related issues. And there's an 'Ask Ben' button on the intranet where staff can ask the Chief Executive questions directly.

Solving the bed occupancy problems

One key action lifted the immediate pressures on staff and gave them 'breathing space': the trust bought 12 beds from East London NHS Foundation Trust. Iain Dimond, Service Director, Greenwich Adult Community & Mental Health and Adult Disability Services says, "Positive improvements were felt quite quickly, which enabled colleagues on the ground to think more about some of the knotty problems, for example, how do we improve care planning? How do we ensure good service user involvement? Then we could co-produce solutions."

"The atmosphere on the wards improved. Wards could be a bit chaotic, but after the changes were introduced there were better relations between staff and patients, and fewer complaints."

Joanne George, Inpatient Manager and Modern Matron

on wards. Director of Nursing Jane Wells said, "The principles were really helpful – a visible marker to people that we'd taken some bold action."

Three service improvement groups were established, which met weekly. Each group included a board member and a service director, along with a cross-section of staff from different roles and positions. According to Ben, staff at the meetings were set improvement challenges, "How are you going to do it? How are you going to own the actions that you are going to take. There was buy-in and enthusiasm from staff."

Jane Wells was the executive member on one of the boards, "My role was to make sure it was compassionately done and to make sure everyone had a voice and influence. To me, the way we did things was as important as what we did."

She explained how the meetings evolved, "After the second or third week I could see people really enthusiastically wanting to come to the group and proud of some of the developments; by week five or six it was 'can we stay behind and show you our care plans'; they started self-auditing and peer reviewing."

Medical director Ify Okocha was also enthused by the approach, "The most exciting thing for me from a staff perspective was that people spent time every week thinking and talking about change."

An oversight group, chaired by the chief executive met every two weeks to review progress from the service improvement groups. "We reviewed action plans", says Ben Travis, "and looked at bottlenecks. We offered support and advice. There was always expert advice in the room in the form of the medical director or nursing director, for example. These review meetings gave me the confidence to report to the Board."

Involving patients and people who use services

Patients are also involved in discussing improvements. Every ward has a community meeting at least every week for the multidisciplinary team and patients. And every two weeks there is a service user forum that can pick up issues from the community meetings if necessary. People who use services chair the forum meetings, set the agenda and write the minutes. Any issues raised at the forum go to the directorate's quality board, chaired by the clinical director.

A number of activities took place to gain assurance that change were being made. The Quality and Governance team visited services to see how action plans were being delivered and peer reviews were carried out.

> **"I get daily bed occupancy reports, but I will go to the wards to see what the situation is like."**
>
> **Andy Trotter, Chair**

The chief executive also asked a senior clinician, a psychologist, to spend a day a week carrying out 'soft' inspections where he listens to and talks with staff to get a different perspective from more formal reporting routes.

Staff engagement and empowerment

Of the areas highlighted for improvement in CQC's report, the trust particularly needed to address problems with managing the risks from ligature points and with care planning.

The main concern was with ligature points in communal areas of the wards. The trust rapidly carried out assessments of all communal areas and made sure that teams developed plans to address risks. On wards, these included photographing points that could not be removed for reasons of cost or practicality and collating information for all staff. New staff or agency staff are briefed on risks and mitigations.

Staff drove the development of new care plan templates. According to Ward Manager LaToya Martin, "Care plans needed to be more individualised. Better care planning helps patients and nurses to build relationships. The new multidisciplinary team template is a big improvement; before, the plans were mostly about medical and nursing care, now all teams input." People who use services and carers were involved in the development of the new plans through the service user forum and carers' group.

In response to CQC's concerns about ensuring people had the capacity to consent to treatment, the trust reviews capacity and consent to treatment forms, which now include patient views on their medication treatment plans. There's also an easy read leaflet about medication and rights for each ward.

Relationship with CQC

Andy Trotter thinks the report was a driver for improvement. "I do think there is a value in having a 'burning platform'." Ben Travis agreed that the inspection helped "although it was quite daunting and labour intensive. It gave us the impetus to make systematic improvements." In addition, Ben highlighted that CQC agreeing to re-inspect services in six months helped to focus minds and made the trust the determined to succeed.

> **"Looking back we can appreciate the balanced view of the [CQC] report. The things that needed to change, changed: patients and staff have reaped the benefits."**
>
> **Joanne George, Inpatient Manager and Modern Matron**

Iain Dimond, Service Director said, "The report has been incredibly helpful. It made me and the organisation realise that perhaps because of the pressures we had experienced, we had inadvertently crossed some lines on quality and had started to do things where the practice was less than optimal."

Next on the improvement journey

Chair Andy Trotter says the trust should now be aiming for outstanding. One of the ways it is doing this is by launching a trust-wide quality improvement programme. The improvement work to get to good has, says Ben Travis, provided a platform to build on. He is confident about the methodology around 'bottom-up' solutions and says that the key is to engage front line staff.

Working together on safety

Following a serious incident where a person using the service stabbed two members of staff with a kitchen knife, the trust carried out an urgent review of sharp implements. Throughout the review, the trust was conscious that it needed to maintain the extensive and valuable programme of therapeutic activities and protect people using the self-catering facilities.

The occupational therapy team worked with the trust headquarters on a kitchen sharps policy. The review team then moved on to the therapies programme, who risked assessed anything that could be used as a weapon.

Patsy Fung, who led the project, involved the people using the service, explaining, "They were really, really engaged because they said 'we need to feel safe, so we need to work together'. When something catastrophic happens it can make or break a service but for us it pulled us together."

Somerset Partnership NHS Foundation Trust

March 2017

Rated as good. Community mental health services for people with learning disabilities and autism were rated as good overall and as outstanding for well-led

November 2015

Improvements made but more still to do

September 2015

Rated as requires improvement. Enforcement action taken about the safety of community mental health services for people with learning disabilities or autism. This service was rated as inadequate

Somerset Partnership NHS Foundation Trust provides a wide range of integrated community health, mental health and learning disability services to people of all ages. The trust employs around 3,800 staff and serves more than one million patients each year

Reaction to the initial inspection report

While many members of staff were not surprised at the overall rating of requires improvement, they expressed "shock and disappointment" over the rating of inadequate given to the community mental health services for people with a learning disability or autism.

Mel Axon, Lead Nurse and Team Manager was not surprised at the rating as she knew there were issues as to how records were kept and information was stored and, although she initially felt guilty, she saw the report as an opportunity to improve.

Phil Brice, Director of Strategy and Corporate Affairs explains that the overwhelming majority of the inspection findings were not a surprise, as the trust board had diagnosed a lot of the issues and had begun working on them before the inspection. The rating of inadequate, however, was "not anticipated at all. It caused a significant recalibration of how we saw ourselves and our work".

Leadership

There was significant change to the leadership of the learning and disability team just before the September 2015 inspection and in the aftermath. Jane Yeandle took up her position as Service Director, Mental Health

and Learning Disabilities a week before the September 2015 inspection and Tony Wolke was appointed in June 2016 as the Service Manager for Learning Disabilities.

Before these appointments there was a feeling that the learning and disability service was not seen as an equal partner in the trust and was left to be managed by the local authority, with whom they were co-located, rather than seen as a health provision.

Jane explains that she recognised the immediate priorities after the September 2015 inspection were to make sure that she provided "effective and efficient management" and to act as a go-between and bridge between the trust executive team, the non-executive team, the clinical commissioning group and staff to make sure that the staff felt supported.

Staff commented that the learning and disability team's leaders' visibility, transparency and commitment to involving staff in the improvement plans was evident. This, coupled with the support provided to staff, were all key factors in the service being able to make the required improvements. Judi Crossman, Community Nurse confirms, "Direct management was a welcome addition that lifted morale and raised awareness of our existence."

Jane also observed that she benefited greatly from the "light touch" approach from trust senior management who allowed her to implement improvements with minimal input from them, although still providing support when needed.

Culture

After the September 2015 inspection, morale among staff was incredibly low. While some staff viewed the unfavourable report as a catalyst for change, many others left the trust due to the "relentless onslaught of work required to improve" and to comply with the warning notices issued.

According to Phil Brice, there was an acknowledgement by the trust leaders that it was very important to foster a positive and inclusive attitude following the outcome of the inspection, rather than cultivating a blame culture. At the same time there was a need to recognise that staff would also share the responsibility and accountability for ensuring improvements were made.

Amy Owen, Medical Secretary observed that previously there was little or no involvement of administrative staff in implementing any improvements. In the current environment, however, staff are not only encouraged to put forward suggestions, but are actively involved in effecting change. As a result she feels more "valued and listened to".

Governance

When Tony Wolke was appointed as the Service Manager of the Learning and Disability team he recognised that staff lacked good supervision, clear guidance and clarification as to their responsibilities. As the team is relatively small, he felt it was essential to "prioritise work effectively and focus on what could be done well rather than spreading themselves too thin".

"The big step change here was a devolvement of responsibility down to local management and local staff. Our staff survey was very low in terms of staff feeling they contributed to change. However, with the introduction of our current model of working, staff now have a culture of not waiting to be told what to do, but taking responsibility and contributing to change. The subsequent outstanding rating for well-led for the learning disability service team is a testament to this culture change and the service is now being used as a model to aspire to across the trust."

Phil Brice, Director of Strategy and Corporate Affairs

Quality improvement groups

The trust set up working groups that were initially aligned to each of CQC's key questions (safe, effective, caring, responsive to people's needs and well-led), and all staff either chose or were assigned a group. This showed that they were part of the solution to the concerns raised. The groups are now fully embedded in the trust culture as 'Quality Improvement Groups', which share good practice across the trust.

A number of actions were taken to improve the governance structure and performance of the team:

- The team was restructured and a more streamlined management structure was put in place.
- Regular monthly audits were introduced to monitor care plans and make sure that accurate notes were recorded on the electronic care records system. Encouragement was given to those doing well and guidance offered to those who needed improvement to inspire an ethos that there are "no mistakes, only learning opportunities."
- A buddy system was set up so that staff skilled in particular areas could assist their colleagues and upskill them by sharing their knowledge and good practice.
- Tony implemented and continues to operate an open door policy so that staff can come and raise any issues as and when they arise.

Outward looking

As well as studying relevant CQC inspection reports, Mel Axon also got the chance to go to Cornwall Partnership NHS Foundation Trust as part of a clinical lead group. "We went for two nights to observe good practice and it was really good to be together as a group." Jane Yeandle confirms the support from Cornwall and stressed how useful it was to have a nurse with learning and disability experience come and assist on the team.

The trust also conducted a peer review of the learning and disability service in Cornwall and also had the National Development Team for Inclusion act as external consultants and conduct a review of the learning and disability team.

The trust continues to maintain effective relationships with other external stakeholders including Healthwatch, and the clinical commissioning group. The learning and disability team also has an improved and more effective relationship with the council now that they are no longer co-located with the local authority. Managers meet regularly to discuss any concerns including those involving care plans.

The trust has also developed a single point of access for people using services. This means that there are now focused referrals where information is recorded accurately. This enables cases to be triaged and the person allocated to the appropriate service team for treatment. This has improved the quality of person-centred care provided to people and resulted in better developed care plans. It has also allowed staff to focus on the clinical aspects of their roles. Previously the lines became blurred between social care needs and health requirements – for example psychologists would be tied-up doing assessments to see if people could get income support, rather than providing counselling or therapy services.

Relationship with CQC

There was a general consensus that CQC's inspection report and subsequent engagement with the trust, and the learning and disability team in particular, was effective. "CQC provided clarity around what exactly was required" says Sarah Browning, Speech and Language Therapist. "I felt it was useful to be able to discuss directly with the inspector, so he could

identify recording risks and also point out where changes or improvements could be made."

Laura Lanning, Clinical Psychologist, reflected positively on her interaction with the CQC inspection team and felt that having an inspector in the room while she was conducting a mental health review was very helpful. "I received feedback that my supervision notes were accurate and thorough, which felt validating and the service user was pleased that he had been selected to be observed as part of the inspection."

Phil Brice spoke about developing a really effective liaison with the local CQC inspection team. "The inspection manager has been very supportive and the guidance provided definitely helped. There were no surprises from the subsequent inspections as we were part of a constant two-year conversation."

Next on the improvement journey

The learning disability service are now keen to continue building on the improvements made so far. Improvement is no longer seen as CQC-led because the staff are focused on providing a better, more person-centred service. They are not complacent with the good rating they have received but want to be rated as outstanding. They are now in a position to examine other aspects of their inspection report aside from the issues highlighted during the September 2015 inspection to see what else requires attention.

Specific examples of work that will be carried out include:

- Exploring how to embed improvement by educating families as to what service they should receive and what services should be accessed by those with learning disabilities.
- An audit and evaluation of the single point of access referrals, which will examine out-of-county referrals.
- Producing user-friendly templates to record service feedback, client feedback and staff feedback on the electronic care records system.

"We have begun recording service users' goals on our electronic care records system. These personal goals are recorded in the words of the service user, which they find empowering."

Michelle Hurley, Assistant Psychologist

Lincolnshire Partnership NHS Foundation Trust

April 2017

Rated as good

December 2015

Rated as requires improvement

Lincolnshire Partnership NHS Foundation Trust provides mental health and learning disability services for around 718,800 people.

Reaction to the initial inspection report

Justin Hackney, Assistant Director of Social Services at Lincolnshire County Council says the local authority was not surprised by the rating and that it "echoed the systems at the time and that there were always areas to improve – particularly around risk management and oversight". He added that the trust had started its improvement journey before the inspection.

Dr John Brewin, Chief Executive, explained that "it took some time for the findings to sink in and for us to reflect and hold a mirror up to ourselves and admit we were wrong. But we viewed the report as invaluable external feedback on where we were." This view is reflected by Dr Jaspreet Phull, Clinical Director and Consultant Psychiatrist at the trust who describes the rating as a "springboard" to make the improvements needed.

In particular, concerns relating to safety in the initial inspection report were an immediate priority for the trust.

Phillip Jackson, Non-Executive Director, explains that the trust's approach to safety has improved, "Our main focus initially was around patient safety, especially around ligature risks, which was an area CQC picked up. We have much more robust processes in place now and it's obvious to me when I go around the trust how tuned in people are to this. I find myself looking around for risks. It's now part of everyone's mindset, which is very positive."

> **"We were really pleased by the CAMHS outstanding rating and I have the outlook that if they can do it we can do it, so this was a motivator for all the other services. We all need this inspiration."**
>
> **Anne-Maria Newham, Director of Nursing and Quality.**

Leadership

Many of the executive team outlined how following CQC's inspection, the trust signed up to NHS Improvement's Culture and Leadership programme, which develops and implements leadership strategies in order to drive cultural change. Following this, the trust implemented its own Continuous Quality Improvement programme that many staff said helped the trust on its improvement journey. This programme was sponsored by executive directors and brought the senior team together with staff across the trust to drive improvements.

> **"The leadership team had a very high visibility and this went from the Board to the ward, it's all about working together. We have to be inclusive and make everyone feel useful."**
>
> **Deborah Blant, Service Manager in the Older Adults Division**

Trust Secretary Peter Howie said, "There was a lack of direction along with a feeling of distrust before the original inspection. Once a number of new Board appointments were in place there were lots of changes, for example we introduced champions from different departments to lead on specific areas of work. The culture needed changing and the CQC report definitely helped us engage more to achieve improvement."

Culture

Anne-Maria Newham feels one main obstacle to improvement was a culture across the trust that discouraged people from coming forward with ideas, "Many people still felt like they were in the old culture and didn't dare put ideas forward as they assumed it didn't work in the past so wouldn't now. We had to get over this fear and tell them it was a new world with different relationships."

The trust recognised the need for investment in order to affect some of those cultural changes, particularly surrounding the estates and environment. Even small changes helped boost morale of staff and patients.

Celebrating good practice was a key part of the cultural shift. Dr John Brewin gave the example of a Book of Brilliance, which highlights staff achievements. This has led to a new found confidence, "We've been putting forward our improvements for awards," explains Anne-Maria Newham. "We've been presented with a silver award for being a good employer for military personnel, recognising that work."

Continuous Quality Improvement programme

Areas for improvement and actions across the CQC report, clinical audits, staff survey, patient surveys and serious incident lessons were brought together into a single quality improvement plan. This plan identified four key areas for the trust to focus on:

- improving data
- supporting our people
- safe and harm free care
- strategic change.

A project team was created to work on the plan: a core group met weekly and the wider group met fortnightly. Each of the trust's divisions was asked to nominate a champion to represent front line staff in the core group. The core group also included two executive directors and a communications specialist. This mix made sure that staff at all levels were connected to the process and working together.

Changing the environment

Suzanne Chapman, Head of Compliance, outlines some of the changes to the environment, "We began liaising with staff about the improvement plans, however small these may be. It was about empowering people to try changes to see if they work." She described the creation of an outside area for staff and patients to use, a 1950s and 60s style lounge for the older adult patients along with memory boxes and pet therapy.

Local staff surveys during 2017 showed significant improvement. The trust says that it has had an excellent response rate for the 2017 national staff survey, and has high hopes for another positive outcome when the results are released in March 2018.

Pete Burnett, Senior Delivery and Improvement Lead at NHS Improvement notes that the trust's leaders "recognised the importance of cultural change – this is the hardest thing to change in any organisation but they made that happen between inspections. The staff survey and report showed that".

Involving patients and people who use services

During the improvement journey, the trust has worked to consider the diversity of their staff and patients. They approached this by focusing on involvement. For example, in recruitment. "We are developing materials to reach out to the learning disability community and we are ring-fencing posts for people with lived experiences or learning disabilities," says Dr Ade Tams, Head of Workforce and Recruitment.

"We've developed a number of groups through our equality and diversity lead," explains Peter Howie. "We have a black and ethnic minority group, a group for those with mental health problems and an LGBT allies group too. Those groups are engaged in a number of workshop forum days and also across the whole of the health and social care community in Lincolnshire."

Dr Jaspreet Phull is passionate about how a focus of equality and diversity can drive improvements. "Inclusivity is important," he says. "Through having an equality agenda we can ensure there are multi-access points for patients and carers to feed back into the division and trust."

Outward looking

Dr John Brewin outlines how many staff visited other trusts in order to gain insight to improve, "The main focus was to find out what good looked like in other parts of the country. I'd already spotted East London NHS Foundation Trust before they got their outstanding rating. We visited there on a regular basis, as well as Tees, Esk and Wear Valley NHS trust. Our acute crisis services team have also visited Northumberland, Tyne and Wear NHS Foundation Trust. The priority is to get out and see where that excellence is."

This outward facing approach was also adopted in recruitment. Dr Ade Tams says, "The trust wasn't really having a presence locally or nationwide before, so we developed some dedicated recruitment brochures that showcased the trust, as well as a guide to living and working in Lincolnshire. We really upped the game in terms of our presence, especially online."

Next on the improvement journey

The clear message from the trust's leaders is the need to continue the culture and programme of continuous quality improvement. "We must not stand still," says Dr John Brewin. "It is a continuous loop." For John, trust leaders must continue to engage with staff to sustain this improvement, "I always ask what it's like to be on the receiving end of things, everyone is part of this and we must be more self-aware and reflective."

A significant challenge for the trust is the changes they would like to make to their estates and information systems. Jane Marshall, Director of Strategy says, "Clearly next is sorting out some of our big estate issues and the inpatient wards to improve the experience that patients have of our care. At the moment the estate we have is a constraint – the actual quality of patient care from our staff is excellent."

For Dr Jaspreet Phull, the estates challenge is linked in with a need to continue work to reduce out of area placements, "How can we impact on out of area placements by reinvesting in our wards and ensure we have the right services for our patients?"

> **"I want there to be great services for people wherever they are in the system."**
>
> **Dr John Brewin, Chief Executive**

Effective recruitment

Dr Ade Tams describes how the trust "went all over the country last year attending careers fairs and engaging with universities to recruit mental health students. With our local university we managed to recruit all 42 students in that cohort by making conditional job offers and fast tracking them into their roles".

This has seen the vacancy rate reduce from 16% to 1.7%, and for the past three consecutive years none of the newly qualified nurses who joined the trust have left in the first 12 months.

South West Yorkshire Partnership NHS Foundation Trust

April 2017

Rated as good

March 2016

Rated as requires improvement

South West Yorkshire Partnership NHS Foundation Trust (SWYPT) is a specialist trust providing community, mental health and learning disability services to the people of Barnsley, Calderdale, Kirklees and Wakefield. They also provide some medium secure (forensic) services to the whole of Yorkshire and the Humber.

Around 14,300 local people are members of their foundation trust, and they employ more than 4,400 staff across 12 sites.

Reaction to the inspection report

When the trust received its rating of requires improvement there was a feeling of disappointment, surprise and frustration among staff, who felt that they "were going to be rated as good," says Amanda Miller, team manager at Wakefield Recovery College.

However, there was also recognition that the rating of requires improvement would help the service to improve, "It was frustrating … but regulation is necessary because it stops services from becoming complacent. It was right for CQC to come in and say where we needed to improve," says Deborah Taylor, a former service user and peer project worker at Creative Minds therapy service, which is part of the trust.

Chief Executive Rob Webster, who joined in May 2016 just before the publication, echoes this view, "I recognised the findings in the report. We had good people, generally good services, but some of them were

struggling. We could have spent time arguing about the rating but we decided to try and fix the problems."

Culture

Although they didn't agree with some of the findings, the trust's leaders accepted what the report was saying and quickly decided to use the findings to make improvements.

One of the major areas for change was a cultural change in leadership so that the right people felt empowered. "We introduced an operational management group to avoid overloading the EMT [Executive Management Team], and issues are now brought to them by escalation only", explains Mike Doyle, Deputy Director of Nursing and Quality. "Previously, responsibility for changes would have been held centrally, but now we have the governance at board level and the accountability placed with the people that are best placed to make those changes."

Improved visibility and transparency of the leadership team also provided them with credibility throughout the improvement process to help shape the culture at the trust. As Deborah describes, "The visibility of senior staff is important. Rob listens, which is crucial as a service user. Often you feel like people hear what you're saying but don't really listen or do anything about it."

As a relatively new member of staff, Mike Doyle was also impressed at how honest and transparent the trust was, "It was a big eye opener for me. You'd see even junior staff airing their views where they might not have previously. People feel more able to express their views and opinion."

Outward looking

Involving partners was key to making changes. For example, Rob described how the trust "worked with our supplier … to make our electronic patient record system more effective. Rather than arguing about whose problem it was, we made it collaborative".

However, it is putting people who use services first that is essential for Rob. He believes that there is no reason why anyone should have difficulty accessing SWYPT services.

> **"The phrase 'hard to reach' is one of my banned phrases. People aren't hard to reach… In our system, we know where people live through their GPs, we have fantastic insight into the sort of issues they might have. We need to design services they can access."**
>
> **Rob Webster, Chief Executive**

"We [also] have a Black and minority ethnic staff network now, which ensures our views are more representative of our overall population," he adds.

In addition, SWYPT visited other trusts to find out what they were doing well and to learn from them. As Mike explains, "[the trust] visited places

Visibility directly improving patient care

"At creative minds we offer regular coffee mornings, where service users can come in, and get a cup of tea and a piece of cake. Our Chief Executive, Rob Wesbter dropped in without any fanfare and didn't tell people who he was. One service user who was an inpatient talked about a door slamming through the night outside their door on the ward. In the day, Rob had gotten somebody to go out and put some felt around the door so it didn't slam. Just listening, and acting, and making that small change, made such a huge difference to that service user. He really does listen, perhaps if she'd said to someone else they might not have done anything about it, but he took action. As a service user it's crucial to feel listened to, to finally have a voice is priceless."

Deborah Taylor, a peer project development worker at Creative Minds and former service user

Engaging with the local community using sports

"We do some work with Barnsley Football Club as they approached us after recognising they had fans with dementia, and wanted to know how to support them to keep coming to games. We did some dementia awareness training with the stewards, and they also have a museum with an archive which allows us to work with those fans on a portrait of their life using artefacts. We also have a good mood 5-a-side football league. It's not just for people that are accessing our care, it's also for staff. Nobody talks about mental health it's just about using it as a support therapy. Next year the European cup will be held in Barnsley."

Chief Executive Rob Webster

where we saw innovation, and other trusts that were rated as good in domains where we weren't, to learn from them. We also created an improvement panel with a mixture of colleagues and commissioners, and even invited CQC to attend as well."

Staff engagement and empowerment

An increased level of staff engagement and better communication was another factor in driving improvements, as staff felt more comfortable pointing out where changes could be made.

> **"I think the beauty of the trust is that the leadership listen to what I say and change services. My service user and carer voice will always come above my worker voice, but I am never frightened to speak my mind since the swap to worker."**
>
> **Deborah Taylor, former service user and peer project worker at Creative Minds**

As well as being able to speak out, Sean Rayner, District Director for Barnsley and Wakefield, says that the trust's leaders now make sure there is a two-way process to provide instant suggestions for improvement. "We have weekly huddles where staff can raise anything they like – what challenges they're facing, what the problems are – but we are able to triangulate and tell them about support available or something that another ward is doing."

Communication that feels integrated, rather than an afterthought, is another improvement at the trust, "Although there was a level of communication there before, now it feels more informal, more just the way we do things," Mike explains.

The effect of this new approach was reflected in the trust's staff survey. "From 2015-16 we had a 26% increase in the number of people who felt they were kept up to date with what's happening. That's thanks to the work that's been done like introducing a weekly staff email and a blog," says Kate Henry, Director of Marketing Communications and Engagement. "Everywhere else I've worked, the vision and values have felt tokenistic, but here you really feel that people are living them."

Relationship with CQC

"The first thing was accepting the rating and deciding to work closely with CQC to make it right, that was our commitment to our staff and patients," says Mike. "As a result of that acceptance, there was a promise from CQC to re-inspect us quickly. We didn't want to wait several years, so we were incentivised to work quickly, which meant patient care was improved more rapidly."

Director of Nursing and Quality Tim Breedon agrees, describing how as soon as they got over the initial shock of the rating they "realised the value of this independent data".

In turn, the trust felt more empowered to have conversations with commissioners about making changes – "the report helped us to have those conversations," says Rob.

Governance

Introducing a different governance structure helped the trust become more focused, as Mike explains, "We already had governance groups but now they're more focused and we base the meetings on key lines of enquiry which we didn't before."

Karen Batty added, "We put all of the areas rated as requires improvement into an action plan and sent them out to our newly created business development units. We asked them to tell us what they were going to do about it. We followed this up with quality monitoring visits and inspected areas using similar metrics that CQC do. We knew CQC were coming back and we wanted to get some assurance by actually going to see what they would find."

Next on the improvement journey

As well as having an ambition to be an outstanding trust, SWYPT want to make a big push to empower people to help themselves. "Informal support for people using services is far more sustainable and productive," says Tim. "We come in and out of people's lives, but family and friends don't [and] we want to support that."

Kate agrees, saying, "The NHS is only involved in 10% of a person's life – it's all the other things like networks, groups, clubs, friends and family that make up the other 90%. There's a lot more going on in people' lives that contribute to their health and wellbeing clinical care, we need to facilitate that."

Examples where the trust has already seen improvements include:

- Using existing resources to get 'more breathing space'.
- Making the environments on some ward areas safer, in terms of ligature points, and ensuring everyone has an individual risk assessment.
- Putting safety first and allocating money for safer staffing – a change that has been welcomed by staff and people who use services alike.
- Introducing a clinical supervision passport, which has been rolled out across the trust. It makes staff feel more secure in the care they're providing for patients.
- Giving people who use services the opportunity try different treatments, and being more responsive to needs, rather than just going down the traditional clinical approach.

Freeing up resources against increasing demand

"Getting people doing group work at the recovery college gave us an opportunity for quicker intervention rather than a one-on-one session with a therapist, which has a longer waiting time. The college then worked with people to build up their confidence in self-managing and even getting to a point where people feel ready to self-discharge. Lots of people decided they no longer needed that community team clinical intervention, which helped free up resources. One lady who had been seeing the community team for a long time had difficulty leaving the house, felt very anxious and low at times. She accessed a course at the recovery college and really enjoyed getting creative and with help from us she set up her own knitting group in the community. She's much more confident and still has days when she feels low but that intervention from us means she now manages that herself and is no longer a user of our services. That extra capacity makes us more responsive to new service users."

Amanda Miller, Team Manager at Wakefield Recovery College

North Staffordshire Combined Healthcare NHS Trust

February 2017

Rated as good

September 2015

Rated as requires improvement

North Staffordshire Combined Healthcare NHS Trust provides a range of inpatient and community mental health services to a population of 464,000 people.

The trust operates from one hospital site (Harplands Hospital) and approximately 30 community-based premises. The trust has approximately 1,216 whole time equivalent (WTE) staff.

Reaction to the initial inspection report

The rating of requires improvement did not come as a shock to Chief Executive Caroline Donovan or others inside or outside the trust. Caroline had been in post for about a year before the inspection, and had started a process of improving services and staff morale.

Chair David Rogers explained that a couple of years before that inspection, the trust had been in a "perilous state. However, we fought our way out and this says a lot about the morale of the organisation and confidence to improve". In 2015, the trust developed a new five-year strategy. The message to staff, says Andrew Hughes, director of strategy and development, was that "if we aren't working in partnership in the delivery of services then why not?" That outward looking approach characterises the way the trust has approached improvement.

Culture

Work had started with staff on a fresh vision and set of values before the first inspection. For the chief executive, the vision needed to be based on a clear quality strategy that was meaningful and that everybody could relate to from a patient perspective. "As we developed, we set an ambition to be outstanding", said Caroline.

According to Caroline, the most significant action in driving improvement was turning the culture to put more emphasis on supporting staff. "We changed so much; decisions used to be made only at executive level, but we radically changed clinical leadership and pushed decisions down so clinicians could lead. I wasn't just going to sponsor people in a senior leadership position; it could be a more junior member of staff who had a fantastic idea and we got them leading a clinical improvement group."

> **"This was the first time some autonomy had been handed back. The biggest change was being able to try things. Staff are more determined to own the environment, which is good for morale."**
>
> **Laura Jones, Ward Manager**

It was important to create a culture where people could really speak up if something goes wrong. Staff can contact her by means of 'Dear Caroline' emails. It is an opportunity to raise concerns anonymously if they feel they are not being dealt with. Every month we publish them all on the intranet so everyone can see what the issues are, what the response is, and what we've done about it.

Having strong leadership at every level has been key to the improvements according to Caroline. And she has been supported by a trust board "that focuses on the right things and is clear that the reason we are here is for our staff and our patients".

Director of Leadership and Workforce Paul Draycott explains, "We had quite a bureaucratic organisation…[but we] stripped the hierarchy and invested in the senior leadership team." The trust put 140 managers through a leadership programme run by Aston Organisational Development. A lot of work has also been done in supporting individuals and teams, particularly when they have been affected by serious incidents. According to Service Manager Darryl Gwinnett "this has been a major cultural change. There was a macho environment before; now it is OK to be upset".

Executive Medical Director, Buki Adeyemo also highlights the move to stronger clinical leadership. "The history of the trust was that it paid lip service to clinical leadership. We consulted with clinicians… and have worked hard to improve the relationships between clinicians and managers."

Governance

A number of important actions were taken to improve governance. Suzanne Robinson, Executive Director of Finance, Performance and Digital explains, "One of the first things was to strengthen the business case process. We wanted to make finance easier to understand and to be meaningful to staff and public."

Suzanne also focused on how the organisation could deliver better value – "better outcomes and better quality at a lower cost". There is an online portal called Value Makers where staff can submit ideas and give examples

Progress on finance recognised nationally

The finance team won the Costing Award in 2016 at the Healthcare Finance Management Association's (HFMA) annual awards and the Havelock training award in 2017. The latter recognises excellence in finance awareness and training and development.

More scrutiny through performance measures

The trust has developed its own performance measures to drive improvement. One example is in children's services. This was the area of greatest concern, reflected in the rating of requires improvement. While nationally it needed to report 18-week waits, it introduced more scrutiny around four weeks for assessment and subsequent treatment. It classifies a child waiting over 18 weeks as a Never Event. "Our view is that these are not statistics, they are children", says Suzanne Robinson, Executive Director.

Non-medical Professional Leadership

Maria Nelligan, Executive Director of Nursing and Quality established a nursing network. Events were held with nurses to develop a nursing strategy. "I made a commitment to support the development of new roles in nursing", said Maria. "The message was well received. It lifted nurse morale. It was great to hear the ideas that people had. Then I started similar work with social workers and allied health professionals. We want all our staff to feel valued and supported."

Inclusion

Paul Draycott said making improvements meant doing a lot of work around inclusion to make sure that all staff were engaged. The trust identified a need to raise the profile of lesbian, gay, bisexual and trans (LGBT) people. "We've had our first conference last year, got the Board talking about issues, and became a Stonewall diversity champion and an NHS Employers diversity partner."

The trust has done a lot more work to improve its profile and perception in the Black and minority ethnic (BME) community. NHS England held a challenging session with the Board looking at the Workforce Race Equality Scheme, ran a session with the trust's leadership academy and ran a focus group with BME staff.

of things that are not adding value. "We have a 'value maker' award as one of our staff awards."

The finance team is one of only a handful of mental health trusts to pioneer the development and implementation of the new patient-level information and costing system (PLICS), which provides a better understanding of a trust's finances by providing individual costings for each patient.

Huge progress has been made in implementing a new electronic patient record system. When the trust was rated as requires improvement it was just starting with the new system – now it has put in a bid to be digital exemplar. There was a programme of engagement across the organisation under the banner of ROSE, which stood for 'Raising Our Service Excellence'. "The success", says Suzanne, "is down to staff embracing change and having an appetite to improve."

Staff engagement and empowerment

For Matt Johnson, Clinical Director for CAMHS and Learning Disability, one of the key actions immediately following the publication of the first report was to engage with staff. "The report was clear that staff were caring and committed – we had to say 'you have done well, but there are some real challenges'. I am clear that as a leader I want to be visible to all the teams. I worked with front line staff to work out what we had to do differently to make people's journey in a service better."

Chief Executive Caroline Donovan also underlines the importance of managers being visible to staff. "The best days I have are when I am out meeting people. It is a big challenge, but our highest priority – and it is built into the timetables of the executive team, that once a month there is a staff engagement day. Ward Manager Maxine Tilson confirmed, "Communications from the board and chief executive have improved. I can speak to the chief executive on a one-to-one basis and she will know who I am."

> **"Away days give us a protected environment where we can have open discussions. We had permission to try things, have a go, learn and develop."**
>
> **Rachael Burke, Team Manager**

Relationship with CQC

Matt Johnson thinks the inspection report helped drive improvement, "External scrutiny holds you to account about service improvement. There were things we needed to do differently." Paul Draycott said that although the inspection felt harsh at the time, "without that wealth of feedback we wouldn't have got where we did so quickly."

Caroline Donovan encouraged a follow-up inspection six months after the first. "People thought I was overly ambitious to ask – how could we possibly make those improvements in six months? But we had started and I knew that it was a fantastic opportunity and gave us a great burning platform to continue and really accelerate change."

Outward looking

The trust has recognised that the best future for people who use services will be achieved through much better coordination and integration of services across the local health and care system.

Chair David Rogers says that he and the chief executive spend at least half their time outside the trust developing relationships with other stakeholders. "We have a confidence and capacity to operate outside the trust that would have been alien three years ago. He goes to most board meetings of other trusts and to local authority meetings. It takes time to build those relationships. We see community care as having to be led by primary care, and we support that. We are not precious about remaining independent. In time there will be an accountable care system for North Staffordshire."

Chief Executive Caroline Donovan echoes this, "Most of our services are now delivered in partnership with another agency. We work with the voluntary sector, NHS and social care, police and fire. We have tried to change the culture, from criticising to being jointly accountable for improving our populations' health."

The trust has continued to build relationships with groups that support people who use services. Kirsty Booth works for Changes, a local charity that helps children and adults with mental health problems. She is also a member of the trust's children and young people's council. "They invited us to team meetings and directorate meetings and asked the youth council to discuss issues and report back. For example, we said that young people did not know what to expect when accessing the service. We suggested a website for the service and this has now been developed," she explains

> **"I encourage public involvement. We invite the media to meetings and have moved much more business into open sessions. If we can't set out our stall in front of the community, what are we doing? As a board, we have to be honest about problems and say what we are doing about them. Being held to account is a genuine thing."**
>
> **David Rogers, Chair**

Next on the improvement journey

Chair David Rogers explains what the future holds for this improving trust, "Our most recent inspection results are imminent and we are hopeful that our services will be rated as either good or outstanding.

"But we're not stopping there. Each of our directorates is drawing up a detailed action and improvement plan to address any issues identified by CQC. We are determined and excited to take all of our services to outstanding. In addition, we are continuing to develop our Leadership Academy and our Towards Outstanding Engagement programme to build our capabilities and performance across everything we do."

Partnership at work

One practical example of the trust's strategic partnership work is its relationship with the North Staffordshire GP Federation, which has 83 GP practices from Stoke-on-Trent and the North Staffordshire area as members.

Paul Roberts is a local GP and Director of the GP Federation who has worked with the trust since the inception of the federation, "The trust has been extraordinarily supportive and facilitative, which is important for the whole system. This allowed us to do things we would never have been able to do as quickly. For example, we were able to get GPs involved in streaming patients at A&E because the trust underwrote the governance."

Improved outcomes for people

For Caroline Donovan a key improvement has been the work done on places of safety. "We had an unacceptable level of patients going to police cells. We linked into another trust that was doing really well and then ran a Listening into Action project. We have reduced by 85% the number of people who go into a police cell unnecessarily."

Calderstones Partnership NHS Foundation Trust

June 2017

Rated as outstanding

October 2015

Rated as good

July 2014

Not rated but serious problems reported

Calderstones Partnership NHS Foundation Trust provided specialist and forensic learning disability services across the North West to a population of around 6.6 million people.

In July 2016, Mersey Care NHS Foundation Trust took over Calderstones Partnership NHS Foundation Trust and it became the Specialist Learning Disability Division.

Reaction to initial inspection report

Chief Executive Mark Hindle, who had only been in post for a few months when the trust received the initial findings of the first inspection in 2014, says, "There were some quite big surprises, particularly around things like cleanliness and the use of restraint. But there were also some positive things, particularly around CQC's view of the compassionate and caring nature of staff, which were important as they gave us things to build on for the future. There was a general view in the system that the quality of care and the infrastructure of Calderstones was quite poor and needed some immediate work on it. CQC came in and reinforced those views and told us that some of the practices at Calderstones were not fit for purpose."

For Mark, the report showed him that, "Some of the board and some of the people leading the organisation weren't fit for purpose in their capability or capacity and it enabled me, as chief executive, to look at those roles and change them fundamentally."

Mark is also clear that being able to bring the board along on the improvement journey was vital, especially in terms of funding urgent improvements, "The board was very supportive to me as chief executive

and to all the things that we were proposing to improve quality and that takes quite a bit of bravery for a board to justify spending money that you haven't got."

Lee Taylor was appointed Director of Operations at Calderstones after the inspection. He says, "CQC set out the priorities in the inspection report, and that's where you have to start. Break down the report into the deliverables – the 'must dos' and 'should dos'. The 'must dos' are really important and we developed an action plan around them, but we didn't miss the rest of the report."

To implement improvements the trust set up a team to bring about changes. Medical Director Dr David Fearnley, who joined the trust shortly after the inspection, says, "My first job was to develop a workforce development plan. The trust had failed to recruit and the medical voice was not being heard. I wanted to bring a medical view to the leadership of the trust and push the medical agenda."

Culture

Changing the culture in the trust was a priority for Chief Executive Mark Hindle, "Culturally people told me that staff were scared of coming forward with ideas, scared of how to implement change and fearful of what might happen to them by putting their heads above the parapet."

"There was", says Mark, "a real 'we can't do' attitude coming out of staff, reinforced by senior leaders. So that required a significant change in those senior leaders in the organisation, especially at the executive level, but right the way down to the front line."

> **"We were too insular and inward looking and we didn't spend enough time seeing what other professionals were doing in the sector."**
>
> **Dr Arun Chidambaram, Deputy Medical Director**

However, Lee Taylor, now Chief Operating Officer, describes how the trust began to change the culture to one "of being open and transparent, reporting things and learning from mistakes".

Fiona Gibson was one of a team of three that worked alongside the board, clinicians, director of nursing and the various departments. She says, "It was about putting systems in place so that we didn't have to rely on people saying things were in place. We did peer checks so that we had ward managers checking each other's areas."

But there was a longer term objective, too, according to David Fearnley, "To start with we needed to get over the line, but then look beyond. This was not about ticking boxes in an improvement plan, but looking further to be good and then outstanding."

Leadership

Prioritising patient safety was key for the leadership team. For David Fearnley, there were some "over my dead body moments – for example we

> **"Personally I was very disappointed and I was upset, but to be fair I thought that there were points that were absolutely right, there things that we missed and left a little bit of an open goal,"**
>
> **Fiona Gibson, Clinical Nurse Manager**

Involving people to reduce restraint

The trust did some direct work with the female secure unit, which used physical restraint frequently. They involved people using the service in changing the way the trust worked, with a view to resolving issues before behaviour became so challenging as to lead to restraint. Patients helped to produce a video for staff on positive behavioural support.

had to stop using mechanical restraint. We had a clear conversation about the date on which it would stop. Things had drifted into practice; lines had to be drawn."

There also had to be an improvement in positive behavioural support plans, safe practices and training in the Mental Health Act. By the time of the second inspection inspectors noted that each patient had a positive behaviour support plan in place and that the quality of the plans was exceptional.

They also reported on a significant reduction in the number of episodes of restraint, use of rapid tranquillisation and seclusion, and eradicating the use of emergency response belts.

The trust also addressed the admissions policy since it had a major impact on the rest of the services. Dr Arun says, "We set up an admissions panel with a medical chair, and gave it the power to make that final decision."

Broader patient safety work also took place. Dr Chidambaram says, "We put in place a safe ward initiative and held safety workshops with staff. We realised that we needed to work more collaboratively as a workforce to make our services as safe as possible and have a greater understanding of what the risk are and how we mitigate against them."

He also says, "We put in place ward round team meetings, where the whole team gets together to plan for the next few weeks. We found that previously ward rounds were taking whole days to do, so we needed to streamline the process. We did this by looking at patient records and allocating specific tasks to people, which made them more accountable and more effective."

Involving patients and people who use services

Mark Hindle emphasises the importance of talking to patients and families. The trust talked "explicitly and frequently with families, asking them for their help and seeking their insight. Involving patients and carers was critical in our different approach to quality and a new way of doing things" leading to services that were "more patient focused and less focused on systems."

"We changed fundamentally the way that we talked to our families and carers and asked them about how it would be best to communicate with them. One example was that we started to have regular meetings on a Saturday and we paid people's travel expenses. Critically there were some quite negative people historically who have now become allies advocating the work that we do."

Engagement included getting people who use services involved as quality champions and, says Fiona Gibson, "in some areas getting them involved in quality audits. We got Healthwatch in to do some audits and we had commissioners coming in and doing a review of a clinical area". A huge amount of work was also done with staff internal communications and engagement.

Stephen Ellis, who uses services, says he "helped in making information easy to read for people using services. I am part of the media group [people working with their occupational therapists]; we have made videos

about families and carers that we use in training and videos about the ward areas so that when people come from prison, medium or high secure units or the community they know what to expect." Stephen and the group have been widely recognised for their work, including at the National Service User Awards.

Mark Hindle says, "I was clear at the time that there was a really big communications job in the organisation. So one of my key things was to engage patiently with staff, doing meetings, roadshows, breakfasts and actually talk to people and listen to what they said to find out what it was really like to work at Calderstones."

> **"Largely staff were brilliant. They came back together after being 'broken'. Bringing people together in difficult conversations gave people confidence."**
>
> **David Fearnley, Medical Director**

Relationship with CQC

Mark Hindle welcomed the feedback given following inspections, "CQC was very helpful in terms off of their regulatory position, but also in terms of their help and support in judging and making sure that we delivered our action plan – not in a punitive way but in a cooperative and supportive way. Without the help and support of particularly CQC and also NHS Improvement we could have fallen over at a much earlier stage."

According to David Fearnley, "Inspection reports help and so does the experience of being inspected. With our second report, the feedback that we could almost be outstanding gave people a sense of the future. From being demoralised, staff could see we were not that bad and we could do better. Inspection was a positive experience."

Next on the improvement journey

Dr Chidambaram wanted to make sure the changes stuck, "After the result of the second inspection we had a celebratory event and used that to start to begin a conversation on how we make sure we can sustain what he have been doing to put things right. There is a real appetite to learn from the journey that we have made and keep focusing on coproduction and people centred care."

Learning from incidents

Calderstones worked with insurance firm Lockton, and legal firm Mills & Reeve, to review the trust's internal processes for reporting and investigating serious incidents. This enabled them to streamline the process, improve the depth of analysis, and embed the opportunities for organisational learning by working directly with senior clinical staff and nurse managers.

Sheffield Health and Social Care NHS Foundation Trust

March 2017

Rated as good

October 2014

Rated as requires improvement

Sheffield Health and Social Care (SHSC) NHS Foundation Trust is based in Sheffield, South Yorkshire and services a population of around 560,000.

The trust operates from 33 different sites and provides a range of community-based and inpatient mental health and learning disability services, as well as specialist services such as drug and alcohol treatment and recovery programmes. It also provides primary care through a network of GP practices. The trust employs around 2,600 staff who are supported by peer support workers (people with lived experience of mental health issues), volunteers and apprentices.

Reaction to the initial inspection report

Reflecting on when the trust received the rating of requires improvement, Liz Lightbown, Executive Director of Nursing, Professions and Care Standards says it was "disappointing, but probably realistic". Catherine Carlick, a service user who is also involved in training staff, agrees with this view, "It was quite fair; lots of issues needed to be improved – de-escalation training, restraint, compassion, service user involvement all needed to be better."

For staff on the frontline, the rating initially affected morale. "Everyone comes into work every single day and tries to do their best – when you get something like that it's a really difficult blow to everyone who is involved", explains Kim Bannister, Ward Manager.

However, despite the rating not being what it had hoped for, the trust reacted positively, as Medical Director Dr Mike Hunter explains, "We have been very brave at putting it [the rating] front and centre. This is what we've got, here's where we need to improve. Now let's crack on and do it."

Leadership

The trust started by creating a care standards team – designed to focus on the journey to the next CQC inspection, but with a longer-term remit to look at ongoing quality assurance. In a fundamental shift from 2014, preparation for the 2016 inspection was very much clinically-led, rather than being led from the corporate level. The quality of care was discussed at all levels from board meetings, right through to meetings at ward level and with people who use services.

> **"It was very important that care quality was embedded as business as usual, and was not just about the inspection."**
>
> **Graham Hinchcliffe, Care Standards Manager**

To support the improvement work, each member of the executive team became a designated 'champion' for one of CQC's five key questions – safe, effective, caring, responsive and well-led. The directors were responsible for driving forward the action plans for each of the questions.

The care standards team set up staff and awareness-raising sessions with people who use services to look at what changes had been made since the last inspection, and what to expect from the next inspection. These sessions focused on being open, honest and proud of good practice. "We wanted to use the rating as an opportunity to provide better care, to do this in a better way… it was about creating a shared narrative," says Jane Harris, Head of Communications.

Frontline clinical staff, such as ward and team managers, and people who use services, were encouraged to self-assess against the five key questions to identify gaps in care quality and to develop detailed action plans for each core service. The care standards team offered support with the action plans before the inspection. Kim describes how, "a lot of it comes from leadership on the wards – developing the staff in a way that is supportive."

Focus groups were held on wards, and the question was always asked – what impact will each change make on the person using the service? Examples of initiatives put in place as a result of this included an inpatient forum – where staff, patients and leaders discuss quality, reducing restrictive interventions and increasing activities – and a nursing leadership group. This group was specifically for nurses to discuss nursing development and good practice, both locally and nationally.

Staff engagement and empowerment

The trust put a real focus on making sure staff at all levels, and people using the service, were regularly updated on changes and improvements. There was regular newsletter and website communications, and in the run up to the inspection a weekly countdown email helped prepare staff and keep morale high.

Mock inspections were also used to help get staff ready for the inspection, with people who use the service playing an integral part in each one. The mock inspections provided immediate verbal feedback so that teams could

Microsystems approach to quality improvement

The trust has established a quality improvement team to help deliver a range of improvements and to support a culture of quality of care across the trust. The team uses the microsystems approach, which looks at the different component parts of how care is delivered and how these can be improved. The approach encourages frontline staff and people who use services to work together in a multidisciplinary group to improve the overall quality of care. Microsystems coaches help build the capability of teams so that they can apply the tools and techniques when they tackle improvement work. Improvements have been made around access to therapeutic activities, the inpatient admission process, staff supervision, access to key interventions, medicine prescribing and caseload grading.

The 15-steps challenge

The NHS '15 Steps Challenge' is used by the trust to develop a more person-centred approach to quality improvement. Each challenge involves a patient, an executive or non-executive staff member, and a frontline staff member. The staff are encouraged to see the ward through the patient's eyes in the first 15 steps – the sounds, the atmosphere, the smells, and other factors. After each challenge, verbal feedback, a feedback report and an action plan is given to the ward. During one challenge, the team identified that a ward had a very clinical feel to it and that it would benefit from more artwork on the walls. The action plan was to encourage people who use services to contribute artwork to make the ward feel more welcoming.

get on with addressing areas for improvement, as well as a written report and action plan.

The focus on improvement has encouraged staff to open up and share their best practice and successes. Jane says, "there's a greater sense of pride in some of the teams…staff are more upfront about shouting about what's good or what's different."

Involving patients and people who use services

Chief Executive Kevan Taylor has encouraged an open culture at the trust – he is always ready to meet and speak with members of staff and volunteers at all levels.

> **"[Kevan] has an open door policy – you can drop in on [him] any time."**
>
> **Adam Butcher, Service User Governor**

"We saw patient engagement and involvement as being one of the key things we needed to do to achieve improvement" explains Mike. 'SUN:RISE', the trust's service user network, is closely involved in the work of the trust. People who use the services help train staff and local students using their own lived experiences of health and care services. They support the quality improvement strategy and service redesign and take part in Board meetings. Catherine acknowledged the changes that have taken place, but that challenges remain, "Before it was them and us – staff and service user. Now we feel at the heart of care, but there is still a long way to go."

Outward looking

The trust also looked outwardly to see where it could improve. Chair Jayne Brown explains, "More so than an acute trust, we occupy a space in the wider health and care system…we took feedback from our partners (local authorities, Sheffield City Council, Sheffield Clinical Commissioning Group (CCG) and other CCGs, South Yorkshire Housing Association and neighbouring NHS trusts) about how they felt we were operating and what kind of organisation we were to work with."

During the period of improvement, SHSC became one of the first trusts to stop sending people out of area for acute mental health care and treatment. The community enhancing recovery team looked carefully at admissions and the time spent on wards, and helped bring people with severe and complex mental health problems back into care in their own homes. Many had been in locked rehabilitation hospitals for some time. The team developed a number of person-centred improvement initiatives, which helped to build the skills of patients and aid recovery times.

Forest Close was repurposed from a standard inpatient ward, to an intensive rehabilitation service with a team of nurses, psychiatrists, psychologists, occupational therapists and a music therapist working together to support recovery and reduce inpatient stays. This work earned the trust a Health Service Journal award in 2016 for acute service redesign – the first time a mental health trust has won this award.

The community learning disability team managed to reduce waiting times from 29 weeks to two weeks by doing a whole system review and rationalising their waiting lists, which were previously all separate.

Relationship with CQC

Staff felt that the relationship with CQC was important for driving improvement at the trust. The inspection was seen as an opportunity rather than a threat, "the relationship with CQC second time round was completely transparent and open" says Kim.

CQC's report was helpful in laying out the issues and helping push forward work already in progress.

Next on the improvement journey

The trust has ambitious plans for the future and has developed a detailed plan for reaching a rating of outstanding. A big goal is "getting everyone to see service improvement as their day job," Kevan explains. Jayne, the Chair, echoes this view, "I'm interested in continuous and demonstrable improvement – that's how the Board sees it." Part of this will involve working towards accreditation with a number of organisations, including the Royal College of Psychiatrists.

Improving the rating under the safe key question is very important for the trust. A safety plan is in place and being led by Mike Hunter as the trust's safety champion. Regular safety huddles are being rolled out in inpatient areas, and the first annual safety day took place in October 2017 to open up discussions on safety with staff, people who use services and their families. The physical environment remains a challenge as services are housed in older buildings, posing a risk to patients, however, a planned move to a new estate should help to resolve many of these issues. There is also ongoing work to monitor and to help reduce restrictive practices and blanket restrictions.

The trust is working to improve consistency of access to community services – people can experience a sense of moving around the health and care system, unsure where to go next. The trust has done a lot of work to develop a city-wide single point of access for community care, but there is more to be done to make sure that everyone experiences the same quality of care.

The trust has a mindfulness programme for people with a learning disability, and a resilience programme is being developed. There is also an annual compassion conference for people who use services and staff to come together and explore compassionate care. This makes sure that people who use the services are really listened to and understood.

"CQC helped the trust to focus on the nitty gritty rather than the big picture of strategy. A big lesson from our first inspection was – we need to get the basics right."

Kevan Taylor, Chief Executive

Care Quality Commission

How to contact us

Call us on 03000 616161

Email us at enquiries@cqc.org.uk

Look at our website www.cqc.org.uk

Write to us at

Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

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NHS
North Staffordshire
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REPORT T0 TRUST BOARD (OPEN)

Enclosure No:17

Date of Meeting:	22.3.18		
Title of Report:	Meir Locality Partnership		
Presented by:	Andrew Hughes, Director of Strategy, Development and Estates		
Author:	Andy Oakes, Head of Partnerships/Social Care Lead		
Executive Lead Name:	Andrew Hughes, Director of Strategy, Development and Estates	Approved by Exec	☒

Executive Summary:	Purpose of report	
The Meir Locality Partnership is a vivid example of the Trust's success in delivering improved outcomes in partnership with other public and voluntary sector providers. The attached Report, produced by the Co-operative Working Team hosted by Stoke-on-Trent City Council, describes the significant progress that has been made through the hub. In addition to the reports/evaluation included work has been completed on reviewing the data and the impact of the Meir Partnership Model for the Trust. The data collected from May 2017 to November 2017 indicates that the model has had significant impact on referrals from the locality both to the Access Team and in relation to referrals into the Sutherland CMHT. During this period the CPN, based at Meir for three days per week, was involved in 44 individual cases. All of these cases would have previously been referred to Access. The Access Team received 375 cases from the whole of the Meir Locality GP population, 184 of which were referred on to the CMHT (54%). The Meir CPN is therefore taking 12% of all referrals from Meir but only had to refer 6 people of the 44 onto secondary care (14%). These figures are based on the 3 days per week input and if this was increased to a full time post based upon current workloads the CPN could have taken 73 cases (19.5%). These figures exclude all Acute/Emergency referrals to Access from Meir over the same period which were 44. Further analysis is required to confirm the current indicated impact however there is clear evidence that the new model in Meir works positively in avoiding the need for secondary care and is potentially more efficient for service users and the Access service. The model also supports the development of an emergency/acute access service with all non-urgent referrals being taken within the localities. Additionally, anecdotal evidence from both staff and service users indicates improved outcomes from the partnership approach and greater service user satisfaction. This evidence is being collected as part of the evaluation being undertaken by Sheffield Halam University. It should also be noted that in addition to the Meir Locality Partnership winning the 2017 Positive Practice in Mental Health Award for partnership with social care the project has been shortlisted for the 2018 Health Service Journal (HSJ) Value Award. The final three shortlisted for this category will be judged in early April with the award being announced at the end of April.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☐

NHS
North Staffordshire
Combined Healthcare
NHS Trust

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		
Resource Implications: Funding Source:	New models of care based around the locality partnerships will impact and support the proposed locality directorate structure within the Trust.		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	The target must be to scale this project so that residents elsewhere in the City and beyond are similarly served.		
Recommendations:	The Trust Board is asked to: • RECEIVE the report as assurance of the Trust's award-winning involvement in integrated working. • RECEIVE the evaluation of the Meir Locality Partnership model as the template for future reporting on Alliance projects. • AGREE that the Trust should continue to develop the locality partnership model in Meir and take a lead role in extending this model throughout the south of the City. • UNDERSTAND that the Trust will continue to work with partners to widen the involvement in the Locality Partnership Team and extend the colocation of staff from all agencies. • RECEIVE the evaluation as evidence of successful partnership working to deliver improved outcomes.		

Meir Locality Partnership Update

Introduction

The Meir Locality Partnership Project Group met in January 2018 and agreed actions in relation to clarifying purpose and measures for the project in order to further develop the evidence base to support further roll out the model in the city. The Cooperative Working Programme Team have been asked to support this activity and link into the Meir Locality Partnership to provide additional capacity to support transformational activity.

Actions Agreed

Officers from within the Cooperative Working Programme Team met with members of the operational team within the Meir Locality Partnership to identify where support was required to progress actions and further develop the evidence base around the project.

The following actions were agreed:

- Map out work flows for current system and within the Meir Locality Partnership to help demonstrate areas of improved efficiency.
- Map out referral processes into the Hub / Access team to understand where demand is coming in.
- Map out local community resources.
- Develop an Outcomes Map for the project – incorporating purpose, outcomes and measures and align this to the wider priorities set out in the STP. Ensure partners are engaged in this process to get a broader perspective of the expected outcomes.
- Use the outcome map to develop clear measures and mechanisms for collecting appropriate and robust data.
- Develop a clear neighbourhood profile for Meir to understand the potential needs of the wider community if the project expands.

Progress Update

To date the Cooperative Working Programme Team have focussed on developing the Outcomes Map and reviewing the current processes within the Meir Locality Partnership. An initial draft of the Outcomes Map has been prepared and is currently being refined by the Meir operational teams and associated partners. Further comments from the Project Group are welcomed.

In addition data has been collated relating to the local population and a community profile developed. A profile of the local demographic is provided for information which focusses on

providing some of the key statistics for the wards immediately adjacent to the GP's attached to the project. This report also provides information related to the outcomes defined within the outcomes map in order to provide a baseline position.

Initial work has also started on the workflow mapping within the Meir Locality Partnership itself, however further work is required to develop this and provide something comparable to the 'existing' system in order to evidence where waste has been removed. The initial work flow for referrals into social care in attached for information. This activity has also highlighted a number of barriers for the team in terms of progressing cases, these are highlighted and the Cooperative Working Programme Team will undertake work to provide further evidence of the impact of these barriers in order to support the Project Group in addressing them in the longer term:

- Social workers are often unaware of admissions/discharges to and from hospital.
- MASH paperwork doesn't utilise the Carefirst Forms.
- Bennet/Sutherland Centres proving difficult to get information from. STR/CPN passed information straight away no problems. Calling the public line for client information, no dedicated line.
- Information coming from the contact centre is often incomplete (wrong GP, no GP, wrong name).
- High volume of inappropriate work comes through the contact centre.
- Gap in provision for over 65 mental health care.
- District nurses presence in the hub a big gap.
- OT presence in the hub a big gap.

Next steps and Timescales

The focus of activity for the Cooperative Working Programme Team over the coming weeks will be on:

- Complete mapping of workflows both within the existing system and the Meir Locality Partnership.
- Develop an approach to monitor demand coming into the Meir Locality Partnership.
- Engagement with associated partners to sign off on the Outcomes Map.
- Develop mechanisms to measure key performance indicators relating to an individual's perception of their own well-being, GP appointments, community involvement and health outcomes.
- Develop a directory of local community groups and resources to support staff within the partnership to access appropriate services for customers in the area.

It is anticipated that much of the work will be completed by the middle of March; however the collection of performance data will be an on-going process.

In order to progress with some of this work further links with local GP practices will need to be developed in order to secure appropriate data. Further support from the project group may be required to help facilitate this.

Meir Locality Care Partnership

Purpose

People with a history of complex needs live safe and healthy lives through engagement with services and support in their local community

Reduce costs to the Health and Social Care economy

Accountability line

Outcomes

People are connected and active

- People work towards gaining employment
- People explore volunteering opportunities
- People participate in social groups and activities
- People form meaningful relationships
- People feel less isolated in the community
- People feel less lonely
- People feel safer in their homes and communities
- People maintain personal choice and control over their care needs
- People are able to remain safely in their own homes for longer

People have improved resilience

- People feel more motivated
- People have increased levels of self-awareness
- People make positive choices
- People participate in enjoyable activities
- People feel listened to and understood

People are able to learn

- People experience increased social interaction
- People understand and are able to set themselves realistic goals
- People are engaging in educational activities
- People are engaging in work related activities
- People understand how to access the most appropriate support for their issues

People share their skills and experiences

- People volunteer their skills to help others
- People use their knowledge to help others
- People develop friendships through sharing of experience

Reduced demand on health care services

- Fewer GP appointments
- Fewer referrals to social care
- Fewer A&E presentations
- Improved access to services and support
- More people feel connected to their communities
- Increased prevention of relapse
- Fewer people escalate to acute services
- People are housed appropriately
- People receive support to engage in community activities
- Fewer recorded admissions due to falls

Activities

· Engage with individuals and groups appropriately · Support and direct people towards existing community groups	· Advocate for residents to improve access to services for vulnerable people
· Develop new community groups and opportunities · Co-location with other professionals within the locality	· Joint working to improve information sharing and reduce the number of assessments
· Contribute to plans that meet the individuals needs · Develop informal opportunities	· Direct contact with named individuals within different services · Co-locate with other services in the locality to promote prevention
· Help and support people to develop and use their skills · Promote a strengths based approach to encourage people to perform tasks and support themselves · Increase understanding of legislation and how it guides service choices and opportunities	· Take ownership of cases to support people to address root causes of issues · Ensure access to formal care and support services as appropriate · Change culture to focus on self help
· Identify strengths, assets and opportunities to deliver confidence building · Pull in support partners for specific tasks (e.g. home fire risk check, area safety) · Identify the root causes of people's issues · Help people to develop sustainable solutions to their problems	· Develop opportunities for mutual support · Develop self-confidence · Encourage ownership for people to make their own informed decisions · Shared principles and values across partner agencies

Inputs

Partners:
- Local authority Wellbeing Team
- Combined Healthcare
- Changes Wellbeing Group
- GPs
- PCSOs
- SFRS
- CAB debt worker
- Housing
- Meir Community Centre
- District nurse
- Third sector
- Cooperative Working Programme Team
- Recovery Support Worker
- Saltbox

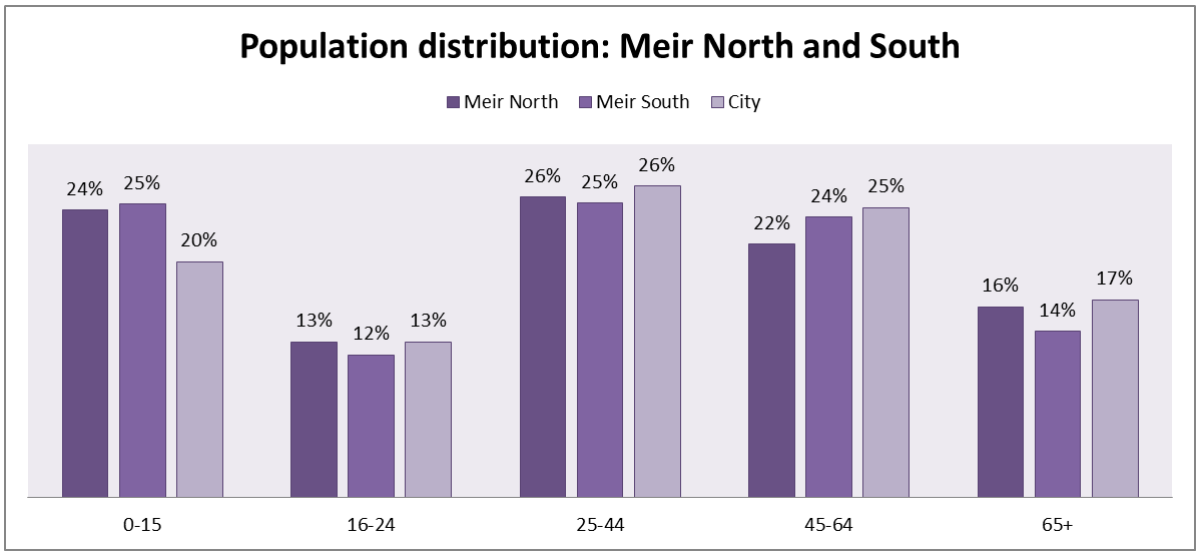
- Occupational Therapists
- Enablement Service
- Primary Care
- Community matrons
- Voluntary services
- Meir Community Education Centre
- Children's Centre
- Growthpoint (New and Old)
- Library
- Primary Health Centre
- Local business'
- Existing opportunities within the local community
- Local clubs and societies
- Clubhouse Network

Staff:
- Resilience
- Skilled workers
- Empowerment
- Willingness to learn
- Willingness to adapt to change
- Creative
- Realistic
- Trustworthy

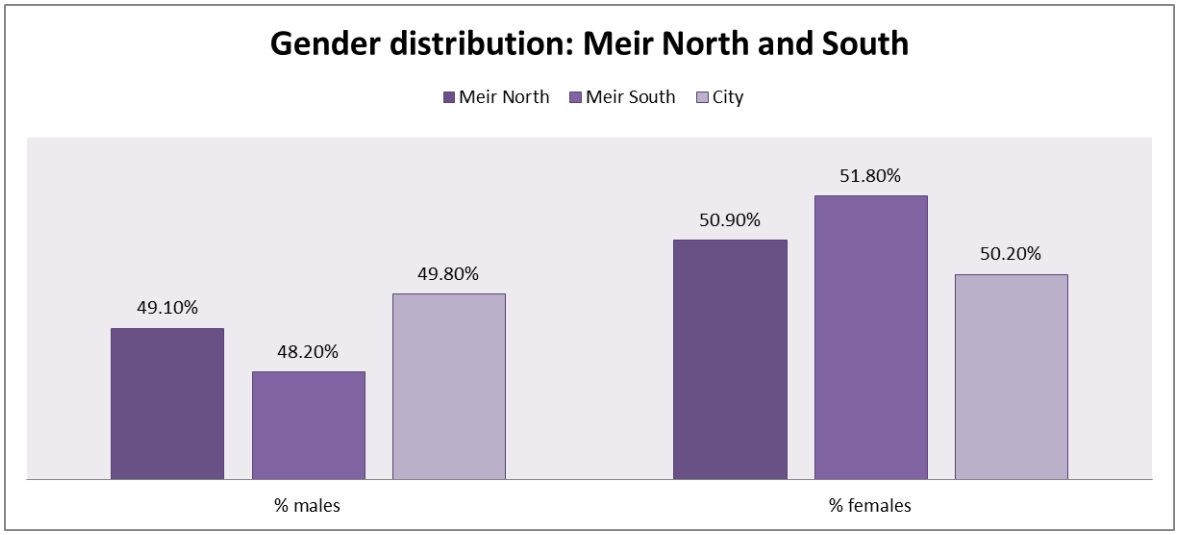
Meir demographic profile

Age, gender and ethnicity

Meir North and South are the two predominant wards that serve the GP surgeries attached to the Meir Hub. The age band population is fairly typical of the whole city profile with the exception of a slightly larger 0-15 years age group that account for 24/25% of the population compared to 20% citywide. A higher number of residents in this category mean fewer in some of the older age ranges but not to any significant degree.



The gender split in Meir North and South is largely typical of the citywide profile. Both Meir North and Meir South have fewer males/more females than the citywide profile but not to any great degree of significance (<2 percentage points).



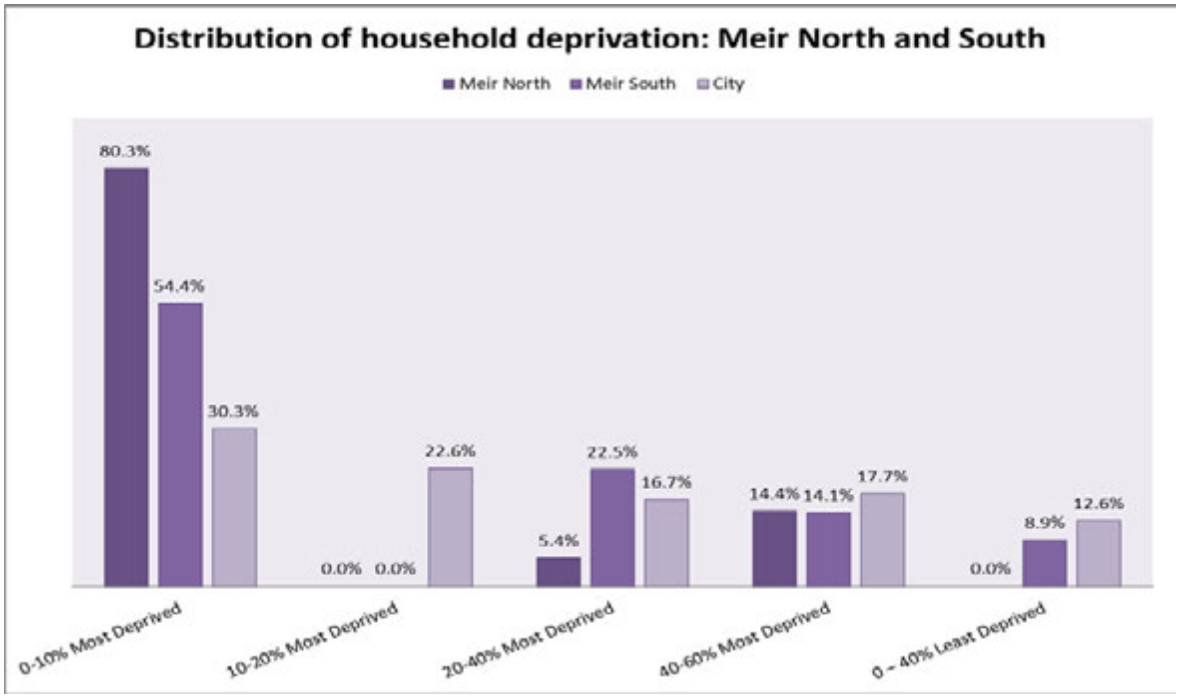
In terms of ethnicity, there are no stand out differences when comparing the two Meir wards and the whole city. The majority (c. 86%) of people living in these wards (and the city) are White British/Irish, between 5 and 7% are Asian/Asian British with smaller but consistent numbers of Black/Black British and multiple or mixed ethnic groups.

	White: British/Irish	Mixed / multiple ethnic groups	Asian/Asian British	Black/Black British	Other Ethnic Group	Not given
Meir North	86%	2%	6%	2%	0%	4%
Meir South	87%	2%	5%	1%	0%	5%
City	86%	2%	7%	1%	1%	3%

Based on age range, gender and ethnicity both Meir North and South wards provide good examples of a typical Stoke on Trent demographic.

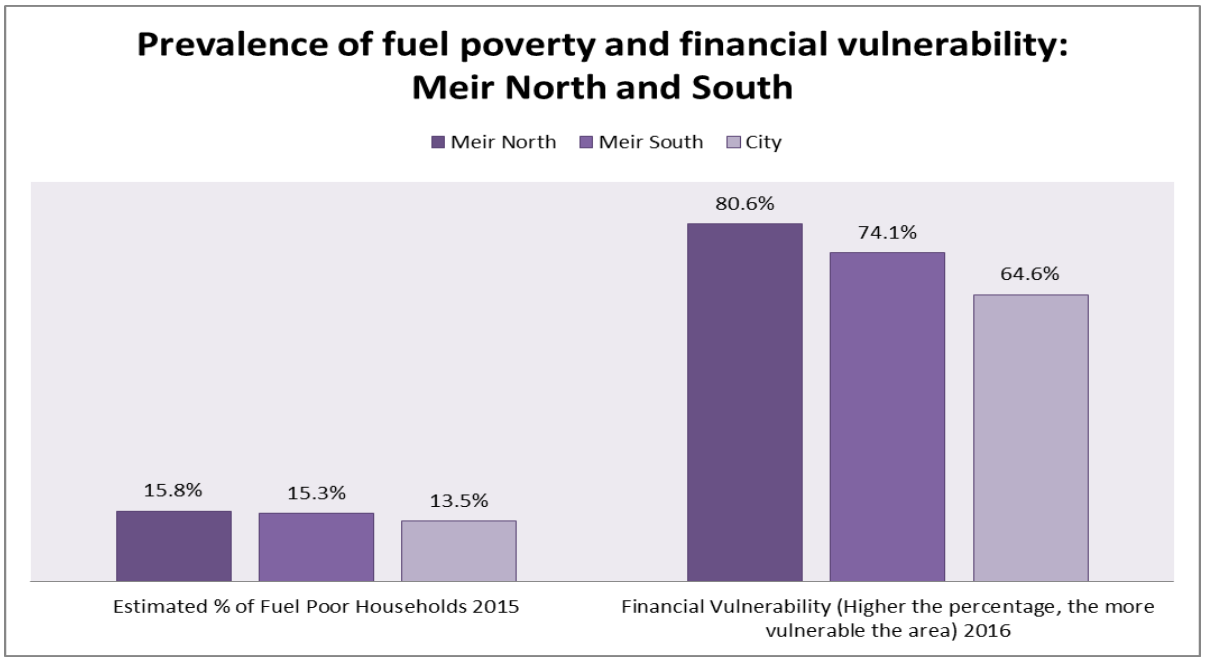
Deprivation and poverty

As a city, almost a third of the households in Stoke on Trent fall into the 0-10% most deprived category. Comparatively, huge differences in both Meir North and South are observed. In the Southern ward the citywide 30% of households in this most deprived category jumps to more than 50% whilst in the Northern ward this rises to just over 80%.



Neither ward has properties in the 10-20% most deprived category whilst in the South almost a quarter of those properties lie between 20 and 40%. The distribution of deprived households across the city is much more even.

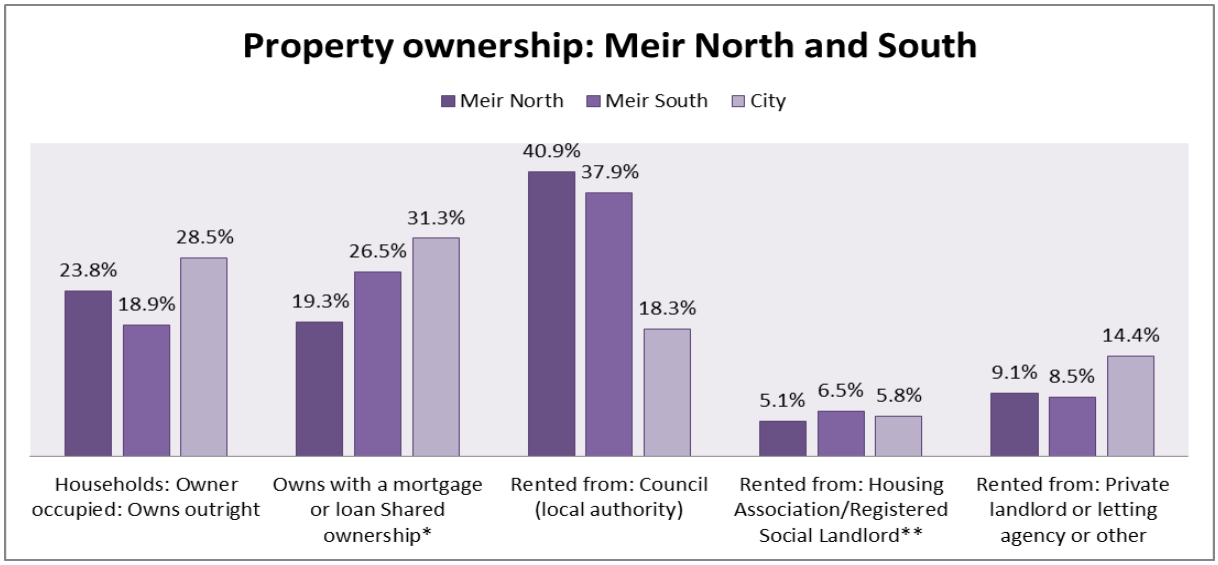
The percentage of fuel poor households in the two Meir wards closely reflects the picture across the city with only slight differences observed. Citywide 13.5% of households are deemed to be fuel poor. This increases to 15.3% in Meir South and 15.8% in Meir North. The more obvious differences are observed when looking at financial vulnerability. Here, a high percentage is more vulnerable and again data for Meir North asserts that 80.6% of households are classed as financially vulnerable compared to 74.1% in Meir South and 64.6% citywide.



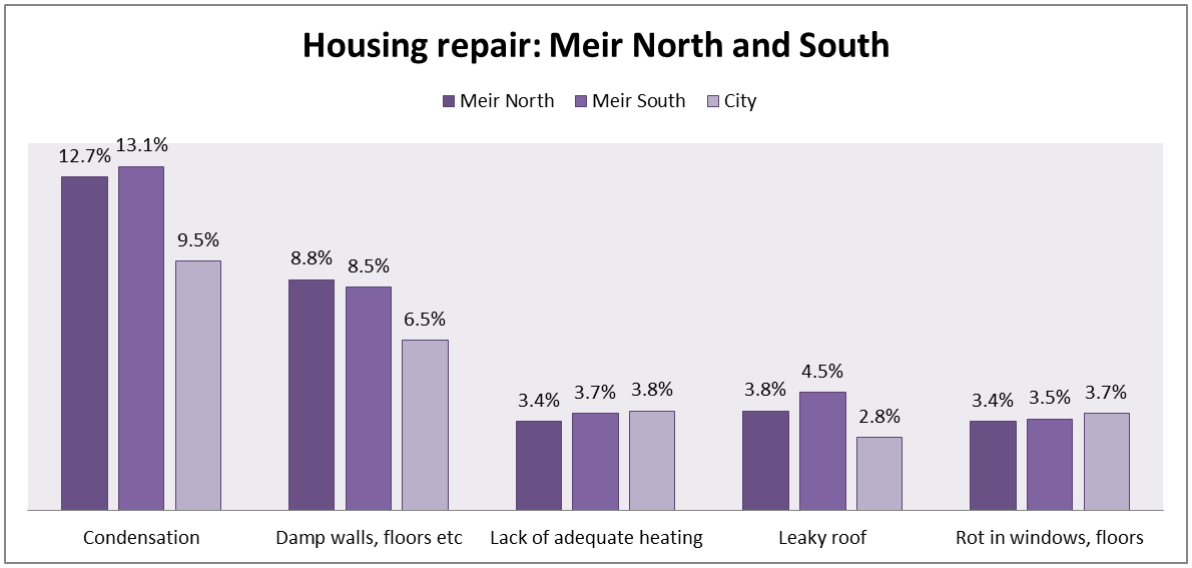
There are clear differences between the two Meir wards and the citywide picture when looking at deprivation and poverty. Statistically the community in Meir North struggles with extremely high rates of deprivation and financial vulnerability, often key indicators of an increased likelihood of support needs around mental and physical health.

Housing, work and benefits

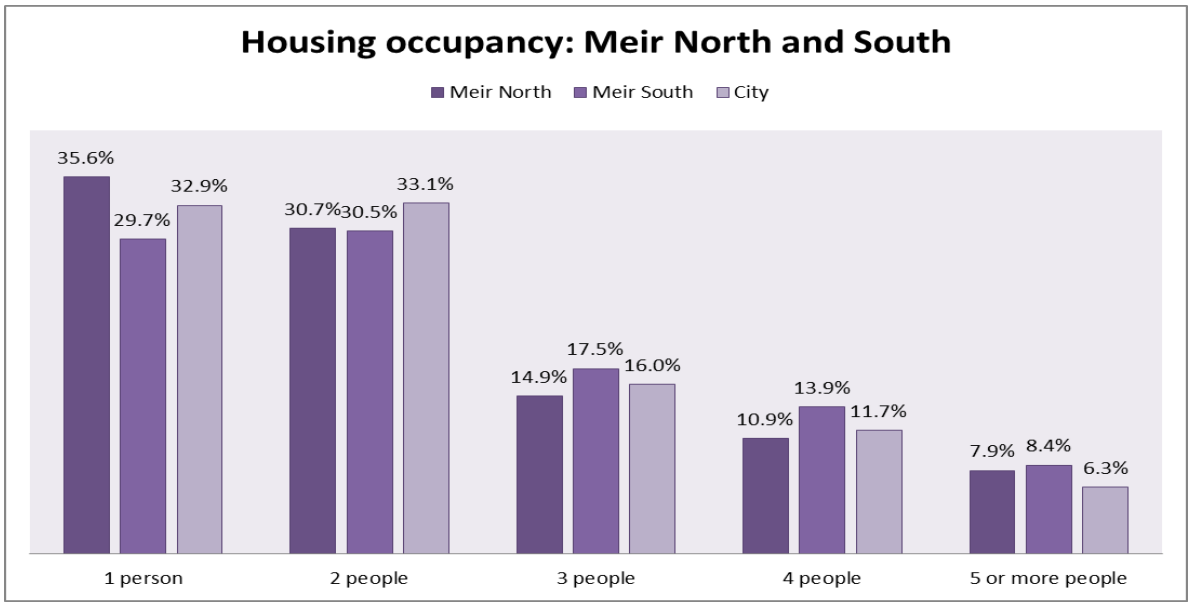
Housing stock in both Meir North and South is split fairly evenly between rented local authority properties and owner occupied or mortgaged households. These types of property ownership in both wards account for between 70 and 80% of the total. In both wards, local authority rented properties are the single highest type of property tenure. In Meir North this accounts for almost 41% of the housing stock with a further 37.9% in Meir South. Citywide this figure drops to just over 18% with higher proportions of outright owned homes, mortgaged homes and private rentals.



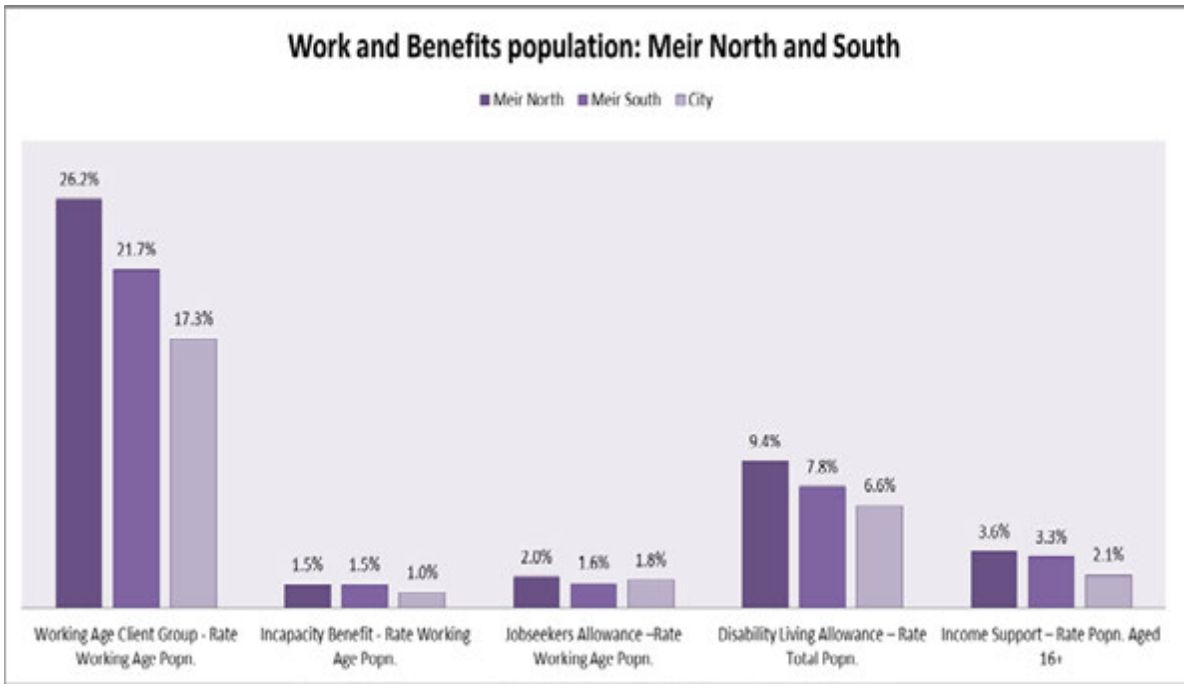
Some of the issues associated with fuel poverty, financial vulnerability and deprivation often manifest themselves in the standard of housing repair. It is easy to link the higher incidence of poverty and deprivation in both Meir wards to problematic housing repair. In the two Meir wards there is increased incidence of problems with condensation, damp walls and floors and leaky roofs compared to their prevalence across the city as a whole.



The occupancy profiles of both Meir wards are similar to that of the whole city with a few marked differences. More than a third of the houses in Meir North are occupied by a single person; this is three percentage points higher than the city average. Furthermore, Meir South has less than 30% single occupier households. Both wards have fewer two person occupied properties than the city average whilst Meir South has a higher proportion of houses occupied by three, four and five or more people.



The work and benefits profile of the two wards offers further insight into the local community. When compared to the citywide profile, both North and South wards are home to a higher percentage of working age people. This is observed particularly in Meir North where just over 26% of the population are of working age. This falls to 21.7% in Meir South and 17.3% citywide.



Against this backdrop there are a higher percentage of residents in both wards claiming disability living allowance and in receipt of income support. The figures in both wards come in higher than the average for the whole city. Other indicators around incapacity benefit and jobseekers allowance are in line with the citywide picture.

Health and well-being

	% of all h/holds : with one or more person with a limiting long-term illness
Meir North	36.40%
Meir South	34.70%
City Total	30.40%

The prevalence of limiting long-term illness is at its highest in Meir North whilst Meir South is also above the citywide average. In each ward more than a third of the households have at least one person resident potentially receiving and/or in need of health and social care support for their illness.

Meir North has comparably higher reported percentages of residents with 'bad' or 'very bad' health with an incidence of 10% of the population reporting this; a further 11.7% state that their general health is only 'fair'. This ward also has higher reported percentages of residents whose day to day activities are limited to some extent through their health. Both wards score higher than the city wide average.

	Day-to-day activities limited a lot All People	Day-to-day activities limited a little All People	General Health : Bad/ Very Bad	General Health : Fair
Meir North	15.6%	12.6%	10.6%	11.7%
Meir South	13.1%	11.3%	9.5%	11.1%
City Total	11.8%	10.9%	8.0%	11.0%

Hospital episode statistics from the Department of Health show a significantly higher rate of emergency hospital admissions in relation to pulmonary disorders such as COPD for residents of Meir North; more than 50% above the city rate and that of its neighbouring ward Meir South. Similarly Meir North also has a higher rate of admission for hip fractures in those aged 65 and over.

	Emergency hospital admissions Emergency Admissions, Chronic Obstructive Pulmonary Disease (COPD)	Emergency admission for Emergency Admissions, Hip Fracture in age 65+
Meir North	229.8	151.4
Meir South	153	99.5
City Total	155.3	107.6

Whilst Meir North has a higher rate of A and E admissions per population than the city average (144.2 v 135.5), in neighbouring Meir South the rate is almost 10 residents per population fewer. Both wards have fewer emergency admissions related to coronary heart disease compared to the city average and there is variation across the wards and city for elective admissions relating to stroke; Meir North is lower than average whilst Meir South is higher.

	Standardised admission ratios (England average = 100)				
	Emergency hospital admissions - All causes	**Elective admissions - All causes**	**Emergency hospital admissions (coronary heart disease)**	**Elective hospital admissions (coronary heart disease)**	**Elective hospital admissions (Stroke)**
Meir North	144.2	111.6	100.2	67.8	106
Meir South	125.8	106.8	103.4	59.3	128.5
City Total	135.5	107.9	108.4	64.9	116.6

Consistently, residents of both Meir wards report a higher incidence of a number of health and lifestyle issues and choices. Meir North residents in particular report higher than the city average incidences of depression (18.5%), Diabetes (10.1%) and high blood pressure (22.4%) with more than 55% of residents reporting that they do not exercise whilst 31.5% smoked cigarettes in the last year.

	Percentage of the resident population				
	Depression	**Diabetes**	**Do not exercise**	**High blood pressure**	**Smoked cigarettes in last year**
Meir North	18.5%	10.1%	55.6%	22.4%	31.5%
Meir South	18.2%	9.6%	54.6%	21.4%	31.0%
City Total	15.6%	9.4%	51.0%	21.4%	25.8%

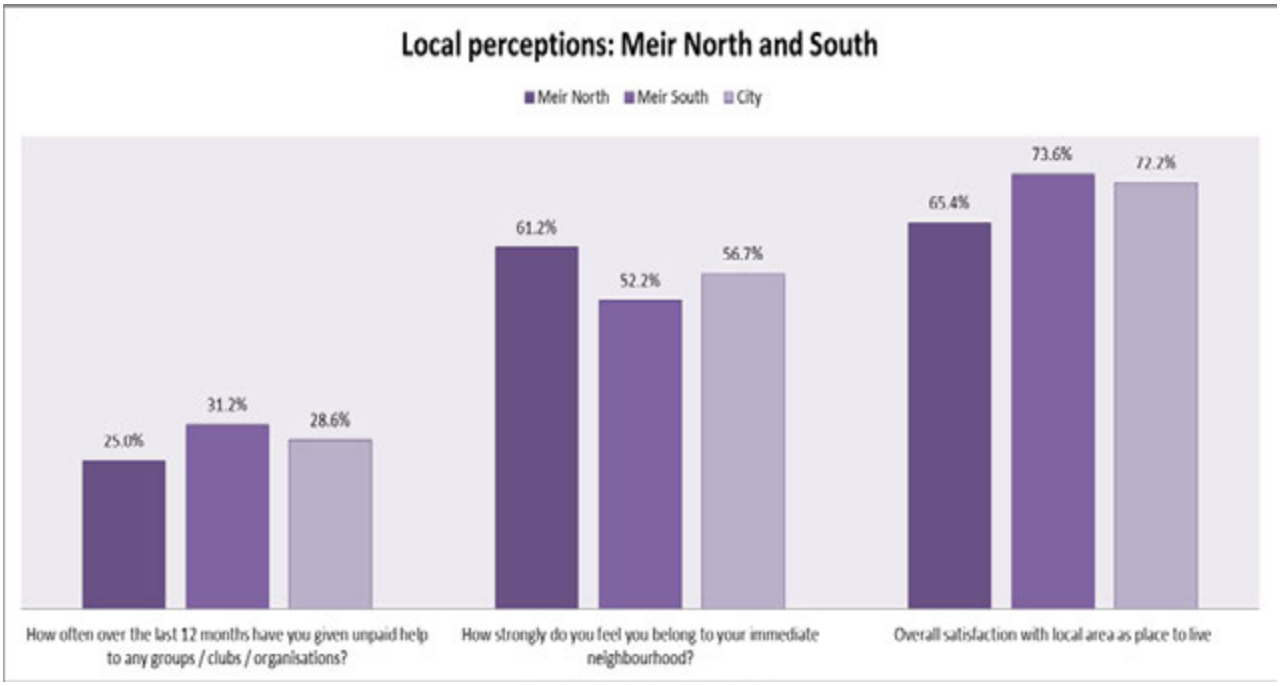
The combination of factors outlined to this point all contribute to a comparatively higher reliance on community based social care, mental health and physical disability/ illness related services. Again, particularly in the Northern ward the rate per 1000 population aged 16 and over of people accessing community based social care is much higher than the city average v 33.5). There is similarly high demand for mental health

	Rate per 1,000 population aged 16+		
	Community Based Social Care Services Total	**Mental Health Services**	**Physical Disability / Frail / Temporary Illness Services**
Meir North	47.2	12.6	27.1
Meir South	32.9	11.4	18.3
City Total	33.5	10	19.1

services (12.6 per population v 10 citywide) and greater demand (27.1 v 19.1 per population) for physical health services. By contrast, the statistics for Meir South fall in line with the city average.

Local perceptions

Perception of the local community and feeling part of it are at the heart of place based care. When asked about their overall satisfaction with the area, respondents in Meir North were less satisfied than those in Meir South and citywide by between seven and eight percentage points. Despite this, Meir North residents reported that they felt more part of their immediate neighbourhood than their counterparts in Meir South and across the city. Meir South has a higher rate of residents that volunteer for groups and organisations and do unpaid work. 31.2% of the people asked (in Meir South) responded that they had given their time up to do this during the last 12 months, more than the 28.6% citywide figure and 25% in Meir North.



Resident's perception of how safe they feel in their neighbourhood can be key to the creation of an active, engaged and supportive community. The percentage of residents stating that they felt very or fairly safe both after dark and during the day was lower in Meir North compared to the city average. Data for Meir South suggests that residents feel safer after dark than they do across the city (including Meir North) but comparably less safe during daylight hours.

	% of respondents very/fairly safe	
	How safe or unsafe do you feel when outside in your local area…..	
	… after dark?	… during the day?
Meir North	33.3%	80.6%
Meir South	40.3%	78.3%
City Total	36.7%	82.2%

Key points

- Basic population statistics suggest both Meir wards are typical of the overall city profile.
- Meir North has significantly higher volumes of the most deprived households in the city in addition to comparably higher volumes of financially vulnerability and fuel poverty.
- Both wards have a high percentage of local authority rented housing.
- Both wards have comparably more issues with housing disrepair.
- Meir South has more households of 3 or more people.
- Both wards have a comparably higher rate of working age people and higher rates of disability living allowance and income support claimants.
- Meir North has a higher prevalence of depression, diabetes and high blood pressure with more sedentary people. There are also more residents with long term illnesses that affect daily activity.
- The rate of smoking in the two wards is higher than the city average.
- There is comparably greater demand in Meir North for social care, mental health and physical illness/disability services.
- Residents in Meir North feel comparably more connected to their community.
- Residents in Meir South feel comparably safer at night.
- Residents in Meir South are comparably more likely to give up their time to volunteer.

Data sources

2011 Census data in this document is sourced from: Office for National Statistics licensed under the Open Government Licence v.1.0**.**

ONS Mid-Year population estimates 2015

Department for Energy and Climate Change. Experian MOSAIC 2016 (Financial Vulnerability)

MOSAIC, Experian Ltd, 2010

Place Survey, Stoke-on-Trent City Council 2008

www.Nomisweb.co.uk

HES 2009 to 2013

NHS
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Combined Healthcare
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REPORT TO: Trust Board

Enclosure No:18

Date of Meeting:	22 March 2018		
Title of Report:	Assurance Report from the Quality Committee		
Presented by:	Patrick Sullivan Non-Executive Director and Chair of Quality Committee		
Author:	Laurie Wrench, Associate Director of Governance		
Executive Lead Name:	Dr Buki Adeyemo, Executive Medical Director	Approved by Exec	☒

Executive Summary:		Purpose of report	
This report provides a high level summary of the work of the Committee during February 2018 and request for the Trust Board to ratifiy policies and endorse recommendations in the report.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	Approved by Chair of Quality Committee and Executive Lead	Document Version No.	
Committee Approval / Review			
Strategic Objectives (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:	To note policy approval		

Outputs from the Quality Committee
for the Trust Board meeting on 22 March 2018

1. Introduction

During the month of March 2018, the Quality Committee were asked to consider a number of policies, some of which were undertaken by virtual review in the absence of a meeting. The purpose of this report is to notify the Trust Board of the outcome of this work and to recommend ratification of policies and procedures as follows:

2. Policy Report - The recommendations were supported by agreed Chair`s actions, virtual circulation to the Committee and ratification of the following policies by the Trust Board for 3 years or otherwise stated as follows:

- ✓ 1.80 - Resuscitation Policy - Existing Policy - Reviewed and Updated - Approve for 3 years
- ✓ Towards Smoke Free - New Policy - Approve for 3 years.

3. Next meeting:
Thursday 5 April 2018 2.00pm

On behalf of the Committee Chair, Mr Patrick Sullivan, Non-Executive Director
Laurie Wrench, Associate Director of Governance

14 March 2018