NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST
HYBRID BOARD MEETING HELD IN PUBLIC
THURSDAY 9TH MAY 2024, 10.00AM, BOARDROOM, LAWTON HOUSE AND VIA MS TEAMS

ITEM	TIMING	REF	TITLE	LEAD	ACTION	ENC
1	1000	P87/24	Welcome and Apologies for Absence	Janet Dawson	**Note**	
2	1002	P88/24	Declarations of Interests – and changes to be notified	Janet Dawson	**Note**	
3	1003	P89/24	Minutes of the Previous Meeting held on 11th April 2024	Janet Dawson	**Approval**	**Enc. 1**
4	1005	P90/24	• Action Monitoring Schedule • Matters arising not covered by the rest of the Agenda	Janet Dawson	**Note**	**Enc. 2**
5	1010	P91/24	Patient Story – Held in Private Board session at wishes of patient.	Kenny Laing	**Note**	
6	1010	P92/24	REACH Recognition Team Award – **Community Directorate CYP Eating Disorder Team**	Dr Adeyemo	**Note**	**Verbal**
7	1020	P92/24	Chief Executives Report	Dr Adeyemo	**Note**	**Enc. 3**
8	1030	P93/24	ICB Briefing 18th April 2024	Dr Adeyemo	**Note**	**Enc. 4**
9	1035	P94/24	Chairs Report	Janet Dawson	**Note**	**Enc. 5**
10	1045	P95/24	Questions from Members of the Public	Janet Dawson	**Note**	**Verbal**
	10 minute break					
	QUALITY					
11	1100	P96/24	Committee Effectiveness Review 2023/24	Nicola Griffiths	**Assurance**	**Enc. 6**
12	1115	P97/24	Quality Committee Assurance Report from meeting held on 2nd May 2024	Pauline Walsh	**Assurance**	**Verbal**
13	1125	P98/24	Improving Quality and Performance Report (IQPR) Month 12	Eric Gardiner	**Assurance**	**Enc. 7**

Partnerships We will actively promote partnership and integrated models of working			**PARTNERSHIPS**			
14	1135	P99/24	Children and Young People's Complex Project	Elizabeth Mellor	**Assurance**	**Enc. 8**
Sustainability We will increase our efficiency and effectiveness through sustainable development			**SUSTAINABILITY**			
15	1145	P100/24	Finance Report Month 12	Eric Gardiner	**Assurance**	**Enc. 9**
16	1155	P101/24	Finance and Resources Committee Assurance Report from the meeting held on 2nd May 2024	Russell Andrews	**Assurance**	**Enc. 10**
17	1205	P102/24	Board Assurance Framework Quarter 4 (BAF)	Nicola Griffiths	**Approval**	**Enc. 11**
CONSENT ITEMS						
18	1215	P103/24	Remuneration Committee Terms of Reference	Nicola Griffiths	**Approval**	**Enc.12**
19	1225	P104/24	Safer Staffing Monthly Report March 2024	Kenny Laing	**Information**	**Enc. 13**
20	1225	P105/24	Any Other Business	Janet Dawson	**Note**	**Verbal**

Date and Time of Next Meeting
Thursday 13th June 2024 at 10.00am, Boardroom,
Lawton House and via MS Teams

TRUST BOARD

Minutes of the Public Section of the North Staffordshire Combined Healthcare NHS Trust Board meeting held on Thursday 11th April 2024 At 10:00am in the Boardroom, Lawton House and via MS Teams

Present:

Chair:

Janet Dawson
Chair

Directors:

Russell Andrews
Non-Executive Director / Vice Chair

Jennie Koo
Non-Executive Director

Dr Buki Adeyemo
Chief Executive

Ben Richards
Chief Operating Officer

Dr Dennis Okolo
Chief Medical Officer

Elizabeth Mellor
Chief Strategy Officer

Pauline Walsh
Non-Executive Director

Phil Jones
Non-Executive Director

Kenny Laing
Chief Nursing Officer

Kerry Smith
Interim Chief People Officer

Dr Keith Tattum
Associate Non-Executive Director

Tony Gadsby
Associate Non-Executive Director

Eric Gardiner
Chief Finance Officer

In attendance:

Lisa Wilkinson
Corporate Governance Manager

Nicola Griffiths
Deputy Director of Governance / Board Secretary

Jenny Harvey
Unison Representative

Claire Tallentire
Communications and Engagement Officer

Patient Story – ARRS Team
Caroline – Service User
Rebecca Myatt – STR Worker

REACH Individual Award
Becky Jones – Ward Manager, Ward 4
Jayne Underwood – Crisis Care Service Manager

Members of the Public
None

The meeting commenced at 10:00am

69/2024	**APOLOGIES FOR ABSENCE** Sue Tams, Service User Carer Council, Joe McCrea, Associate Director of Communications	**Action**

70/2024	**DECLARATION OF INTEREST RELATING TO AGENDA ITEMS** There were no declarations of interest. ***Noted***	
71/2024	**MINUTES OF THE OPEN AGENDA – 14th March 2024** The minutes of the open session of the meeting held on 14th March 2024 were approved. ***Received***	
72/2024	**ACTION MONITORING SCHEDULE AND MATTERS ARISING FROM THE MINUTES** No actions were recorded ***Received***	
73/2024	**PATIENT STORY – Caroline's Story – Community Mental Health Team** Kenny Laing, Chief Nursing Officer introduced the patient story. Caroline received support from the Trust's Community Mental Health Team. The team works within the primary care networks in Stoke on Trent and closely with colleagues in GP surgeries to try and provide quick access for people with mental health problems. Caroline had challenges and difficulties with anxiety and obsessive compulsive issues. Caroline talked about the referral process and shared her journey and talked about the therapy she received. Kenny Laing advised this was a new service and a new investment that the Trust made into primary care networks over the last two to three years. Russell Andrews talked about his own experience having a grown child who suffered with Obsessive Compulsive Disorder (OCD) adding how life limiting it could be adding that Caroline was very brave to share her story. Russell Andrews asked if Caroline could share more information about how her exposure therapy was going and how she saw it developing over the next six months. Caroline advised she was well but was hoping to improve more adding that she could do more 18 months ago but it was slow progress and sometimes she felt better than others. Caroline advised she hoped to improve further over the next 6 months. Dr Dennis Okolo noted that Caroline had highlighted the challenges of the benefits system and the impact it had adding this was common for a lot of patients, highlighting the fact that the Trust was able to provide support to go through the appeal process which was very positive. Dr Keith Tattum highlighted the benefit of early detection and intervention with the appropriate therapy and asked the team what the ideal duration of support was, whether this varied in each case and how much capacity they had to maintain that. Rebecca Myatt advised she felt this was individualised and that everybody was unique and received a unique plan. Dr Keith Tattum asked if there was the flexibility and freedom to provide therapy for individual needs? Rebecca Myatt advised within her Primary Care Network (PCN) there was.	

	Dr Buki Adeyemo noted the support Rebecca Myatt received from her PCN and asked if this flexibility varied across PCN's. Rebecca Myatt felt it did. Ben Richards added that the Trust was providing support to other PCN's across the Staffordshire. Caroline was thanked for sharing her story. The video will be made available on the Trust public website. ***Noted***	
74/2024	**REACH RECOGNITION INDIVIDUAL AWARD – Becky Jones, Ward Manager, Ward 4** Dr Buki Adeyemo introduced the award. Dr Buki Adeyemo talked about the commendation from the nominator of the award and how they had been impressed by how much Becky Jones had grown since becoming a Ward Manager particularly around a case involving complex negotiations between the local authority and the family. As a result there was a positive outcome, not just for the person involved, but their family which also improved relationships between the local authority and the Trust. The family were kept informed at all times and they have praised the care received from Ward 4 under Becky Jones's leadership. One of the outcomes, as part of learning lessons, was that Becky Jones would be taking the lead to help others understand in the Trust how we can negotiate complexities like that in the future, which demonstrated the values of the Trust. The Board congratulated Becky Jones on her award. ***Received***	
75/2024	**CHIEF EXECUTIVES REPORT** Dr Buki Adeyemo, Chief Executive Officer updated the Board on activities undertaken since the last meeting and drew the Board's attention to other issues of significance or interest. A report was circulated prior to the meeting. Dr Buki Adeyemo wished to highlight the fantastic news that Janet Dawson was the new Chair for the Trust and acknowledged this was her first Board meeting as Chair. Dr Buki Adeyemo talked about the financial challenges that the system continued to face and asked Eric Gardiner, Chief Finance Officer to provide an update. Eric Gardiner advised the last Finance and Resource Committee received the latest version of the partial plan, which shared as a system there was a deficit of over £120 million but as part of that plan, the deficit was going to be shared with providers. The Trust had reported it could break even if it did not have a share of the deficit and Midlands Partnership University Foundation Trust (MPuFT) had also taken steps to do the same. As of yesterday, the Integrated Care Board (ICB) had agreed that deficit would not be shared out equally amongst all partners. Therefore, we will submit a balanced financial plan again for 2024/25. Janet Dawson thanked Eric Gardiner and the Finance Team for all their effort. Can I just ask what we think would be the balance on that basis of the deficit for the system. Eric Gardiner advised University Hospital of North Midlands (UHNM) would manage the contract in such a way that it would be distributed with the ICB. Eric Gardiner advised there was pressure to reduce the £135 million on the back of MPFT and our	

	Trust slightly improving our position by around £7 - £8 million but there remain challenges to improve whilst maintaining services. Jenny Harvey noted the other two providers within the system had written to their staff regarding this matter and although we may not be facing redundancies like some systems, it might be worth discussing the pressure around replacing vacancies or not as the case maybe. Jenny Harvey highlighted her disappointment that systems were not acting in the same way. Jenny Harvey felt we should find a way of reassuring staff. Eric Gardiner felt this was important and this was something the Board were aware of adding that some information had been shared through the Trust's regular Exec Exchange that was held with staff, but the Board were also conscious that the position that we had was not going to be the final position which made things even more complicated to share. Eric Gardiner acknowledged there was still lots of workforce challenges are particularly for our organisation, we needed to reduce our agency costs which would help enormously and in recruiting substantive staff. Pauline Walsh suggested in terms of communication with staff short videos that could be viewed on the internet at leisure. Dr Buki Adeyemo acknowledged there were opportunities to communicate with staff and personal communication in time was her preference. Dr Buki Adeyemo highlighted that Exec Exchange was recorded and uploaded to the Internet and people could access. Russell Andrews asked if information would be readily available to all members of the Board as he acknowledged he would often have sight of items as the Chair of the Finance and Resource Committee. Eric Gardiner advised as things progressed he would provide a Finance Planning Paper that would be shared with the Board. Kerry Smith wished to provide assurance that although information was shared at Exec Exchange there were also broader discussions held at the Joint Negotiating Consultative Committee (JNCC) as part of the Trust's recognition agreement. Kerry Smith acknowledged the need to be proportionate and ensure what that message really looked like when moving at pace but gave assurance the Trust would link in with staff side colleagues as further detail became available. Tony Gadsby asked if this position removed any anxiety that the Trust would not receive the full amount of the Mental Health Investment Standard (MHIS) this year and there would be transparency it would be received. Eric Gardiner advised the Trust was still awaiting transparency around this issue. Tony Gadsby asked if there was still a risk relative to this. Eric Gardiner confirmed there was but maybe not for our organisation but as a system there remained a risk. Dr Buki Adeyemo confirmed clear Instructions had been received from NHS England that the MHIS was none negotiable. ***Received***	
76/2024	**CHAIRS REPORT** Janet Dawson, Chair provided a verbal update. Janet Dawson highlighted what a pleasure and honour it was to have been appointed as Chair adding what a wonderful opportunity it was to continue to lead the Board in a way that David Rogers led and build on his legacy but also to do things differently. Janet Dawson acknowledged Pauline Walsh's appointment as a Non-Executive member of the Board and advised Pauline Walsh had kindly agreed to be the Senior	

	Independent Director (SID) and Russell Andrews had been appointed as the Vice Chair and Freedom to Speak Up Non-Executive Director. Janet Dawson advised Phil Jones had advised he would be stepping away from the Board in June 2024. Phil Jones advised he had written a book and was looking to write another which would take him away from his Board member responsibilities and he had therefore made the difficult decision to leave the organisation. Phil Jones added it this had been the best organisation he had ever been involved with by a country mile and wished everyone well with the future. Phil Jones confirmed he would remain with the organisation to see through the accounts for the year. Janet Dawson referred to the recent Well Led Review which had been undertaken advising this would be a good platform for the Board to consider how it operated going forward. Janet Dawson also highlighted planning guidance had been issued and the Operational Plan was an agenda on today's meeting. Janet Dawson introduced Jennie Koo. Jennie Koo thanked the Board for welcoming her as a new Non-Executive Director. Jennie Koo advised she was a financial services risk professional by trade with a firm passion in all things diversity and inclusion, driving greater awareness through society. Jennie Koo acknowledged the NHS had a huge part to play in that, particularly in the way that it supported the general public and being able to be a part of that was a huge honour. Jenny Harvey asked if there was a communications piece that could be shared to explain the roles of the Non-Executive Directors and what they bring as a group to the Trust for all staff to see. Janet Dawson confirmed a video would be useful. ***Noted***	
77/2024	**QUESTIONS FROM MEMBERS OF THE PUBLIC** The Trust continued to encourage the use of Ask the Board Online as part of its ongoing commitment to openness, transparency and innovation. ***I recently attended your Engagement Event at Port Vale. It was a great opportunity to get involved with interactive debates, hearing from experts and networking with new and potential partners. A key detail I picked up on was how you are starting to engage with isolated communities, for example, visiting a farmers market. Please can you share how you intend to reach the homeless community? This demographic is disproportionately affected by mental health, substance misuse, and homelessness which are inextricably linked.*** Ben Richards provided a response: The Trust offers support to people who are homeless or at risk of homelessness in a number of ways: - Should a patient be experiencing homelessness or be identified as being at risk of becoming homeless, then their Combined Healthcare key worker would provide the relevant support to meet their individual needs. - Our teams and services have direct links with local authorities who provide designated support to those at risk, whether this be a professional referral to the Rough Sleepers Team, a telephone call to Streetlink, supporting with a referral for social housing or putting a plan in place to help individuals gain access to immediate basic needs i.e. food parcel etc. - Crisis Care Centre (CCC) support homeless people attending the centre in a number of different ways: we provide thorough holistic assessments of their	

	presenting mental health, however utilise a biopsychosocial approach to ensure all of their needs are highlighted and responded to accordingly - Crisis Care have a designated Rough Sleeper Practitioner, Simon Bratt: Simon remains aligned with the Crisis Care Centre (CCC) and is undertaking the rough sleeper role. He mainly focuses on referrals from Access and Home Treatment for those at risk or experiencing homelessness. In addition to this Simon spent a large proportion of time at the Homeless Hub, a fantastic place to collaborate closely with Housing, Community Drug and Alcohol Service (CDAS), and the Rough Sleepers Team. There is a real sense of community and shared purpose among everyone, which Simon felt was making a tangible difference. Simon particularly enjoys the outreach efforts with the Rough Sleepers. It has been more than just rewarding; it's given him a chance to really connect with the community on a personal level. Building these relationships has been key, and based on this, Simon has started a mental health group which is attended by eight males at the moment who are currently homeless. We have currently got 37 entrenched rough sleepers so Simon is hoping the groups will get bigger. Together with others, Simon is tackling everything from coping skills to managing anxiety, and the engagement has been amazing. Collaborating with CDAS on joint visits has opened up some great networking opportunities, too. Simon feels like we are really starting to weave a tighter support network for ladies and gents. Although it's still early days, Simon is optimistic that by engaging directly with our community on the streets, we can start to lessen their need for CCC support. - Multiple Disadvantaged Team: work with people who are homeless/other connected disadvantages (MH need/substance misuse/contact with Police). This team links strategically to the Multi Agency Referral Group (MARG) and also offers support to wider partners. ***Noted***	
78/2024	**QUALITY COMMITTEE ASSURANCE REPORT** Pauline Walsh, Non-Executive Director presented the report from the meeting held on 4th March 2024 highlighted the following: The Committee received the Safer Staffing Report which outlined the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during February 2024. During February 2024, an overall fill rate of 100.5% was achieved; this was an increase from 98.5% in January 2023. The fill rate for Registered Nurse (RN) shifts had decreased; from 77.5% in January 2023 to 76.1% in February. The Darwin Centre recently had a Mental Health Act CQC visit and this was positive, with some initial feedback around staff attitude and blanket restrictions. The Trust is still awaiting formal feedback. The Committee received the Reducing Restrictive Practice Report Quarter 3 report, there was a real feeling of how positive this report was and improvements were noted in terms of the reduction of the number of restricted practice incidences. Progress was also noted against the annual restrictive practice reduction work plan although it was felt more detail was required around actual interventions. The risk around outbreak measures required to be implemented, as a result of Covid-19 pandemic and other associated Respiratory Viruses was discussed and a request for a score change was approved as the Winter Flu campaign was now completed, and national and regional epidemiology indicate Flu season had ended reducing the impact of operational risk on staff and patient of outbreaks. Ongoing monitoring is required for Measles and Covid19 and any operational impact.	

	The Improving Quality & Performance Report (IQPR) Month 11 report was received. Particular attention was paid to the Community Directorate and the fact that the targets were not being met. The Committee discussed whether the targets were appropriate and required review if they were consistently not being achieved. Following discussion it was agreed whilst we were not achieving those targets in comparison to other health providers, we were performing quite well. It was agreed more benchmarking data was required to make a reasonable judgement. The following policies were approved for 3 years: • 5.32 Patient Safety Incident Response Framework Policy (approve for 3 years and remove 5.32 Serious incident Policy) • 1.75a Medicines Incident Management Policy The following policy was approved for an extension of 12 months: • 1.67 Towards Smoke Free Policy The Committee had a discussion around what process a policy had been through prior to Committee approval. It was agreed that a piece of work would be undertaken to look at how this can be reported back to Committee. Pauline Walsh advised there would also be a piece of work undertaken going forward around how items are presented at Committee and how outcomes are noted which will be shared with the Board once agreed. Tony Gadsby referred to the Community Directorate targets within the IQPR adding he felt that teams were perhaps too optimistic when setting targets rather than being realistic, highlighting this did not help the teams. Janet Dawson felt this had been discussed previously and it was agreed that effectively we should treat that date as a review date. Dr Buki Adeyemo advised in terms of performance as a whole, a conversation had taken place with directorates in the last Senior Leadership Development Forum around how we move forward in terms of unrealistic targets and our ambition. Dr Buki Adeyemo added it was almost immaterial how others are performing outside of the Trust if that did not align with our benchmark of outstanding and that was where we needed to be. Dr Buki Adeyemo asked if there were discussions around complaints that were outstanding. Nicola Griffiths explained some of the rationale around delays were discussed at Quality and Finance and Resource Committees. Nicola Griffiths noted there were some issues reported around accuracy. Janet Dawson felt it would be helpful particularly with new people chairing some of the Committees if we had a look at the committee agenda scope, as an item could be discussed in various Committees for a slightly different reason through a slightly different lens. Janet Dawson acknowledged this could be a piece of work that could be undertaken over the next couple of months to bring the Committees more in line. Phil Jones supported this he felt summaries from Committees did not always provide granular detail. Janet Dawson highlighted another element to consider was what the Board expected the Committed to do on its behalf. What do the Board expect in terms of assurance reporting and how the Board does not duplicate the work of the Committee. Janet Dawson acknowledged the need to make the process much slicker without losing any of the effectiveness and perhaps focus some conversations on what may need to be brought to the attention of the Board, as numbers are available in lots of places. Russell Andrews felt it was enormously helpful to have the Chair of the Quality Committee and the Finance and Resource Committee.	

	Nicola Griffiths highlighted as part of this review we had also just completed the committee effectiveness surveys adding that Lisa Wilkinson had been working hard on pulling that information and data together and providing some analysis that would be fed back to Chairs and Committees. ***Received***	
79/2024	**IMPROVING QUALITY PERFORMANCE REPORT (IQPR) – Month 11** Eric Gardiner, Chief Finance Officer presented the report: Eric Gardiner advised that performance remained very good in the Trust. In Month 11 there were 16 RAG rated measures that had achieved required standard (16 in Month 10) and 13 that had not met the required standard and highlighted as exceptions (13 in Month 10). There were 2 special cause variations signifying concern, compared to 4 in Month 1 and there was 1 special cause variation signifying improvement, compared to 1 in Month 10: Eric Gardiner reported there was a really good discussion with the senior team this week, which would lead to some changes in the form of the reports. There was also a long discussion at the Finance and Resource Committee around the Performance Improvement Plans (PIP) process and how this can be improved. Kenny Laing advised work had been undertaken that looked at improving performance in terms of complaints. Extra training around compliant investigations for the officers that are involved in responding to complaints, the piloting of using QR methodology and a different process which would commence in the Community Directorate and the process around sending complaints between Investigation Officer, Initial Reviewer and sign off etc. to make the process more efficient. ***Received***	
80/2024	**OPERATIONAL PLAN** Elizabeth Mellor, Chief Strategy Officer presented the report. Trust Board is asked to approve the content of the Trust Operational Plan for 2024/25. The document submitted for review was a final draft with the caveat that the final system planning submission was still in progress. Any amends required following approval by Trust Board would be shared to ensure approval was maintained. The planning cycle commenced in November 2023 when conversations with our teams and directors took place about what our priorities looked like. We have been building this plan for a significant amount of time with a better focus and connectivity this year with the ICS Strategy. Elizabeth Mellor acknowledged that there was more to do around service user and carer engagement within the planning process. Pauline Walsh suggested the need to include percentage increases or what the target is within the final version of the action plan. Liz Mellor agreed. Tony Gadsby asked how this related to the Board Assurance Framework (BAF) to ensure it aligned with this document. Nicola Griffiths advised this work had already commenced as we had started to look at 2024/25 BAF and review the risks from last	

	year and what needed to be carried forward. Nicola Griffiths advised we had been on a journey for the last 12 months in terms of our BAF and seen the development work along the back. So now as we start to look at 2024/25 this will absolutely be aligned with the strategy. Elizabeth Mellor thanked everyone for their input. . ***Approved / Received***	
81/2024	**MONTH 11 FINANCE REPORT (2023/2024)** Eric Gardiner, Chief Finance Officer presented the report. Eric Gardiner advised the Trust position was really positive. We have a surplus of almost £500K. In month 11, 99% of invoices received by the Trust (both value and number) were paid within 30 days against the Better Payment Practice Code target of 95%. The Finance Team are in the process of pulling together our accounts and we can then close them down. Russell Andrews acknowledged the great achievement having given something back to the system. ***Received***	
82/2024	**FINANCE AND RESOURCES COMMITTEE ASSURANCE REPORT** Russell Andrews, Non-Executive Director / Chair presented the assurance report from the Committee held on the 4th April 2024 highlighting the following: The Committee received an update around business opportunities and focused on the commencement of an All Age Continuing Healthcare tender from November 2024. The working group to develop this service specification has Trust representation. Trust Finances were discussed and are on track. All indicators were positive without the exception of agency which the Committee usually scrutinises. The Committee discussed the ICS system finances noting the Trust made a positive contribution to the system deficit. In terms of planning for 24/25, the Trust's own planning was very much on track. The Committee also noted that there was an improvement in the System position from the high-level submission on 27th February. There was an escalation meeting on 10th April with NHS England. Workforce planning was expected to have no growth. Final plan due to be submitted on 2nd May. The Committee received an update around Estates. The backlog plan is on track. We are continuing to finalise the sub lease for Lawton House. The Edward Myers Unit (EMU) business case was approved at Board, working with Town Hospitals Limited (THL) to move this forward. Completed issuing availability notices for the PFI as per the contract requirements. THL have acknowledged the issues with the fire doors and will repair faults. Ward 1 been successfully handed over within the Project Chrysalis programme. The Committee approved for 3 years the Investment policy. Janet Dawson asked if the Cost Improvement Programme (CIP) remained at 4% for next year. Eric Gardiner confirmed this was correct.	

	Received	
83/2024	**CHARITABLE FUNDS COMMITTEE ASSURANCE REPORT** Russell Andrews, Chair / Non-Executive Director presented the summary report from the meeting held on the 4th March 2024 highlighting the following: Russell Andrews advised a new Executive Director was now leading on Charitable Funds and were looking into the proposal of outsourcing the delivery of charitable funds to the University Hospital of North Midlands (UHNM). The difference now being that it has been confirmed that the Trust will be receiving a substantial legacy of over £200K. A further update following the Committee in June will be brought to Board. ***Received***	
83/2024	**PEOPLE, CULTURE AND DEVELOPMENT COMMITTEE ASSURANCE REPORT** Janet Dawson, Chair / Non-Executive Director presented the assurance report from the Committee held on the 3rd April 2024, highlighting the following; Janet Dawson advised given the current vacancies on the Board she would continue to Chair the Committee for the time being. Janet Dawson provided an update in terms of industrial action and pay reviews, ongoing further action remains a cause for concern but has been managed to date by the Trust. Whilst there is currently no further Junior Doctor strike action planned to date, as the pay dispute remains ongoing, further action remains highly likely. The recent pay deal for Consultant staff has been rejected, an improved offer has been made and the BMA are balloting their members on the deal, to date there is no further planned strike action for Consultant staff. Pay review processes are underway via respective National Pay Review Bodies however, it is anticipated that there will be some challenges not just for medical terms and conditions but also wider Agenda for Change staffing groups as indicated by a number of trade unions including, Unison, Unite and the RCN. The Committee received a powerful staff story relating to the experiences of a neuro-diverse staff member who had recently joined the Trust. The staff member had been supported via the Differently Abled Buddy scheme (DABS). The staff member remained throughout the Committee and provided some really useful contributions and feedback around the recruitment processes that we use, whether we are full putting appropriate adjustments in place for people and also the Combined Ability Network were praised as being a wonderful support to her and we should recognise the great work that they do. The Committee received the Trust Inclusion and Belonging Strategic Plan 2024-2028. The plan looked focussed on debiasing our Trust recruitment processes, reducing health inequalities and volumes of our service users and high visibility around anti discriminatory approach leading to delivering the race code and associated accreditation. A very important part of how we do our work and what we do and what we stand for. The Committee received the Gender Pay Gap Reports. The Committee received a detailed report and the 2023 data informs the Trust that it had an improved mean gender pay gap of 14% (down from 15.6% in 2017, and from a high of 17.7% in 2019 & 2020) which was broadly average for the NHS and was very much in line with our local partners. There was an improvement on our	

	distribution of females through the salary quartiles, although it was noted that there remained an over representation of men in the highest quartile and underrepresentation in the lowest quartile. Of note, was our negative overall ethnicity pay gap with more work to do to analyse the data around this matter. The following policies were approved for 3 years: • 3.25 Flexible Working and Employment Break Policy • 3.46 NSC Cover Arrangements • 3.49 Agile/Homeworking Policy • Fit & Proper Person Policy (this is a new policy, following recent changes in governance reporting arrangements and with previous submission to JNCC) The following policy was agreed for a 12 month extension: 3.01 Disciplinary Policy (awaiting agreement from staff-side as this is a key policy, there is no fundamental issue of disagreement, however changes regarding the embedding and incorporating of Just Restorative Culture is now required) Ben Richards referred to the GP ballot and although that was no direct impact on our workforce potentially it did have a wider impact. Therefore he advised the Trust would be actively monitoring the risk. Pauline Walsh asked if there was a Gender Pay Gap action plan. Kerry Smith confirmed there was and advised the strategic plan would be incorporating those key drivers and crystallising what the plans were to incorporate that. Kerry Smith also confirmed there wsa a lot of work being undertaken around succession, talent management focusing on areas where we know there are gaps.Kerry Smith advised the Trust was also looking closely at its inclusive recruitment campaigns to to see how it could level the whole inclusion and belonging strategic plan. Kerry Smith also highighted the new pay deal, which was now being approved by the British Medical Association (BMA) was removing the Clinical Excellence Award which in time may address some issues moving forward as we know we have more senior male medics with Clinical Excellence Awards than we do females. Pauline Walsh noted that similar issues caused the University gender pay gap and one of the things they looked at was promotion prospects and targeted mentoring for early career people. Pauline Walsh asked if the Trust had anything similar. Kerry Smith advised the Trust was working through its scope for growth succession / talent management explaining the challenge with succession and talent management was if we were not actually representative and inclusive, that could cause more issues as you can never then really address the true population representation aspect that we are striving to do. Kerry Smith acknowledged there was more work to do particularly in terms of diversity and inclusion and really levelling up both from disability and race, for the Trust as well. ***Received***	
84/2024	**SAFER STAFFING MONTHLY REPORT FEBRUARY 2024** Circulated for information only ***Received***	
85/2024	**ANY OTHER BUSINESS** There were no other items of business for discussion.	

	Noted	
	DATE AND TIME OF NEXT MEETING The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday 9th May 2024 at 10.00am, Boardroom Lawton House and via MS Teams.	
	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 12.10pm

Signed: _____ Date_____
Chairman

Board Action Monitoring Schedule (Open Section)

	Trust Board - Action monitoring schedule (Open					
Action	**Meeting Date**	**Minute No**	**Action Description**	**Responsible Officer**	**Target Date**	**Progress / Comment**
			There were no actions recorded.			

REPORT TO PUBLIC TRUST BOARD

Date of Meeting:	9th May 2024		
Title of Report:	CEO Board Report		
Presented by:	Dr Buki Adeyemo, Chief Executive		
Author:	Claire Tallentire, Communications and Engagement Manager Kerry Smith, Interim Chief People Officer		
Executive Lead Name:	Dr Buki Adeyemo, Chief Executive	**Approved by Exec**	☐

Enc 3

Purpose of the report:							
Approval	☐	**Information**	☒	**Consider for Action**	☐	**Assurance**	☒

Executive Summary:

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

Seen at:	SLT ☐ Execs ☐	Document Version No.	1
Committee Approval / Review	• Quality Committee ☐ • Finance & Resource Committee ☐ • Audit Committee ☐ • People, Culture & Development Committee ☐ • Charitable Funds Committee ☐		
Strategic Priorities (please indicate)	1. **Growth** - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care ☒ 2. **Access** - We will ensure that everybody who needs our services will be able to choose the way, the time, and the place in which they access them ☒ 3. **Prevention** - To will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce. ☒		
BAF / Risk / legal implications: Risk Register Reference	1. We will provide the highest quality, safe and effective services ☐ 2. We will attract, develop and retain the best people ☐ 3. We will actively promote partnership and integrated models of working ☐ 4. We will increase our efficiency and effectiveness through sustainable development ☐ Any Risk/legal implications: (please reference if any)		
Sustainability:	1. Reduce the environmental impact of health and social care in Staffordshire and Stoke on Trent ☒		

	2. Build a network of climate and sustainability champions across Staffordshire and Stoke on Trent ☒ 3. Share learning and best practice ☒	
Resource Implications: Funding Source:	N/A N/A	
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	There is no direct impact on the protected characteristics as part of the completion of this report.	
ICS Alignment / Implications:	N/A	
Recommendations:	Board is asked to receive for information and assurance	
Version	Name/group	Date issued
1	Dr Buki Adeyemo, Chief Executive	3 May 2024

Chief Executive's Report to the Trust Board
9 May 2024

1.0 PURPOSE OF THE REPORT

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

2.0 NATIONAL CONTEXT AND UPDATES

Community mental health survey 2023

The Care Quality Commission (CQC) has published its annual community mental health survey 2023, which asks people who use NHS community mental health services in England about their experiences of care. 53 providers of NHS mental health services participated, including North Staffordshire Combined Healthcare NHS Trust, with 14,770 people responding across England. The Trust had a response rate of 22% (the national average was 20%). The survey had 33 key questions and the Trust scored 'about the same' as other NHS mental health providers, with one question 'better than expected 'and one question 'worse than expected' when benchmarked nationally. The full analysis and improvement plan will be presented to the Quality Committee for assurance.

The Economic and Social Costs of Mental Ill Health – new report

A new report commissioned by the NHS Confederation's Mental Health Network and delivered by the Centre for Mental Health has revealed the economic and social costs of mental ill health in England. The total cost in 2022 was £300 billion, through research and evidence published in 'The Economic and Social Costs of Mental Ill Health' report. The report will inform our approach to future planning and work on health inequalities as part of our strategy.

3.0 STAFFORDSHIRE AND STOKE-ON-TRENT INTEGRATED CARE SYSTEM (ICS)

SEND inspection report

A report from an Area SEND inspection of Stoke-on-Trent Local Area Partnership led by Ofsted and the Care Quality Commission (CQC) has recently been published. The report highlighted that for children and young people with special educational needs and disabilities (SEND) in Stoke-on-Trent '…there is a city-wide determination that they will get the support they need to thrive.' Ofsted highlighted five key areas for improvement which has been assessed by the city council and Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) and an improvement plan agreed. The Trust is working with all partners to support this improvement and is a member of a number of meetings and forums which will enable change to happen for these children, young people, families and practitioners.

2024/25 planning and finances

On 26 April 2024 at an Extraordinary Trust Board meeting, the Board signed off the financial plan for the year. The NHS is financially challenged in 2024/25 with Staffordshire and Stoke-on-Trent Integrated Care System (ICS) having a deficit of £90m. The ICS has reduced its deficit by £49m compared to the previous plan submission; this includes £40m of stretch savings schemes with work ongoing to develop detailed savings plans across 6 agreed programmes of work.

Combined Healthcare has a balanced financial plan for 2024/25 which is predicated on delivering at least £5m of savings which equates to 4% of turnover. The Trust has also accepted a share of the additional £40m stretch savings target of £1.4m, the plan is for this target to be re-distributed across the system throughout the year as the 6 programmes of progress.

4.0 OUR TRUST

The Annual Accounts were submitted on time and our external auditors, Grant Thornton, have started their review process with a view to completing the audit in June 2024. The annual report and accounts will be presented at the Trust's Annual General Meeting (AGM) in September 2024.

4.1

Step On results for 2023-24

Combined Healthcare delivers the successful Step On NHS Service in collaboration with Midlands Partnership University NHS Foundation Trust (MPFT). The service, which recently celebrated its 10th anniversary, has released its annual statistics for 2023-24. The team received 716 referrals and engaged with 914 new clients, supporting 253 people into paid employment.

4.2

Long service recognised at Combined

The Trust is looking forward to celebrating the long service of our next cohort of colleagues who will be reaching significant working milestones within the NHS. They will be joining us for afternoon tea at Port Vale F.C. later this month in this year's celebration event.

4.3

Sustainability update

We are committed to sustainability and carbon reduction, aiming to decrease our Trust's impact on the environment whilst providing outstanding patient care and working environments. Sustainability also forms one of the key enablers in the Trust Strategy 2023 – 2028.

The Trust has launched 'Proud to be Green', a 12-month communications campaign to increase engagement and sustainability action amongst staff. The campaign is split into quarters, with each quarter shining the spotlight on two areas of focus for the Trust to deliver zero carbon by 2040.

For World Earth Day, the Trust partnered with Stoke-on-Trent City Council's service Growthpoint to create a duck sculpture made entirely of recycled materials for this year's theme of 'Planet vs. Plastic'. The plastic had been donated by wards at Harplands Hospital and Growthpoint, who have encouraged staff, patients and members to consider collecting recycled materials to contribute instead of throwing them away.

4.4

Maternal Mental Health Awareness Week

Maternal Mental Health Awareness Week was recently marked at Combined Healthcare with the Trust's Lotus Service raising awareness of the week and its offer through a series of activities. The service hosted a stand at Royal Stoke University Hospital's maternity and visiting maternity wards, a drop-in to County Hospital's maternity team, as well as attending the Just Family CIC group to offer emotional support. There was also a coffee and cake drop-in at The Bridge Centre for all current and former Lotus Service service users.

Eid Mubarak and Vaisakhi

Combined Healthcare's Sutherland Centre recently celebrated Eid with a lunchtime event. Staff wore traditional dress and shared food and gifts with colleagues who had been celebrating Eid with their families. The Trust's ENRICH (Equality Network for Race Inclusion and Cultural Heritage) Network also recently celebrated Vaisakhi at a special online event, with guest speakers who shared their expertise and stories.

Staffordshire Veterans Support Network event

Colleagues from Combined Healthcare attended the recent Staffordshire Veterans Support Network (SVSN) event, held at the Staffordshire Chambers of Commerce Festival Park. This inaugural event by SVSN was an opportunity for veteran reservists and their families to connect with valuable resources and for local organisations to support, with Combined Healthcare in attendance to signpost to mental health services support for veterans.

5.0 Conclusion

The Trust now focuses on implementing its operational plan for 2024/25 alongside the wider vision of our Trust Strategy 2023-2028. Challenging times are ahead, but we continue with our commitment to delivering an outstanding service for our patients, families and carers.

REPORT TO PUBLIC TRUST BOARD

Date of Meeting:	9th May 2024		
Title of Report:	Integrated Care Board (ICB) Update		
Presented by:	Dr Buki Adeyemo, Chief Executive Officer		
Author:	ICB		
Executive Lead Name:	Dr Buki Adeyemo, Chief Executive Officer	**Approved by Exec**	☒

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Purpose of the report:								
Approval	☐	**Information**	☒	**Consider for Action**	☐	**Assurance**	☒	

Executive Summary:

The attached briefing aims to keep the Board informed of discussions and decisions made by partners in the Integrated Care System (ICS) as reported at the April 2024 Staffordshire and Stoke-on-Trent ICB meeting.

Seen at:	SLT ☒ Execs ☐	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Resource Committee ☐ • Audit Committee ☐ • People, Culture & Development Committee ☐ • Charitable Funds Committee ☐		
Strategic Priorities (please indicate)	1. **Growth** - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care ☒ 2. **Access** - We will ensure that everybody who needs our services will be able to choose the way, the time, and the place in which they access them ☒ 3. **Prevention** - To will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce. ☒		
BAF / Risk / legal implications: Risk Register Reference	1. We will provide the highest quality, safe and effective services ☒ 2. We will attract, develop and retain the best people ☒ 3. We will actively promote partnership and integrated models of working ☒ 4. We will increase our efficiency and effectiveness through sustainable development ☒ Any Risk/legal implications: (please reference if any)		
Sustainability:	1. Reduce the environmental impact of health and social care in Staffordshire and Stoke on Trent ☐ 2. Build a network of climate and sustainability champions across Staffordshire and Stoke on Trent ☐ 3. Share learning and best practice ☒		

Resource Implications: Funding Source:	N/A N/A	
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	There is no direct impact on the protected characteristics as part of the completion of this report.	
ICS Alignment / Implications:	N/A	
Recommendations:	Trust Board are asked to receive for information.	
Version	Name/group	Date issued

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Integrated Care Board Briefing

Staffordshire and Stoke-on-Trent ICB Meeting

18 April 2024

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

This briefing aims to keep partners informed of the discussions at the NHS Integrated Care Board (ICB) meeting in public. To watch the recording and read the papers visit the ICB website.

Integrated Care Board (ICB) Chair and Executive update

- David Pearson, Chair, drew attention the to the Fit and Proper Person's test criteria and confirmed it is close to being embedded in the governance arrangements of the Board. A more detail report confirming all Board members have been through the process will be coming to a future Board meeting.
- Peter Axon, CEO, confirmed all 11 ICBS within the midland's region approved the delegation arrangements for specialised commissioning. As of 1 April 2024, the ICBs collectively have that delegated authority. There will be a West Midland's Joint Committee led oversight of the specialist commissioning. That group will direct development activities to improve the commissioning of specialist commissioning arrangements. Peter confirmed that there will be direct activities locally, to influence the regional West Midland's processes.
- Peter drew attention to the NHS IMPACT tool and commented that this tool gives us the opportunity to be able to fundamentally understand our productivity and efficiency position and make necessary changes.

The Board asked how the delegation of specialist commissioning is being integrated into the portfolios. Peter confirmed many of the services will move into the Planned Care portfolio but depending on the nature of the service, they will be integrated into the most appropriate portfolio. The Board asked what communications are happening with patients breaching 65 and 78 weeks waits. Phil Smith, Chief Delivery Officer, responded stating that there is a continuous validation process occurring to address the long waiters and that there is a process run through the Acute Trusts to monitor and communicate with these patients. The Board commented on the Staff Survey results and were pleased with the results. The Board asked where the ICB Staff results were going to be monitored. Mish Irvine, Interim Chief People Officer, confirmed that a full analysis of the results has happened, and conversations are being held with Executives before individual meetings with Directors being planned, and action plans are created. These action plans will fit in with the overall system-wide action plan. Heather Johnstone, Chief Nursing and Therapies Officer, confirmed that the NHS IMPACT tool is part of a wider system programme of quality improvement. The Board asked if there was a cause behind the increase in attendances at University Hospitals of North Midlands NHS Trust (UHNM). Phill Smith confirmed that 1000 of these attendances are currently being reviewed, with an indication that Norovirus and trauma demand was a cause of the increased attendances. Further analysis will highlight if missed opportunities to direct people elsewhere occurred. The Board asked if the NHS IMPACT tool will align with other local tools that measure the quality of services. Peter confirmed this tool will fill in any gaps we have in the system and create rigour in everything we do.

Emergency Preparedness, Resilience and Response (EPRR) Annual Report

- Phil Smith, Chief Delivery Officer, and Katie Weston, EPRR Strategic Lead, introduced this report.
- Phill confirmed the annual assurance position for 2023 of substantial compliance.
- Katie confirmed there has been demonstrable progress against the EPRR priorities and excellent engagement in training by all on-call managers.
- Katie outlined the three recommendations to the Board:
- Recommendation 1 - Board are asked to confirm the ICB has put in place adequate resources to meets its roles and responsibilities with respect to EPRR and Business Continuity planning.

- Recommendation 2 – Board are asked to note the 2023 EPRR annual assurance compliance rating of substantial compliance.
- Recommendation 3 – Board are asked to note and support the EPRR annual assurance 2024/25 priorities as listed.

The Board thanked Phil and Katie for the report. The Board asked if the key partners across the system are giving the same level of assurance regarding resources. Katie confirmed that all NHS health providers can give the same level of assurance. Other key partners work towards similar resilience standards and are meeting these standards. The Board acknowledged the hard work it has taken to get to this level of compliance, and Katie's leadership on this project. The Board approved all the recommendations.

Quality and Safety Report

- Heather Johnstone, Chief Nursing and Therapies Officer introduced the report.
- Heather commented that there has been some variation in understanding of compliance in relation to the number of Looked After Children who receive an Initial or Review Health Assessment. There are several pieces of work happening to meet or exceed the 85% target.
- Heather confirmed the 38 outstanding Learning from Lives and Deaths of People with a Learning Disability and Autistic People (LeDeR) reviews have been brought back into the ICB. 27 of these reviews are under review already.
- Josie Spencer, Non-Executive Director, confirmed there has been continued improvement in maternity and neo-natal services.

The Board thanked Heather for the update. The Board commented that there is a fundamental need that we understand our safeguarding duties in relation to children and young people. The Board asked if there was any intelligence around the number of dentistry appointments for children. Paul Edmondson-Jones, Chief Medical Officer, and Deputy Chief Executive Officer responded that it would be appropriate to bring a full report regarding Dentistry to an upcoming Board meeting, so this will be organised for a future Board meeting.

System Finance and Performance Report

- Paul Brown, Chief Finance Officer, Phil Smith, Chief Delivery Officer, and Megan Nurse, Non-Executive Director, introduced the finance report.
- Paul Brown confirmed we are closing the financial year ending 31 March 2023 and we have the met plan agreed with regulators.
- Phil Smith, Chief Delivery Officer, presented the performance report and stated that the pressure in Urgent and Emergency Care has been high following the Easter period. The challenges are still significant, and the teams are working hard to maintain flow. We are now able to de-escalate some of the winter capacity.
- Phil shared that an event to reflect on the effectiveness of the winter period was recently held. A full report will be provided, but some headlines include that there has been a 6% improvement in 4-hour performance, and there has been a 39% improvement in category 2 ambulance response times. This review highlighted the positive relationships between Urgent and Emergency Care providers.
- In terms of Planned Care, there has been an improvement with 78-week waiters. All these waiters aimed to be seen by the end of June.
- In terms of Cancer, there has been significant reduction in the backlog at University Hospitals of North Midlands NHS Trust (UHNM) and strong improvement in the 28-day faster diagnosis standard.
- Megan Nurse shared that work on the System Recovery Programme 2024/25 needs to be accelerated, and meetings are happening to implement this.

- Megan shared that the Finance and Performance Committee approved two Outline Business Cases for Integrated Community Hubs, and the Final Business Cases (FBCs) will be worked up. The FBCs will be required to identify the net revenue cost by the utilisation of these facilities to support the delivery of the System recovery, therefore creating a revenue neutral solution for the System.

The Board thanked Paul, Phil, and Megan for this report. The Board asked when we would investigate the key deliverables of population health not being met and how this would impact 2024/25 planning. The Board will bring this to the Executive Board meeting for discussion, and it is being incorporated into the operational planning.

Board Assurance Framework (BAF) Summary

- Claire Cotton, Associate Director of Corporate Governance, introduced the refreshed Board Assurance Framework (BAF) for the final Quarter 4 for 2023-24. The BAF has been structured around eight key strategic risks, previously agreed by the Board, which threaten the achievement of the Strategic Ambitions set out within the Integrated Care Partnership (ICP) strategy and has been mapped accordingly.
- Claire shared work is still ongoing to develop the BAF and the reporting taken from it.

The Board received the BAF and agree they are an accurate reflection of the position.

All Age Continuing Health Care (CHC) Arrangements Proposal

- Heather Johnstone, Chief Therapies and Nursing Officer, Kirsten Owen, Associate Director of Special Projects and Claire Underwood, Director of Nursing for CHC introduced the proposal. The proposal shares the commissioning options for the All Age Continuing Health Care Service.
- Kirsten highlighted that although The ICB is accountable for CHC, it can commission someone else to deliver the service on our behalf. Due to the complexities around the service, the most suitable proposal is that these services are initially in housed while new joint working arrangements are developed between the ICB and Local Authorities (LAs) and the wider emerging collaboratives.

The Board thanked Heather, Kirsten, and Claire, and commended them on their system partnership working, and the engagement with the Local Authorities (LAs) over this subject. The Board commented that this partnership working has built trust between the ICB and LAs and is an important factor in the LAs supporting this proposal. The Board thanked Heather's team for bringing out the complexities of this subject in this proposal. The Board asked how we will communicate this to the public. Claire confirmed those with lived experience are involved in the discussion, and there has been public engagement to develop the proposal. The Board approved all the recommendations.

Operational Planning update

- Paul Brown, Chief Finance Officer, updated the Board on the Operational Plan. Paul confirmed that there is strong engagement across the system and there has been a successful process behind the plan.
- In relation to operational targets, we are compliant and there is a commitment to meet those targets.
- In relation to workforce, there has been significant workforce growth in the past few years. The plan is to maintain the workforce and drive-up productivity over the next year.

- In relation to Continuing Health Care (CHC) there is a target to reduce the spend, which is likely to be achieved whilst also improving the quality of care patients receive.
- In relation to the System Recovery Plan, there is a strong commitment across the system.
- Work to date indicates a predicted financial deficit of £130million in 2024/25. Escalation meetings are happening with regional and national colleagues. However, the level of efficiency in the current 2024/25 plan is making in-roads into the underlying position and if we continue with the approach taken in 2024/25 of holding costs flat, and all Cost Improvement Programs (CIP) are delivered recurrently, then we could return the system to break-even in 2026/27.

The Board thanked Paul for his report. The Board stated that there are benefits to a multi-year recovery, including to patients and this should be discussed with NHS England. The Board stated that the other collaboratives need to be as efficient and focused as the Continuing Health Care Collaborative to see wider progress across the system. The Board noted the recommendations and comments made.

Date and time of next meeting in public: 16 May 2024 at 12.30pm held in Public at Midlands Partnership NHS Foundation Trust Headquarters Boardroom, Mellor House, St George's Hospital, Corporation Street, Stafford, ST16 3SR.

REPORT TO PUBLIC TRUST BOARD

Date of Meeting:	9th May 2024		
Title of Report:	Chair Board Report		
Presented by:	Janet Dawson, Chair		
Author:	Janet Dawson Chair		
Executive Lead Name:	Janet Dawson Chair	**Approved by Exec**	☐

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Purpose of the report:							
Approval	☐	**Information**	☒	**Consider for Action**	☐	**Assurance**	☒

Executive Summary:

This report updates the Board on the Chair's activities including, Well Led, System planning, Staff Survey and a Board briefing.

Seen at:	SLT ☐ Execs ☐	Document Version No.	1
Committee Approval / Review	• Quality Committee ☐ • Finance & Resource Committee ☐ • Audit Committee ☐ • People, Culture & Development Committee ☐ • Charitable Funds Committee ☐		
Strategic Priorities (please indicate)	1. **Growth** - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care ☒ 2. **Access** - We will ensure that everybody who needs our services will be able to choose the way, the time, and the place in which they access them ☒ 3. **Prevention** - To will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce. ☒		
BAF / Risk / legal implications: Risk Register Reference	1. We will provide the highest quality, safe and effective services ☐ 2. We will attract, develop and retain the best people ☐ 3. We will actively promote partnership and integrated models of working ☐ 4. We will increase our efficiency and effectiveness through sustainable development ☐ Any Risk/legal implications: (please reference if any)		
Sustainability:	1. Reduce the environmental impact of health and social care in Staffordshire and Stoke on Trent ☒ 2. Build a network of climate and sustainability champions across Staffordshire and Stoke on Trent ☒		

	3. Share learning and best practice ☒	
Resource Implications: Funding Source:	N/A N/A	
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	There is no direct impact on the protected characteristics as part of the completion of this report.	
ICS Alignment / Implications:	N/A	
Recommendations:	Board is asked to receive for information and assurance	
Version	Name/group	Date issued
1	Janet Dawson, Chair	1.5.2024

Chair's Report to the Trust Board
9 May 2024

1. One month in

It has been a very busy first month as Chair and my diary has filled up with additional meetings both as part of my induction and in general. I have enjoyed meeting people from across the Integrated Care System and forming new relationships which I hope I will be able to build on in the future. It is good to hear that generally Combined is held in high regard and to hear what our partners would like us to do more of and perhaps to do differently. As a key player in our health system, we are open to building good relationships and are always happy to listen. I have also had a focus on internal matters and particularly ensuring that with some changes in the non-executive team, we ensure that our Board committees continue to run smoothly. I am grateful to Russell for stepping in to chair our People, Culture and Development Committee on an interim basis while we start the process to recruit two additional non-executive directors to further strengthen our Board.

2. Well Led

Later today we will be considering how our Board might operate going forward and will be using the insights gained from our committee effectiveness review and our recent work done with external support on being well led. As part of a learning organisation, it is important that we keep this under review and work toward being outstanding as a Board. There are opportunities around restructuring the use of the Board's time, improving the time available for and the effectiveness and impact of our discussions at Board. We are also looking forward to spending more time on our development and learning as a team.

3. System Planning

At the end of April we approved our financial plan for 2024/25 which is part of the overall System Planning for Staffordshire. I am most grateful to the executive team and their teams for the extraordinary amount of work they have done to finalise this plan which is challenging but we have agreed is acceptable in the round. Further details of this will be communicated through the usual channels in due course.

4. Thank you for participating in our Staff Survey

I am delighted to have been asked to make a video especially as thank you to all or our staff for the high participation rate in our 2023 staff survey and for telling us both the good news about what has gone well and giving us the opportunity to do even better this year. At the Board we are very keen to hear your views and all of us learn through open and honest feedback done in a spirit of continuous improvement and I know that plans are being developed to look at each area of the trust and work is being done on what we can do differently. We will also provide feedback on what we are able to change. I know there is a special focus on inclusion and being a welcoming organisation which is critical to our success and Combined being a great place to work.

5. Board Briefing

In April we issued a Board briefing to capture the topics we talked about at Board. This is designed to give a quick insight into the work of the Board and improve understanding of what we do and why we are here. We will continue to keep this under review and take feedback to make it more accessible and interesting. We are hoping to speed the time it takes to issue to keep it current and relevant.

REPORT TO PUBLIC TRUST BOARD

Date of Meeting:	9th May 2024		
Title of Report:	Committee Effectiveness Annual Review and Report 2023/24		
Presented by:	Nicky Griffiths Deputy Director of Governance		
Author:	Lisa Wilkinson Corporate Governance Manager		
Executive Lead Name:	Dr Buki Adeyemo, Chief Executive Officer		

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Purpose of the report:								
Approval	☐	**Information**	☒	**Consider for Action**	☐	**Assurance**	☒	

Executive Summary:

All Committees had an effectiveness review led by each Committee Chair; these reviews were subsequently considered by each Committee and shared virtually with Audit Committee in May 2023. These discussions have formed the basis for this summary report to the Board which is presented for assurance, along with recommendations from the review for agreement. Reports of individual Committees are attached to the main report for information.

Reports of individual Committees are attached to the report for information, based on the conclusion of the effectiveness reviews, a number of recommendations were identified. Recommendations will be discussed at Committees, proposals for improving the functioning of the Committees determined and timelines agreed. A 6 month review has been built into the Committee Effectiveness programme whereby a report will be taken to Committees to review progress against recommendations and actions identified from the March 2024 review.

Seen at:	SLT ☐ Execs ☒	Document Version No.	
Committee Approval / Review	• Quality Committee ☒ • Finance & Resource Committee ☒ • Audit Committee ☒ • People, Culture & Development Committee ☒ • Charitable Funds Committee ☒		
Strategic Priorities (please indicate)	1. **Growth** - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care ☐ 2. **Access** - We will ensure that everybody who needs our services will be able to choose the way, the time, and the place in which they access them ☐ 3. **Prevention** - To will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce. ☒		
BAF / Risk / legal implications: Risk Register Reference	1. We will provide the highest quality, safe and effective services ☐ 2. We will attract, develop and retain the best people ☒ 3. We will actively promote partnership and integrated models of working ☐ 4. We will increase our efficiency and effectiveness through sustainable development ☒		

	Any Risk/legal implications: (please reference if any)	
Sustainability:	1. Reduce the environmental impact of health and social care in Staffordshire and Stoke on Trent ☐ 2. Build a network of climate and sustainability champions across Staffordshire and Stoke on Trent ☐ 3. Share learning and best practice ☒	
Resource Implications: Funding Source:	N/A N/A	
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics and other equality groups). See wider D&I Guidance	There is no direct impact on the protected characteristics as part of the completion of this report.	
ICS Alignment / Implications:	N/A	
Recommendations:	The Board is asked to receive the report for information and assurance.	
Version	Name/group	Date issued

REPORT TO PUBLIC TRUST BOARD
Annual Committee Effectiveness Report –2023/24

Introduction

The report details the findings of the Annual Committee Effectiveness Review undertaken in March 2024.

Purpose of the Report (Executive Summary)

All Committees had an effectiveness review led by each Committee Chair; these reviews were subsequently considered by each Committee and shared virtually with Audit Committee in May 2023 (as per timetable Appendix 1). These discussions have formed the basis for this summary report to the Board which is presented for assurance, along with recommendations from the review for agreement. Reports of individual Committees are attached to the main report for information.

Key Recommendations to Consider

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

Background

The Committee Effectiveness reviews are an annual exercise of self-assessment with the aim of reflecting on areas requiring specific focus and development. Surveys are sent to all members of the Committee and the Chair and analysis undertaken to develop a set of recommendations to improve committee effectiveness. A Chair's Self-Assessment questionnaire was not submitted by the current Chairs of Charitable Funds or Quality Committee given the previous Chairs left the organisation in November / December 2023 and therefore results provided by the new Chairs would not be a true reflection of 2023/24.

The review assessed the following areas:

- The Committee had regular attendance from members outlined in the Terms of Reference
- Adherence to cycle of business
- Paper Timeliness
- The Chairs Self –Assessment of composition, establishment, duties, internal control and risk management
- Feedback from members on 6 key themes – Focus of the Committee, team working, effectiveness, leadership and behaviours. What worked well, what did not work well and made suggestions for improvement
- Recommendations following the review

Recommendations

Based on the conclusion of the effectiveness reviews, a number of recommendations have been identified which will be reviewed by Committees:

Finance and Resource Committee (Appendix 2)

- Consider objectives for the year and consider alignment to strategic priorities

- Consider diversity and more focus on specific agenda items
- Review length and volume of papers
- Review membership in conjunction with Audit Committee
- Discuss impact of committee as a result of committee discussions / actions.

Audit Committee – (Appendix 3)

- Articulating the purpose of the audit committee at the commencement of each year, and setting out the particular areas of risk focus for the year ahead
- Implementing a training session on the purpose and functions of the Audit Committee, to reinforce members' understanding of the scope and activities of an Audit Committee, particularly in technical areas as well (This could be delivered by our internal/external auditors).
- Consider widening the membership of the Committee to draw in other executives (outside the Finance and Governance directorates), and making greater use (where appropriate) of calling in relevant executives when an item is under discussion which relates to their responsibilities.
- Reflect and agree at the end of the meeting, specifically, the actions to be logged, and whether all agenda items have been closed off
- Liaise with internal and external audit, to ensure that summaries in reports are clear and succinct.
- Consider holding some Audit Committee meetings in person

Charitable Funds Committee (Appendix 4)

- Review number of Committees per year and membership appropriate to level of funds
- Confirmation of direction and strategy required
- More focus on deliverables and leads for actions
- Staff involvement in Committee

People, Culture and Development Committee (Appendix 5)

- Review Terms of Reference, Agenda and Cycle of Business to allow time to fully debate matters and consider frequency of meetings
- Consideration for staff stories alternate Committee meetings
- Consider the addition of some time out sessions to take the pressure off the regular agendas and otherwise, working with colleagues, feel free to make this committee their own.

Quality Committee (Appendix 6)

- Consider tendency for the focus to shift to operational issues going over issues that have been dealt with in performance meetings
- Summary reports to Board could indicate the actual questions raised and subsequent responses
- Ensure areas of concern requiring more actions to gain assurance are not overlooked
- The Committee can be distracted when a focus is placed on issues that are not within the remit of the Committee or the Trust need to ensure Chair brings the focus back to related agenda
- Stay focussed on agenda items
- Strengthen the link with strategic priorities
- Share terms of reference with new Committee members
- Ensure consistency across operational updates

Remuneration Committee (REMCO) (Appendix 7)

- Sometimes difficult to compare to non NHS role
- Sometimes proposals are not fully backed up with data and these get pushed back for more information

It would be more appropriate for the new Chairs to review the Effectiveness feedback and determine whether the suggested recommendations outlined above appear appropriate and whether any additional

actions are required. Committee Effectiveness reports will be discussed at Committees and a 6 month review has been built into the Committee Effectiveness programme.

Summary

A comprehensive review was undertaken by each Committee, however the Governance Team will be reviewing the process this year and looking for new ways to collate and analyse data for the 2024/25 Committee Effectiveness Review.

Response rates across all Committees improved for the 2023/24 review which increased the value of the feedback received.

Overall the Committees appear to be functioning well. However, areas of development were identified across the Board and require review.

Cross committee analysis shows:
Key strengths include:

- Excellent and efficient chairing
- Generally appropriate membership and good levels of attendance

Areas for development include:

- The length and volume of agendas and papers need consideration
- Duration of meetings.
- Consider more face-to-face meetings where appropriate.
- More succinct summaries to the Board.

Next Steps

Recommendations from the review will be discussed at Committees, proposals for improving the functioning of the Committees determined and timelines agreed. A 6 month review has been built into the Committee Effectiveness programme whereby a report will be taken to Committees to review progress against recommendations and actions identified from the March 2024 review.

Appendix 1

Timetable for Committee Effectiveness Assessments and Returns 2023/24

Committee	Exec and NEDs	Digitalised questionnaires sent by 7th March 2024	Deadline for returns	Analysis of Results by 5th April 2024	Feedback from Deloitte re: Committee Observations	Chair summary produced and sent to Governance	Final report / action plans to Committees	All results shared with Audit Committee 3rd May 2024 and included in papers for Board	Final Report to Board 9th May 2024	Review Committee Actions
Quality Committee	Phil Jones Dr Dennis Okolo, Kenny Laing		28th March 2024			23rd April 2024	2nd May 2024			3rd October 2024
Finance & Resource Committee	Eric Gardiner and Russell Andrews		28th March 2024			23rd April 2024	2nd May 2024			3rd October 2024
People, Culture & Development Committee	Kerry Smith and Janet Dawson		28th March 2024			23rd April 2024	3rd June 2024 (shared virtually prior)			30th September 2024
Audit Committee	Eric Gardiner and Phil Jones		28th March 2024			23rd April 2024	3rd May 2024			16th October 2024
Charitable Funds Committee	Elizabeth Mellor, Eric Gardiner and Russell Andrews		28th March 2024			23rd April 2024	3rd June 2024 (shared virtually prior)			2nd December 2024 (shared virtually prior)
REMCO	Kerry Smith and David Rogers		28th March 2024			23rd April 2024	TBC - (shared virtually prior if required)			TBC

Appendix 2

REPORT TO FINANCE AND RESOURCE COMMITTEE
Finance and Resource Committee Effectiveness Questionnaire Results –2023/24

Introduction

The report details the findings of the Finance and Resource Committee Effectiveness Review undertaken in March 2024.

Purpose of the Report (Executive Summary)

The Finance and Resource Committee is required to produce an annual assessment of effectiveness, received by Board for assurance. The report reflects on the Committee meetings held during 2023/24.

A data template was populated for 2023/24 which detailed member attendance, adherence to cycle of business, frequency of meetings and paper timeliness.

- The Committee achieved 85% membership attendance during 2023/24.
- 89% of items were received in accordance with the Committee Cycle of Business.
- 100% of all papers were circulated to Committee members on time.
- There was one occasion when papers were reissued. (Appendix 1)

Invites to complete questionnaires were circulated to Committee members, of the 13 invites circulated 11 responses were received. (Appendix 2)

Key Recommendations to Consider

The Committee is asked to:

- Receive the report
- Note the areas of attention required
- Review in conjunction with actions from previous committee effectiveness reviews

Background

The review assessed the following areas:

- The Committee had regular attendance from members outlined in the Terms of Reference
- Adherence to cycle of business
- Paper Timeliness
- Feedback from members on 6 key themes – Focus of the Committee, team working, effectiveness, leadership and behaviours. What worked well, what did not work well and made suggestions for improvement
- Recommendations and next steps following the review

Previous Recommendations

Areas of attention:

- Consider objectives for the year and consider alignment to strategic priorities
- Consider diversity and more focus on specific agenda items

- Review length and volume of papers
- Review membership in conjunction with Audit Committee
- Discuss impact of committee as a result of committee discussions / actions

We have considered the objectives and their alignment with strategic priorities. There are some essentials that need to be considered a core part of the committee's role, chief among these are the trust financial position and progress toward forecast out-turn for the year. In addition efficiency savings (CIP), use of agency staff and system finance are currently key items of discussion in each meeting and areas where we regularly seek assurance on progress. Alongside this the estates programme and associated issues to do with the performance of the PFI contract of the Harplands site are kept under continuous review.

Through the year we have put more focus upon specific areas, the key new area being the performance of the PFI contract for the Harplands site. We accepted the recommendation of the full board that this committee 'hold the ring' on issues related to the Green Plan and sustainability. We have recently become the main committee where Agency spend is monitored.

Length and volume of papers continues to be an issue at times however there is a good degree of agreement among committee members that most papers are about right in terms of length and depth. There has been an exercise in-year to shorten papers relating to Digital innovation which is now reported through a dashboard. More use could be made of the report cover sheet instead of an in-depth report and the items related to business opportunities have modelled this approach well through the year.

After some discussion across the F&R and Audit Committees it was decide not to make any major changes until new NEDs have been recruited and inducted. In the meantime specific dates have been included in the Audit Committee cycle of business to receive and scrutinise a progress report from each o the other committees and F&R presented its report in January 2024.

Feedback suggests that the F&R committee is effective however we await the Well Led Review carried out by Deloitte's which will make further recommendations based upon their observations.

Chair's Summary

The committee has continued to meet monthly, in line with its terms of reference, and attendance of members has been very good over the past 12 months. The committee is well supported by four executive leaders (Finance & Performance, Strategy & Partnerships, Operations, Nursing) plus a range of other relevant officers including the governance team. Three Non-Executive Directors (including myself) plus one Associate NED also attend the committee. We currently have one NED vacancy on the committee. In my view as chair the engagement of committee members and attendees in debate and discussion is very positive.

The scope of the committee is wide, encompassing finance (inc system finances), performance, business opportunities and partnerships, estates and the trust's digital strategy. Since November the committee has also been responsible for reviewing progress on the trust's Green Strategy as a first point of governance before it is reviewed at full board. This breadth of scope means that papers have to be clear and focussed and that presentations by officers have to be succinct. By and large this works well and has not been a cause for concern. The quality of papers/presentations and the discussion that follows means that it is rare for committee members not to understand what is being asked of them. The recent revision to the reports on Digital Innovation has been very helpful.

Across that broad scope there are inevitably areas which remain a regular focus for review within the committee. The trust **financial position and progress toward forecast out-turn for the year** remains

a primary focus monthly. In addition **efficiency savings**, **use of agency staff** and **system finance** are currently key items of discussion in each meeting and areas where we regularly seek assurance on progress. Alongside this **the estates programme and associated issues to do with the performance of the PFI contract** of the Harplands site are kept under continuous review. Business opportunities are raised as and when necessary, however there is also more in-depth review quarterly on this area and the committee also operates as the 'first port of call' for higher cost business cases before they go forward to the full board.

When necessary the committee carries out a review in more detail of a specific area (what might sometimes be called a 'deep dive'). In the past 12 months we have done this with efficiency savings, use of agency staff and with **waiting times for adult and children mental health services**. In each case the purpose of the exercise has been to better understand the challenges, constraints and progress in order to gain assurance that all that can reasonably be done is being done. Where we take a closer look at performance metrics this is primarily to understand how the performance monitoring regime relates to any resulting improvement plans and how effective these plans are.

The risk register is reviewed in each meeting and the link from the key regular items identified above, through to risks, operates well; discussion in the committee generally tracks across closely to the highest items on the risk register. We have also recently carried out a focussed review of the 4 BAF risks that are associated with the committee so as to better understand how these risks are being managed.

Next Steps (including timeframes)

We await the final Well Led report from Deloitte's regarding next steps and recommendations but these are likely to include consideration of how we increase the level of scrutiny and 'difficult conversations' within the meetings. There are wider issues about how we ensure that the role of committees fits with the full board and working to avoid over-rehearsal of topics so that debate isn't stifled.

A 6 month review has been built into the Committee Effectiveness programme whereby a report will be taken to Committees to review progress against recommendations and actions identified from the March 2024 review.

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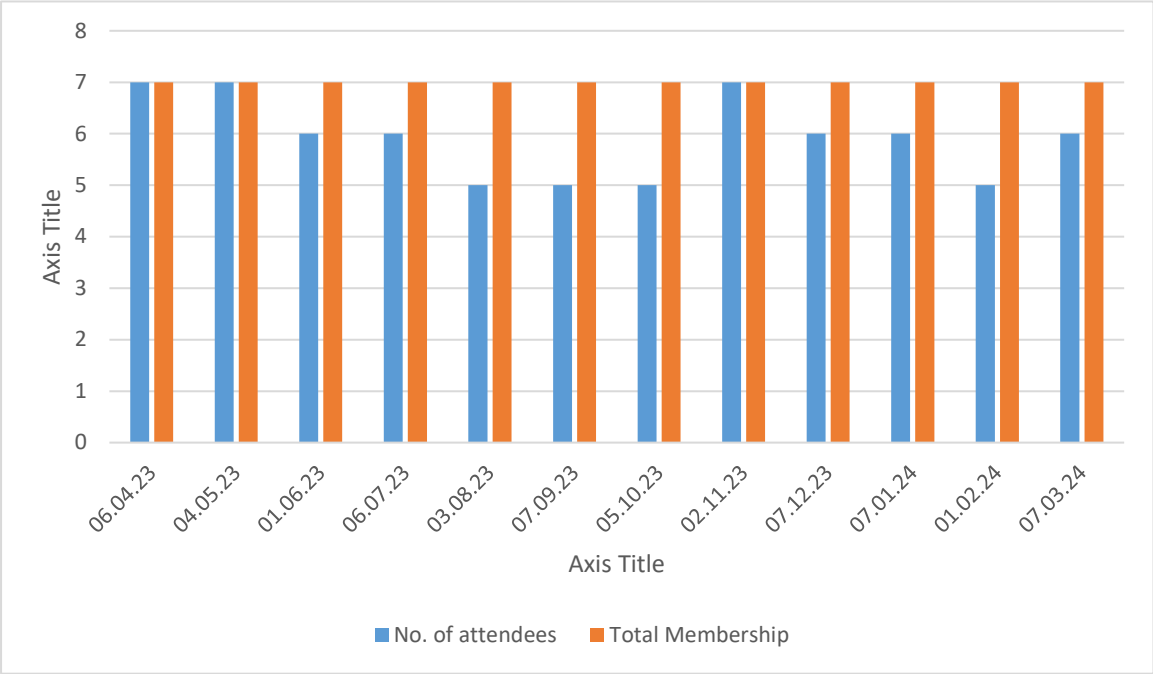
Appendix 1 - Committee Effectiveness Data

Attendance:

Has the Committee had regular attendance from members outlined in the Terms of Reference in the last 12 months?

Date	6.04.23	4.05.23	1.06.23	6.07.23	3.08.23	7.09.23	5.10.23	2.11.23	7.12.23	4.01.24	1.02.24	7.3.24
No of attendees	7	7	6	6	5	5	5	7	6	6	5	6
Total Membership	7	7	7	7	7	7	7	7	7	7	7	7

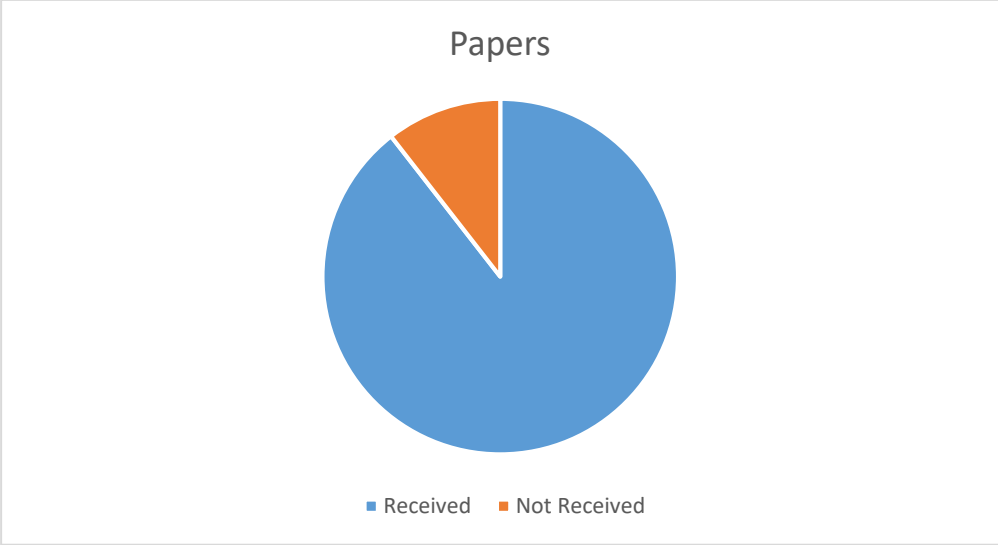


The Committee achieved 85% membership attendance during 2023/24.

Has the Committee / Chair adhered to the Cycle of Business?

*Please note the number of items each month that were scheduled on the cycle of business and how many were not an agenda item

Date	6.04.23	4.05.23	1.06.23	6.07.23	3.08.23	7.09.23	5.10.23	2.11.23	7.12.23	4.01.24	1.02.24	7.3.24
No. of items	10	6	6	9	6	7	9	7	7	12	8	8
Not agenda items	2	0	1	2	0	0	1	0	0	4	0	0



During 2023/24 89% of items were received in accordance with the Committee Cycle of Business

Paper Timeliness

Please advise if the papers were circulated 1 week prior to Committee (yes / no) and if papers were revised / amended after paper deadline

Date	6.04.23	4.05.23	1.06.23	6.07.23	3.08.23	7.09.23	5.10.23	2.11.23	7.12.23	4.1.24	1.2.24	7.3.24
Within 1 week	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Revised / Amended		2.5.23										

100% of all papers were circulated to Committee members on time. There was one occasion when papers were reissued.

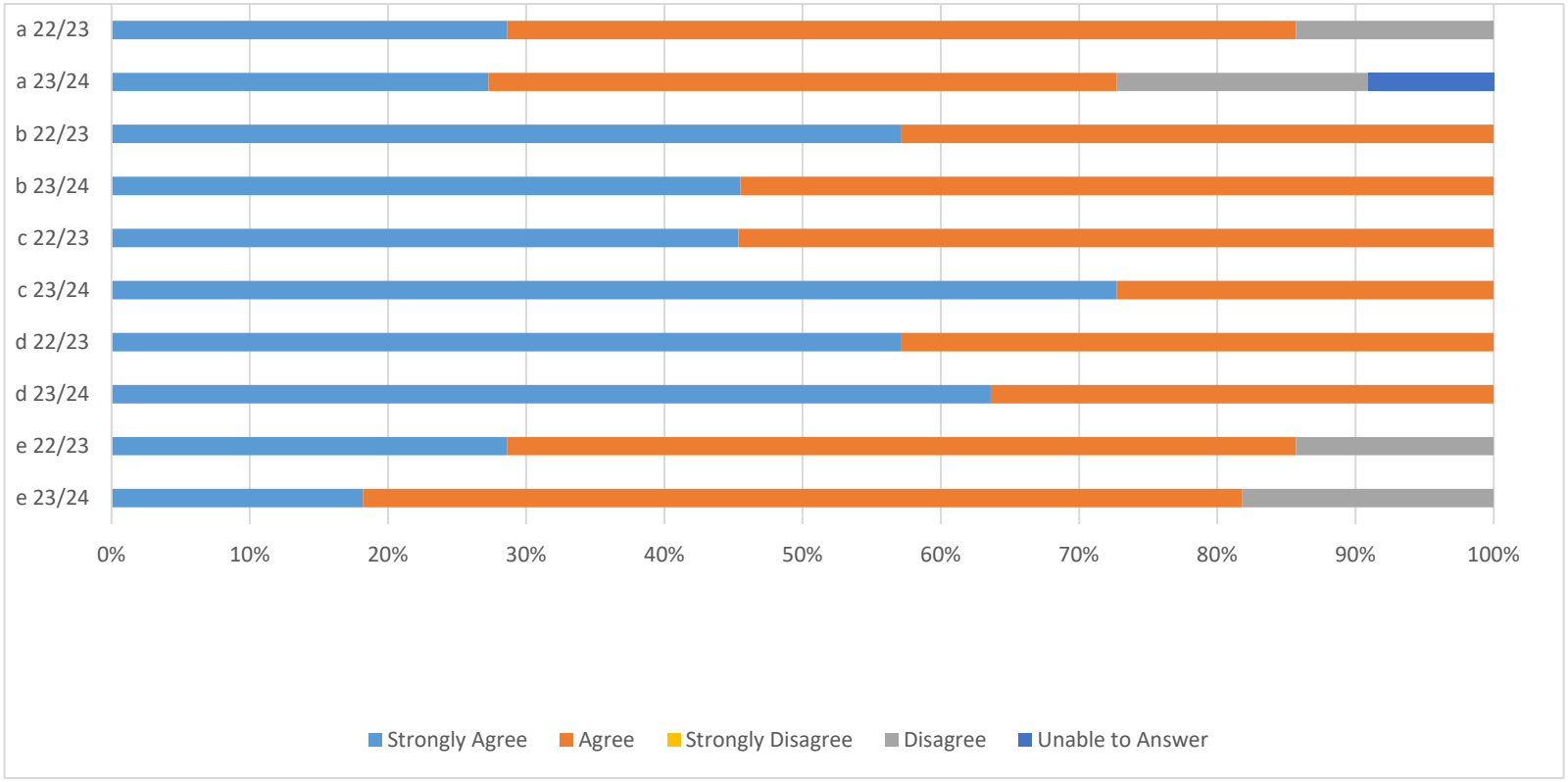
Appendix 2 - Results of Committee Member Questionnaires

Theme 1 – Focus

a. The Committee has set itself a series of objectives for the year	**27.3%**	**45.5%**	**18.2%**		**9.1%**
b. The Committee has made a conscious decision about the information it would like to receive	**45.5%**	**54.5%**			
c. Committee members contribute regularly to the issues discussed	**72.7%**	**27.3%**			
d. The Committee is aware of the key sources of assurance and who provides them	**63.6%**	**36.4%**			
e. The Committees focus is appropriately balanced, with items considered for each associated Strategic Priority	**18.2%**	**63.6%**	**18.2%**		

Additional Comments: 22/23
Some members go off topic frequently and keep going back to the same themes time after time that lack relevance.
Sometimes spend too long on issues that seem to sit outside of the Committee's area & even outside of the Trusts area of business or control
Additional Comments 23/24
Purpose/objectives of the committee are clear via the terms of reference but I am unclear whether in addition to this there are specific objectives that are set for each year. Within the ToR there may be scope to further develop how the partnerships activity is reflected in the agenda and reporting. In terms of Strategic Priority if this is in reference to Prevention, Access, Growth at present I'm not sure if this is clearly balanced against the ToR and how the meeting is structured

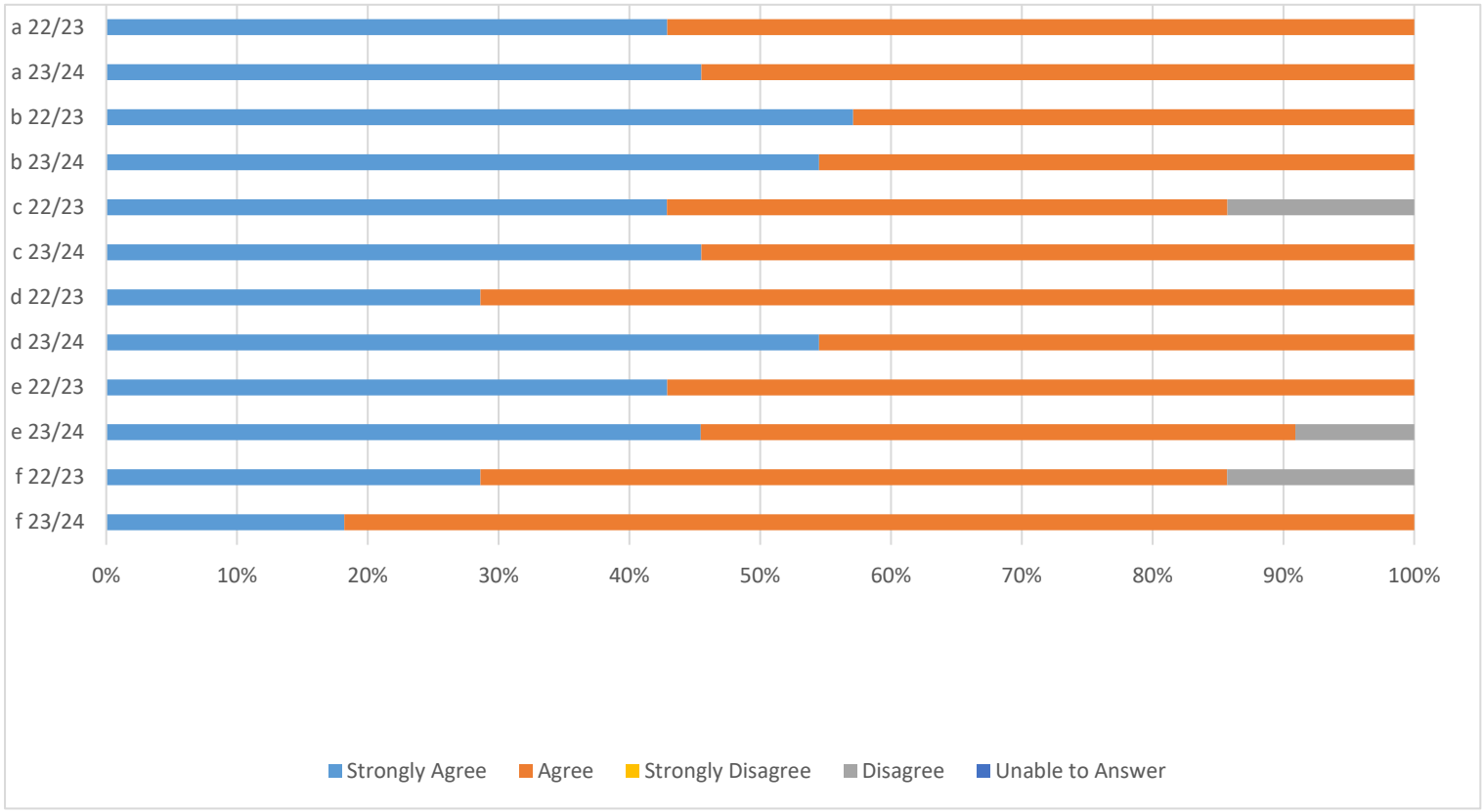
I don't know if the committee sets objectives as i can't recall seeing them. I would like to test if every knows what the strategic priorities are and then see more alignment, i don't think we do that now.



Theme 2 – Team Working

a. The Committee has the right balance of experience, knowledge and skills to fulfil its role	**45.5%**	**54.5%**			
b. The Committee ensures that the relevant Executive Director attends meetings to enable it to understand the reports and information it receives	**54.5%**	**45.5%**			
c. The Committee is fully briefed on key risks and any gaps in control	**45.5%**	**54.5%**			
d. The Committee environment enables people to express their views, doubts and opinions	**54.5%**	**45.5%**			
e. The Chair ensures that assurance providers address issues of late or missing assurances	**45.5%**	**45.5%**	**9.1%**		
f. Decisions and actions are implemented in line with the timescale set down	**18.2%**	**81.8%**			

Additional Comments 22/23
A positive relationship between NEDS and Staff members of the committee exists
Do not feel there is enough focus / challenge on Project Chrysalis given the very material size of the investment
Additional Comments 23/24
Committee is supported by a strong finance team which provides accurate and relative information making debate easy to understand
We could have more challenge but Russell is a great chair.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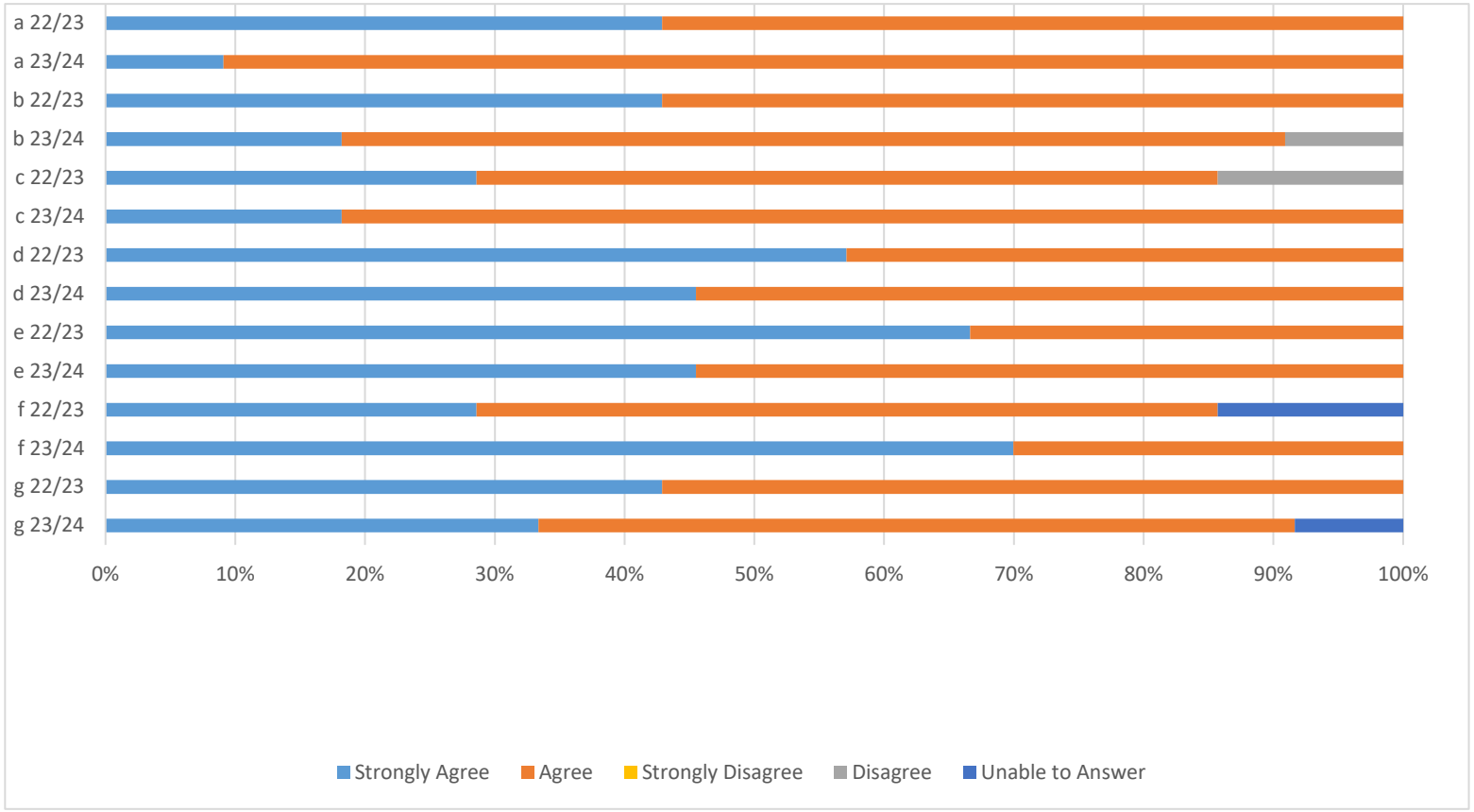
20%
30%
40%
50%
60%
70%
80%
90%
100%
Strongly Agree
Agree
Strongly Disagree
Disagree
Unable to Answer

Theme 3 – Effectiveness

a. The quality of papers received allows members to perform their roles effectively	**9.1%**	**90.9%**			
b. Members provide real and genuine challenge – they do not just seek clarification and/or reassurance	**18.2%**	**72.7%**	**9.1%**		
c. The Committee provides appropriate challenge to assurance providers to gain a clear understanding of their findings	**18.2%**	**81.8%**			
d. Debate is allowed to flow, and conclusions reached without being cut short or stifled	**45.5%**	**54.5%**			
e. Each agenda item is 'closed off' appropriately so that the Committee is clear on the conclusion; who is doing what, when and how, and how it is being monitored	**45.5%**	**54.5%**			
f. The Committee provides a written summary report of its meetings to the Trust Board including items for escalation	**63.6%**	**27.3%**			**9.1%**
g. The Committee has requested 'deep dives' into areas of concern	**36.4%**	**63.6%**			

Additional Comments 22/23
At times some areas of challenge are outside the control of the subject matter expert and not relevant to the paper
Additional Comments 23/24
Committee minutes are comprehensive and allow tracking of discussions
I think we could spend more time on some items and ask for specific agenda items to be discussed. I would give some diversity and interest, can be bit samey.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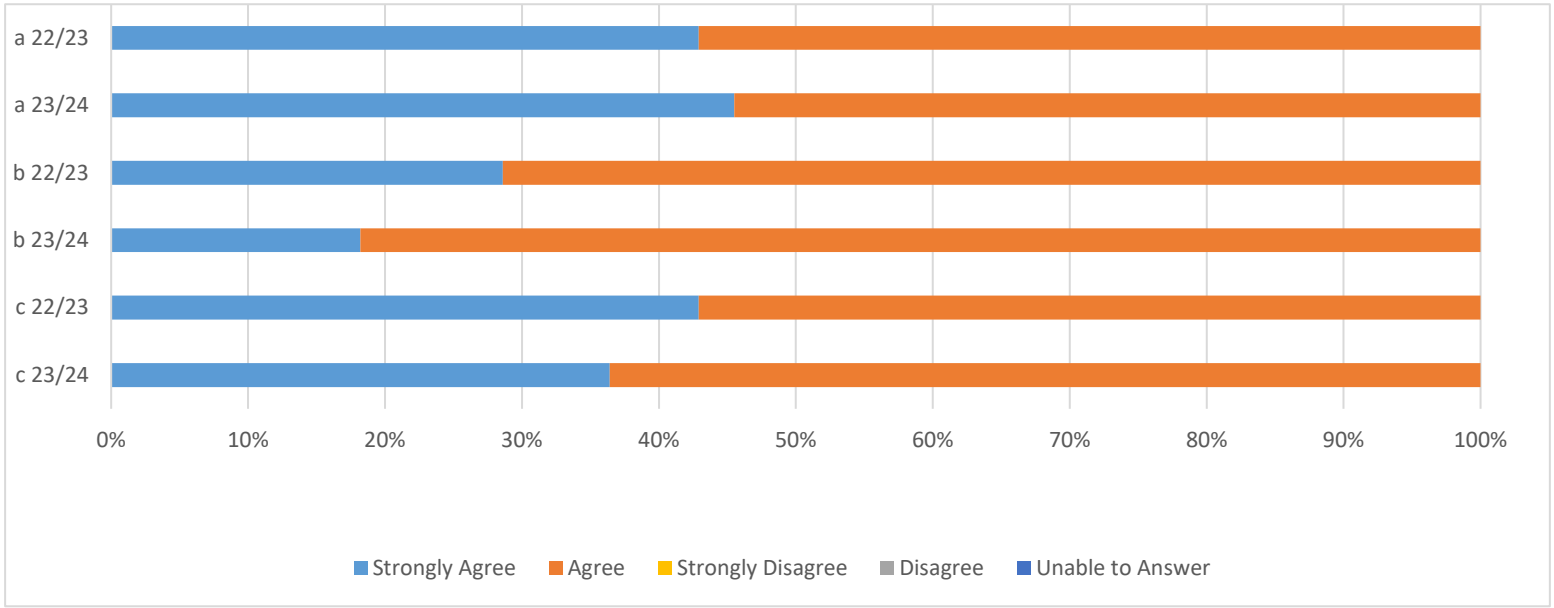
f 23/24
g 22/23
g 23/24
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Strongly Agree
Agree
Strongly Disagree
Disagree
Unable to Answer

Theme 4 – Engagement

a. Membership and attendance enables the Committee to cover all aspects of its terms of reference	**45.4%**	**54.5%**			
b. The Committee challenges management and other assurance providers to gain a clear understanding of their findings	**18.2%**	**81.8%**			
c. The Committee is clear about its role in relationship to other committees that play a role in relation to clinical governance, quality and risk management	**36.4%**	**63.6%**			

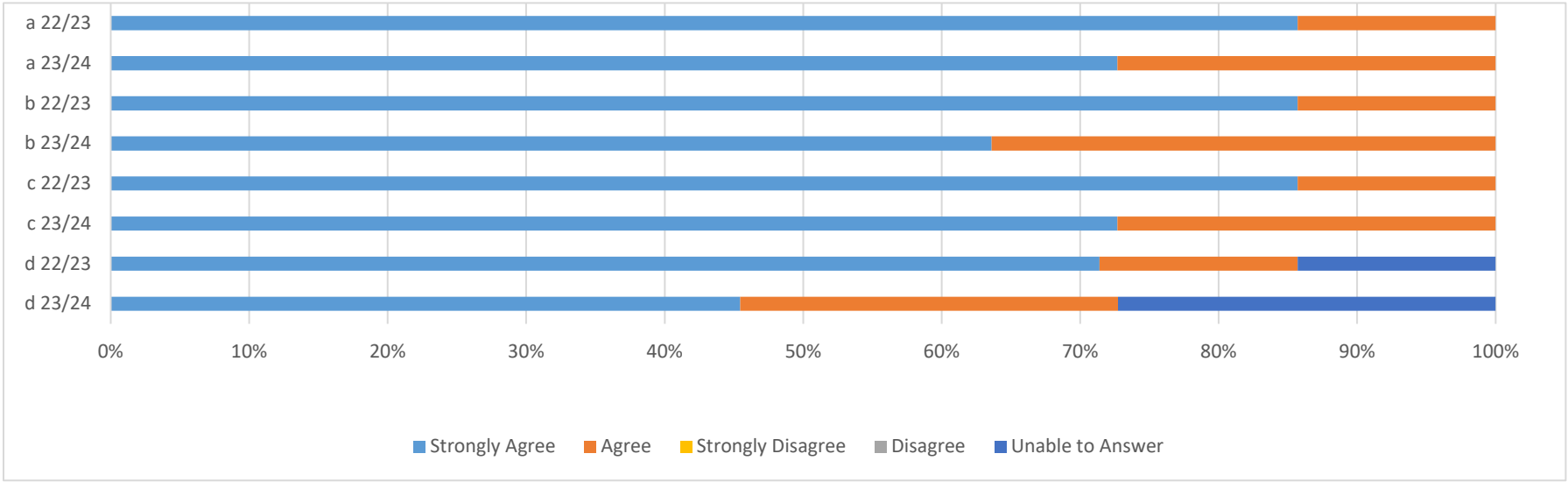
Additional Comments 22/23
As appropriate items are passed to other committees through the Chair
Additional Comments 23/24
Chair will pass appropriate data concerns to other committees for their review



Theme 5 – Leadership

a. The Chair has a positive impact on the performance of the Committee	**72.7%**	**27.3%**			
b. Committee meetings are chaired effectively	**63.6%**	**36.4%**			
c. The Chair allows debate to flow freely and does not assert his/her own views too strongly	**72.7%**	**27.3%**			
d. The Chair provides clear and concise information to the Trust Board on group/committee activities and gaps in control	**45.5%**	**27.3%**			**27.3%**

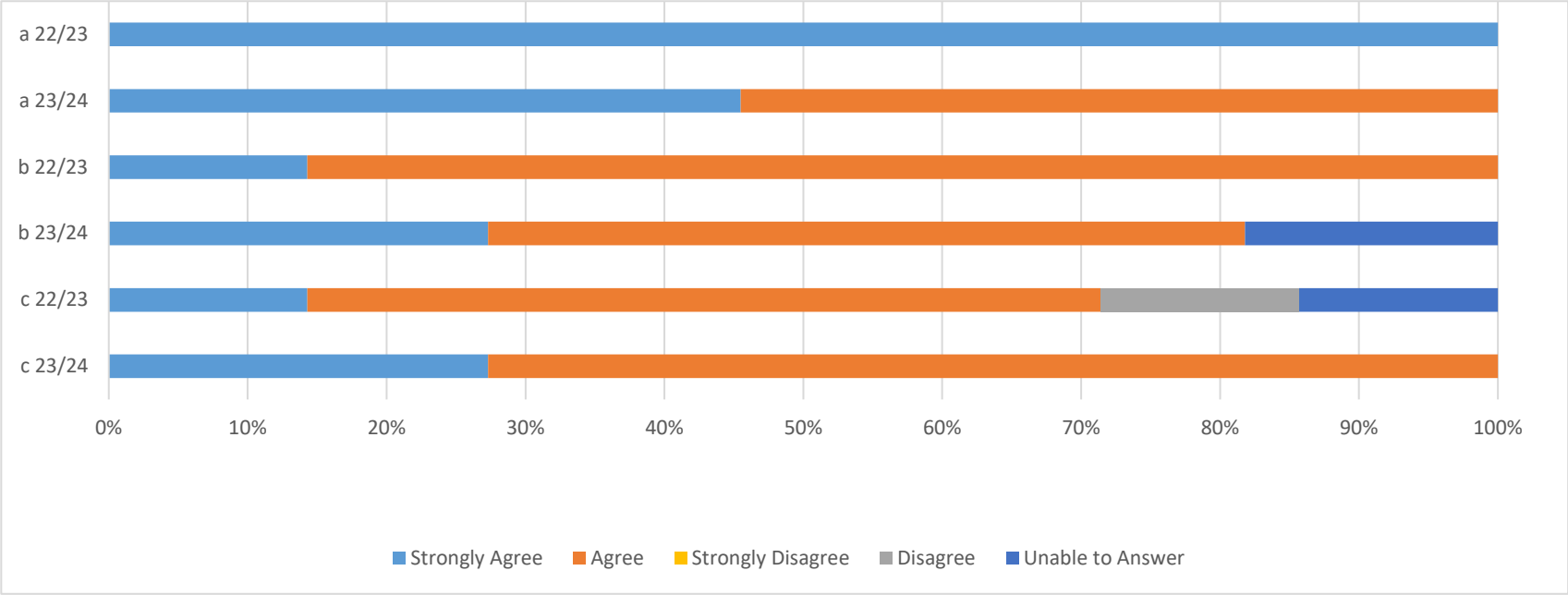
Additional Comments 22/23
Chair is clear of the division between Trust and ICS discussion and achieves a reasonable balance in reviewing ICS activity
No comments received for 23/24



Theme 6 – Behaviours

a. Behaviours are always appropriate	**45.5%**	**54.5%**			
b. If behaviours were not appropriate, the Chair addressed this appropriately during the meeting	**27.3%**	**54.5%**			**18.2%**
c. I would feel empowered to provide feedback to individuals at the time, or afterwards, where inappropriate behaviours were displayed during the meeting	**27.3%**	**72.7%**			

Additional Comments 22/23
Committee is very effective in discharging its responsibilities of both financial and performance issues
No comments were received for 23/24



What works well? 22/23
There is a clear confidence within the committee regarding the issues discussed, probably resulting from the Trusts financial and quality positions and the quality of the finance team in providing clear assurances when questioned Papers are of a good and relevant quality
What works well? 23/24
Well chaired meeting with NEDs exercising their responsibilities diligently and to ensure they have assurance
Right level of debate and consideration of difficult issues.
The meeting is chaired efficiently with exploration and challenge of each agenda item
Level of debate and challenge is appropriate and is non-confrontational Committee is conducted in relaxed but efficient manner
Committee runs very smoothly and effectively and is well chaired

What does not work well? 22/23
"Digital" sometimes appears to be an "add on" at the end of a busy agenda with little challenge often evident
What does not work well? 23/24
Too many papers that are often too lengthy.
We still need to decide the committee objectives for the year and the method of monitoring progress
Works better now that membership has changed, but still need to resolve duplicate membership of F&R and the Audit Committee

Suggestions for improvement 22/23
Maintain the present focus
Suggestions for improvement 23/24
Occasional reduced agenda allowing more discussion on fewer items.
May be helpful to be clearer on the impact of the committee - what has happened/changed/been done differently as a result of the discussions/actions from the committee

Areas of attention:

- Consider objectives for the year and consider alignment to strategic priorities
- Consider diversity and more focus on specific agenda items
- Review length and volume of papers
- Review membership in conjunction with Audit Committee

- Discuss impact of committee as a result of committee discussions / actions

Appendix 3

REPORT TO AUDIT COMMITTEE
Audit Committee Effectiveness Questionnaire Results –2023/24

Introduction

The report details the findings of the Audit Committee Effectiveness Review undertaken in March 2024.

Purpose of the Report (Executive Summary)

The Audit Committee is required to produce an annual assessment of effectiveness, received by Board for assurance. The report reflects on the Committee meetings held during 2023/24.

A data template was populated for 2023/24 which detailed member attendance, adherence to cycle of business, frequency of meetings and paper timeliness.

- The Committee achieved 93% membership attendance during 2023/24.
- During 2023/24 76% of items were received in accordance with the Committee Cycle of Business
- 100% of all papers were circulated to Committee members within the 1-week standard.
- 40% of papers during this time required amending or updating. (Appendix 1)

A Self-Assessment questionnaire was submitted by the Chair. (Appendix 2)

Invites to complete questionnaires were circulated to Committee members, of the 10 invites circulated 8 responses were received. (Appendix 3)

Key Recommendations to Consider

The Committee is asked to:

- Receive the report.
- Note the areas of attention required.
- Review in conjunction with actions from previous committee effectiveness reviews

Background

The review assessed the following areas:

- The Committee had regular attendance from members outlined in the Terms of Reference
- Adherence to cycle of business
- Paper Timeliness
- The Chairs Self –Assessment of composition, establishment, duties, internal control and risk management
- Feedback from members on 6 key themes – Focus of the Committee, team working, effectiveness, leadership and behaviours. What worked well, what did not work well and made suggestions for improvement
- Recommendations and next steps following the review.

Recommendations

- Articulating the purpose of the audit committee at the commencement of each year, and setting out the particular areas of risk focus for the year ahead
- Implementing a training session on the purpose and functions of the Audit Committee, to reinforce members' understanding of the scope and activities of an Audit Committee, particularly in technical areas as well (This could be delivered by our internal/external auditors).
- Consider widening the membership of the Committee to draw in other executives (outside the Finance and Governance directorates), and making greater use (where appropriate) of calling in relevant executives when an item is under discussion which relates to their responsibilities.
- Reflect and agree at the end of the meeting, specifically, the actions to be logged, and whether all agenda items have been closed off
- Liaise with internal and external audit, to ensure that summaries in reports are clear and succinct.
- Consider holding some Audit Committee meetings in person

(** It is for the new Audit Chair to determine whether these recommendations appear appropriate or not.)

Summary

The recent survey completed by committee members and regular attendees has raised some opportunities for review how the committee operates, both in terms of committee activity and how it creates focus for the committee agenda and aligns it to the overall strategy of the Trust. As committee chair, my summary of the feedback is as follows, along with my commentary on the feedback. It is fairly similar to last year's summary.

Objective Setting and Focus

The Audit Committee has a clear work programme, which is driven by a risk assessment at the start of the year, which also feeds into the internal and external audit plan. The objectives which sit behind this are set out in the Committee's Terms of Reference. It might be worth re-articulating the purpose of the audit committee at the start of the year and the particular areas of risk focus in that year (e.g. partnership arrangements, cyber audit arrangements) to increase focus. It would also be useful, in the next twelve months, to initiate a piece of one-off training, in relation to the statutory functions of an Audit Committee, its scope and limitations. This would eb timely with the appointment of a new Audit Chair. The focus of an audit committee is on the financial accounts, financial systems and the processes of governance which operate throughout the Trust. We could therefore achieve clearer focus by (**):

- Articulating the purpose of the audit committee at the commencement of each year, and setting out the particular areas of risk focus for the year ahead
- Implementing a training session on the purpose and functions of the Audit Committee, to reinforce members' understanding of the scope and activities of an Audit Committee, particularly in technical areas as well (This could be delivered by our internal/external auditors).

(** It is for the new Audit Chair to determine whether these recommendations appear appropriate or not.)

Team Working

Members of the Audit Committee feel comfortable that they are able to express their views and opinions openly and understand the messages relayed to them by Internal and External Audit. Greater use could

also potentially be made of asking executives from other Directorates to attend to discuss items under consideration which relate to their responsibilities. I agreed with Chairs of other Committees, that in 2022-23, they will attend one audit committee a year (on a phased basis) to explain to the Committee how they fulfil the terms of reference of their committees through their performance review and other arrangements. This idea was to strengthen the assurance obtained by The Audit Committee about the systems of governance and scrutiny which operate in the key areas of the Trust's activities. Russell Andrews (as Chair of F&R) gave a good explanation to the Audit Committee of how F&R fulfilled its ToRs, and responded to questions from the Audit Committee. A point was raised within the 2022/23 review about the fact that the membership of the Audit Committee, mirrored that of the Finance and Resources committee. While this has not led to any conflicts of interest in practice, it could lead to the perception that such conflicts might be facilitated by the current arrangements. Going forward, with the new NED arrangements, there should be a clearer separation between the membership of the two committees. The two committees, will be seen as operationally independent and distinct. Accordingly, we will (**):

- Consider widening the membership of the Committee to draw in other executives (outside the Finance and Governance directorates), and making greater use (where appropriate) of calling in relevant executives when an item is under discussion which relates to their responsibilities.

(** It is for the new Audit Chair to determine whether these recommendations appear appropriate or not.)

Effectiveness

The quality of papers submitted to the Audit Committee are generally fit for purpose, but feedback also suggests that the summaries relating to external and internal audit reports could be more succinct. Reports of the Committee's work to Board are generally seen as effective and the Committee has also requested deep dives to address particular areas of risk. Feedback is that agenda items are generally closed effectively, but this could be strengthened. This could be built into reflection at the close of meetings. Accordingly, we will (**):

- Reflect and agree at the end of the meeting, specifically, the actions to be logged, and whether all agenda items have been closed off
- Liaise with internal and external audit, to ensure that summaries in reports are clear and succinct.

(** It is for the new Audit Chair to determine whether these recommendations appear appropriate or not.)

Engagement

The feedback suggests that the Committee challenges management and others on assurances provided and clear about its role in relation to other committees. The Committee has commissioned work by its internal auditors to obtain assurance about controls operating in identified areas of key risk.

Leadership

Generally, the Chair is seen to have a positive impact on the performance of the committee and allows debate to flow freely. The Chair also provides clear information to the Board on any weaknesses in governance controls. Visibility within the organisation could be improved, both of the Chair and the Committee, not least as all meetings are held by Teams. But most committees meet via Teams. It is up to the new Chair of Audit to consider whether to:

- consider holding some Audit Committee meetings in person

Behaviours The feedback suggests that: behaviours of the Committee are always appropriate; the Chair would address behaviours if they were inappropriate and that committee members feel empowered to point out inappropriate behaviour if it arose.
Next Steps (including timeframes)
It would be more appropriate for the new Audit Chair to review the Effectiveness feedback and determine whether the suggested recommendations outlined above appear appropriate or not, and whether any additional actions are required.

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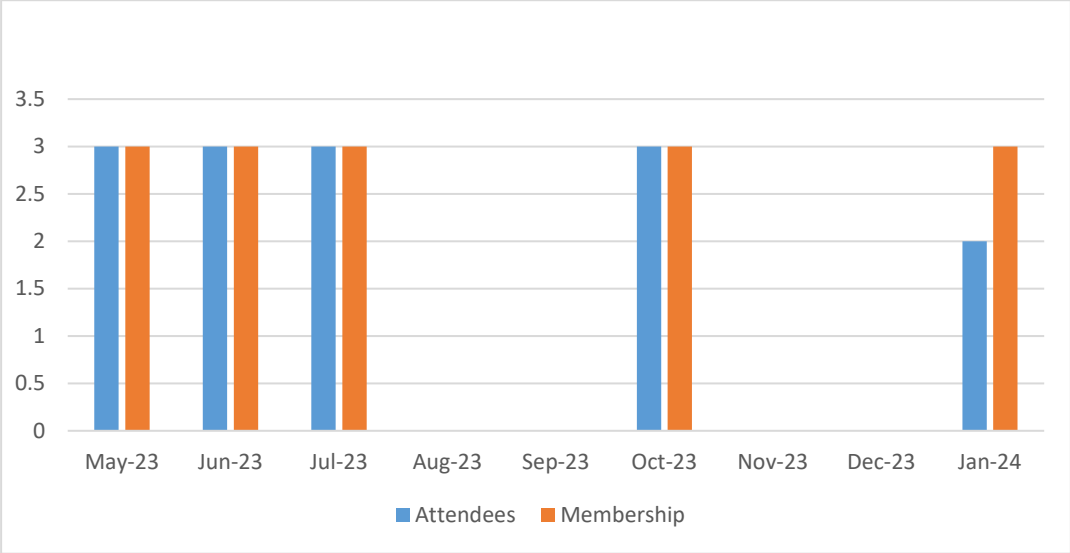
Appendix 1 - Committee Effectiveness Data

Attendance:

Has the Committee had regular attendance from members outlined in the Terms of Reference in the last 12 months?

Date	5.05.23	9.06.23	27.07.23	18.10.23	17.1.24
No of Members in attendance	3	3	3	3	2
Total Membership	3	3	3	3	3

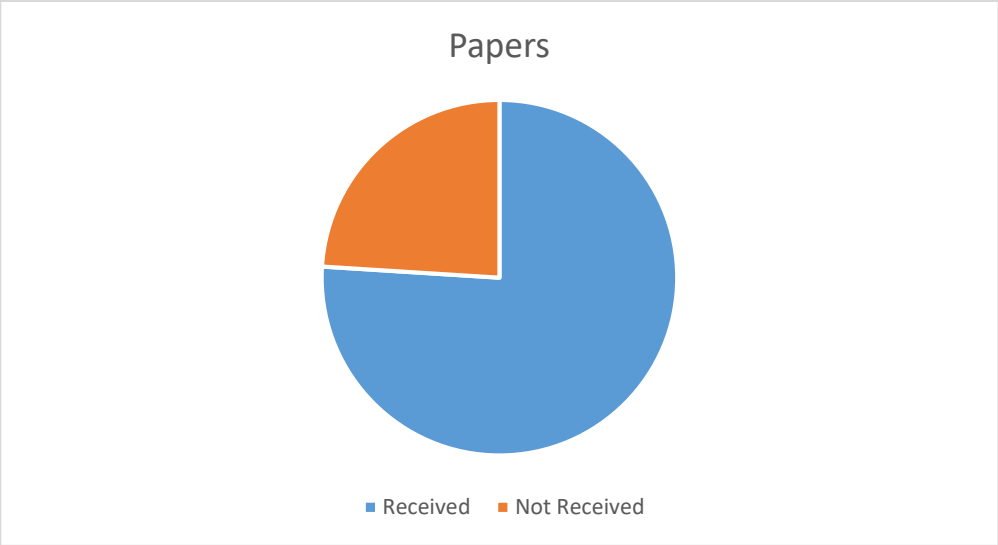


The Committee achieved 93% membership attendance during 2023/24 compared to 94% in 2022/23.

Has the Committee / Chair adhered to the Cycle of Business?

*Please note the number of items each month that were scheduled on the cycle of business and how many were not an agenda item

Date	5.05.23	9.06.23	27.07.23	18.10.23	17.1.24
No. of items	13	20	14	15	16
Not agenda items	2	1	5	4	6



During 2023/24 76% of items were received in accordance with the Committee Cycle of Business a slight improvement on 72% in 2022/23.

Paper Timeliness

Please advise if the papers were circulated 1 week prior to Committee (yes / no) and if papers were revised / amended after paper deadline

Date	05.05.23	9.06.23	27.07.23	18.10.23	17.1.24
Within 1 week	✓	✓	✓	✓	✓
Revised / Amended	2.05.23 4.05.23	7.06.23			

100% of all papers were circulated to Committee members within the 1 week standard as they were in 2022/23. 40% of papers during this time required amending or updating compared to 20% last year.

Appendix 2 - Results of Chair Self –Assessment

Questions	Response	Comments
Composition, establishment and duties		
1. Does the Committee have written terms of reference and have they been approved by Trust Board?	Yes	
2. Are the terms of reference reviewed annually?	Yes	
3. Has the Committee formally considered how it integrates with other Committees that are reviewing risk?	Yes	Active liaison with other Committee Chairs, through formal quarterly meetings and escalation of relevant items to other committees including within Committee Agenda structure.
4. Are Committee members independent of the management team?	Yes	
5. Are the outcomes of each meeting and any internal control issues reported to the next Trust Board meeting?	Yes	
6. Does the Committee prepare an annual report on its work and performance to the Trust Board?	Yes	
7. Has the Committee established a plan of matters to be dealt with across the year?	Yes	
8. Are Committee papers distributed in sufficient time for members to give them due consideration?	Yes	
9. Has the Committee been quorate for each meeting this year?	Yes	

Internal control and risk management		
10. Does the Committee receive and review the evidence required to demonstrate compliance with regulatory requirements – for example, as set by the Care Quality Commission?	Yes	
11. Has the Committee reviewed the accuracy of the draft Annual Governance Statement?	Yes	
12. Has the Committee reviewed key data against the data quality dimensions?	Yes	Yes, although not clear that this question is relevant to the Audit Committee.
13. Has the Committee reviewed the effectiveness of the organisations assurance framework	Yes	Yes, we have done this by inviting Committee Chairs to attend the Audit Committee once a year to be scrutinised on how they are fulfilling their terms of reference and managing key risks on behalf of the Board.
Annual Report and accounts and disclosure statements		
14. Does the Committee receive and review a draft of the organisation's annual report and accounts?	Yes	
15. Does the Committee specifically review: - The going concern assessment - Changes in accounting policies - Changes in accounting practice due to changes in accounting standards - Changes in estimation techniques? - Significant judgments made in preparing the accounts? - Significant adjustments resulting from the audit? - Explanations for any significant variances?	Yes	

16. Is a Committee meeting scheduled to discuss any proposed adjustments to the accounts and audit issues?	Yes	Yes, we respond to the Auditor's report and sign off the final accounts, the make a recommendation to the Board on whether the accounts can be accepted or not.
17. Does the Committee ensure it receives explanations for any adjusted errors in the accounts found by the external auditors?	Yes	In practice, adjusted errors have tended to be non-material.
Internal Audit		
18. Is there a formal 'charter' or terms of reference, defining internal audit's objectives, responsibilities	Yes	
19. Does the Committee review and approve the internal audit plan any changes to the plan?	Yes	
20. Is the Committee confident that the audit plan is derived from a clear risk assessment process?	Yes	
21. Does the Committee receive periodic progress reports from the Head of Internal Audit?	Yes	
22. Does the Committee effectively monitor the implementation of management actions arising from internal audit reports?	Yes	Actions Log monitors IA recommendations at every meeting.
23. Does the Head of Internal Audit have a right of access to the committee and its Chair at any time?	Yes	

24. Is the Committee confident that internal audit is free of any scope restrictions or operational responsibilities?	Yes	
25. Has the Committee evaluated whether internal audit complies with the Public Sector Internal Audit Standards?	Yes	We evaluate annual Internal Audit paper which provides assurance that Public Sector Internal Audit Standards are met.
26. Does the Committee receive and review the Head of Internal Audit's annual opinion?	Yes	
External Audit		
27. Do the external auditors present their audit plans and strategy to the committee for agreement and approval?	Yes	
28. Does the Committee review the external auditor's ISA 260 report (the report to those charged with governance)?	Yes	
29. Does the Committee review the external auditor's value for money conclusion?	Yes	
30. Does the Committee review the external auditor's opinion on the quality account when necessary?	Yes	
31. Does the Committee hold periodic private discussions with the external auditors?	Yes	
32. Does the Committee assess the performance of external audit?	Yes	Informally rather than formally. We discussed doing a formal annual review in the past, but decided to review external audit work informally instead. We are satisfied with the external audit work of our current external auditors.

33. Does the Committee require assurance from external audit about its policies for ensuring independence?	Yes	
34. Has the Committee approved a policy to govern the nature and value of non-audit work carried out by the external auditors?	Yes	
Clinical Audit		
35. If the Committee is NOT responsible for monitoring clinical audit, does it receive a report from the relevant committee?	No	We invite all of the Committee Chairs to attend the Audit Committee to provide assurance as to their systems of governance, including clinical audit (re Quality Committee). Clinical Audit Chair to attend when they have been appointed (position. currently vacant). I have been, pro tem, the Chair of the Quality Committee, as has been another member of the Audit Committee, so we are well sighted on issues of clinical audit.
36. If the Committee is responsible for monitoring clinical audit has it: - Reviewed an annual clinical audit plan? - Received regular progress reports? - Monitored the implementation of management actions? - Received a report over the quality assurance processes covered by clinical audit activity?	N/A	N/A: the Quality Committee is responsible for monitoring clinical audit.
Counter Fraud		
37. Does the Committee review and approve the counter fraud work plans and any changes to the plans?	Yes	
38. Is the Committee satisfied that the work plan is derived from an appropriate risk	Yes	

assessment and that coverage is adequate?		
39. Does the Committee receive periodic reports about counter fraud activity?	Yes	
40. Does the Committee effectively monitor the implementation of management actions arising from counter fraud reports?	Yes	
41. Do those working on counter fraud activity have a right of direct access to the Committee and its Chair?	Yes	
42. Does the Committee receive and review an annual report on counter fraud activity?	Yes	
43. Does the Committee receive and discuss reports arising from quality inspections by NHSCFA?	Yes	

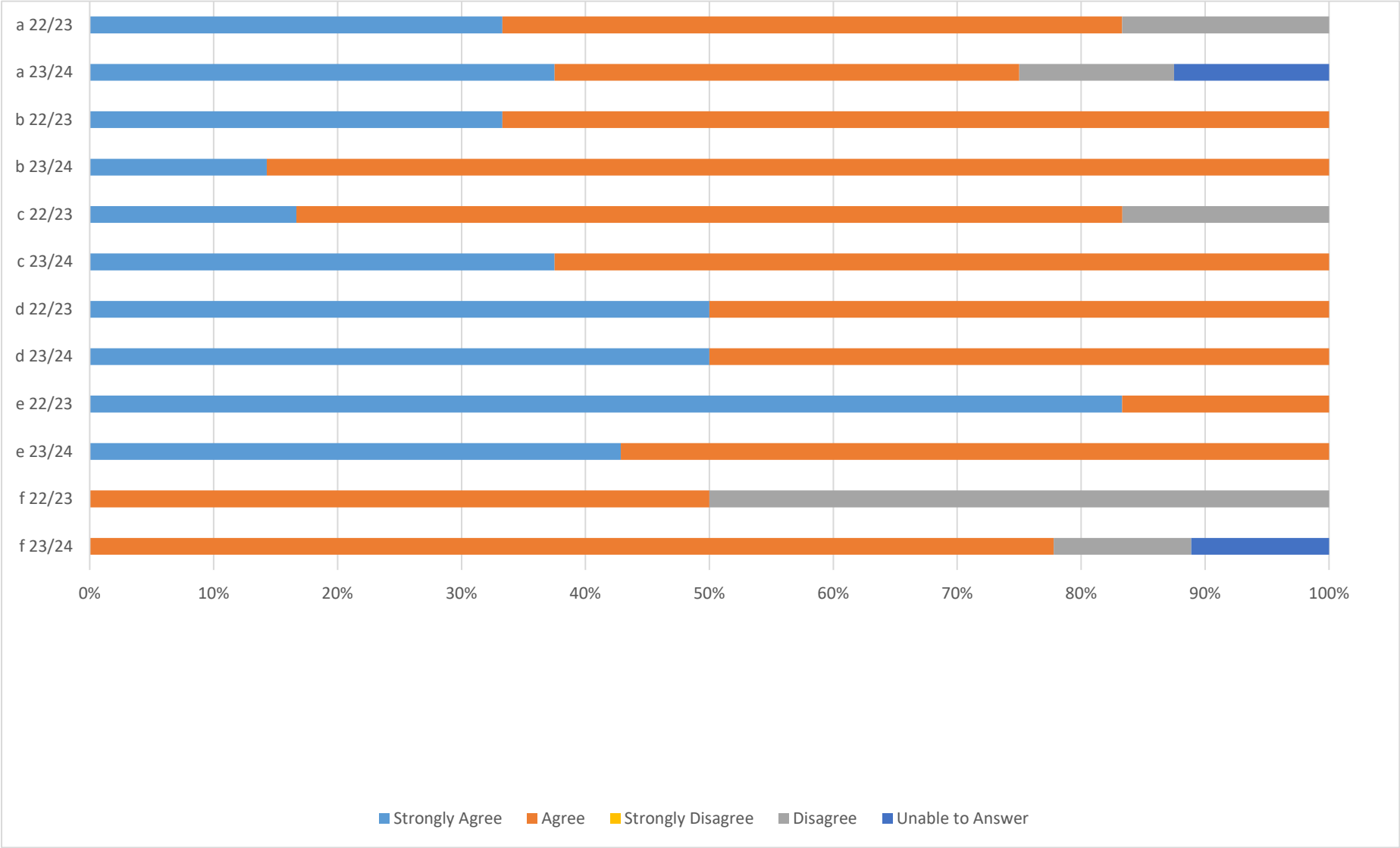
Appendix 3 - Results of Committee Member Questionnaires

Theme 1 – Focus

	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer
a. The Committee has set itself a series of objectives for the year	37.5%	37.5%	12.5%		12.5%
b. The Committee has made a conscious decision about the information it would like to receive	12.5%	75%			12.5%
c. Committee members contribute regularly to the issues discussed	37.5%	62.5%			
d. The Committee is aware of the key sources of assurance and who provides them	50%	50%			
e. The Committees focus is appropriately balanced, with items considered for each associated Strategic Priority	37.5%	50%			12.5%
f. Equal prominence is given to both quality and financial assurance		87.5%	12.5%		

Additional Comments received 22/23
I would like scope in the agenda to address green plan issues including disclosure on carbon and 10 % waver for net zero and social value weighting
Additional Comments received 23/24
The focus is mainly on finance and we need more focus on quality and other controls

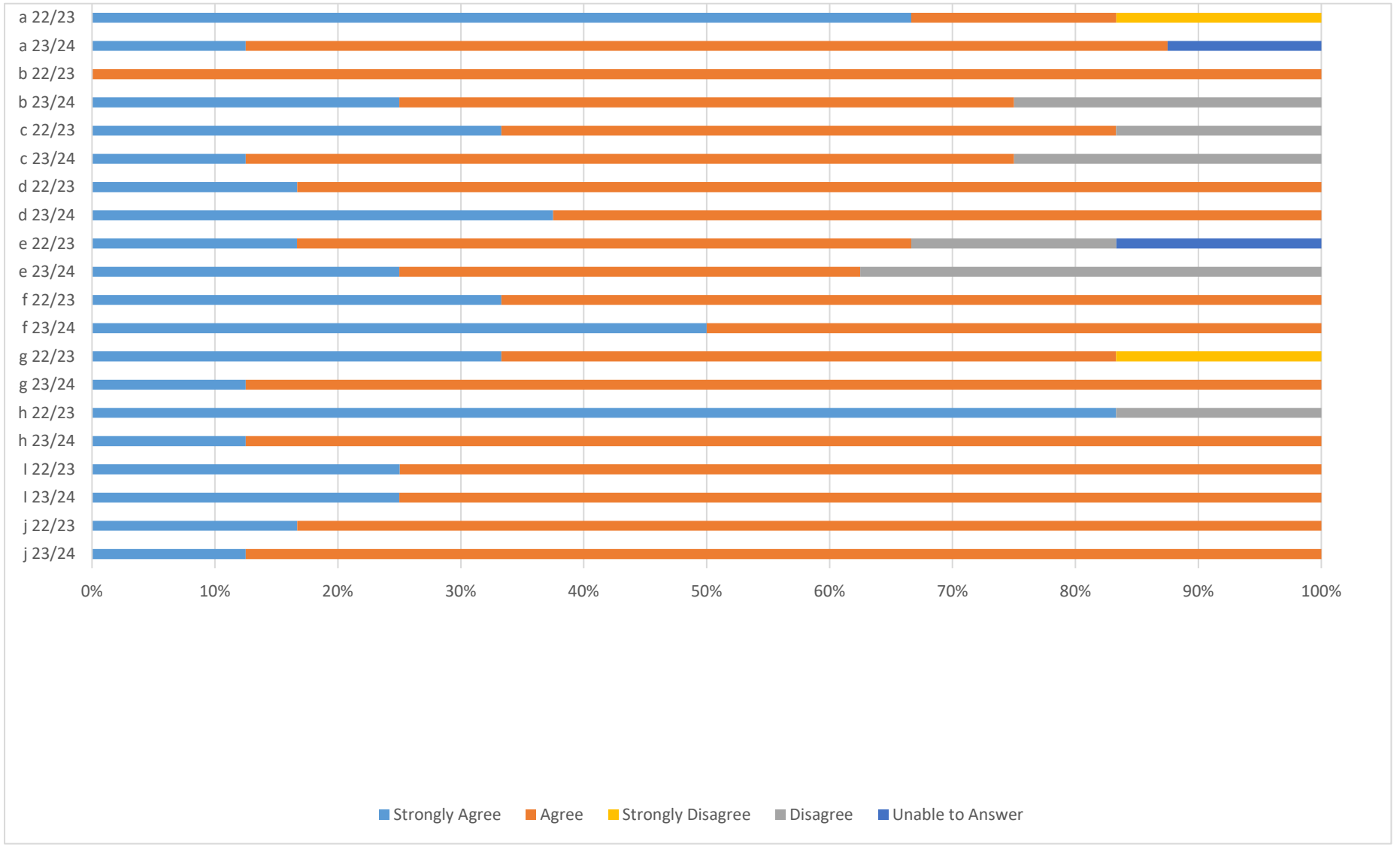
Theme 1 Results 2023/24 in comparison to 2022/23



Theme 2 - Team Working

	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer
a. The Committee has the right balance of experience, knowledge and skills to fulfil its role	12.5%	75%			12.5%
b. he Committee has structured its agenda to cover quality, data quality, performance targets and financial control	25%	50%	25%		
c. The Committee ensures that the relevant Executive Director attends meetings to enable it to understand the reports and information it receives	12.5%	62.5%	25%		
d. Management fully briefs the Committee on key risks and any gaps in control	37.5%	62.5%			
e. Other Committees provide timely and clear information in support of the Audit Committee	25%	37.5%	37.5%		
f. The Committee environment enables people to express their views, doubts and opinions	50%	50%			
g. Committee members understand the messages being given by external audit, internal audit and counter fraud	12.5%	87.5%			
h. Internal audit contributes to the debate across the range of the agenda	12.5%	87.5%			
i. Members ensure that assurance providers address issues of late or missing assurances	25%	75%			
j. Decisions and actions are implemented in line with the timescale set down	12.5%	87.5%			

No additional comments received in 22/23 or 23/24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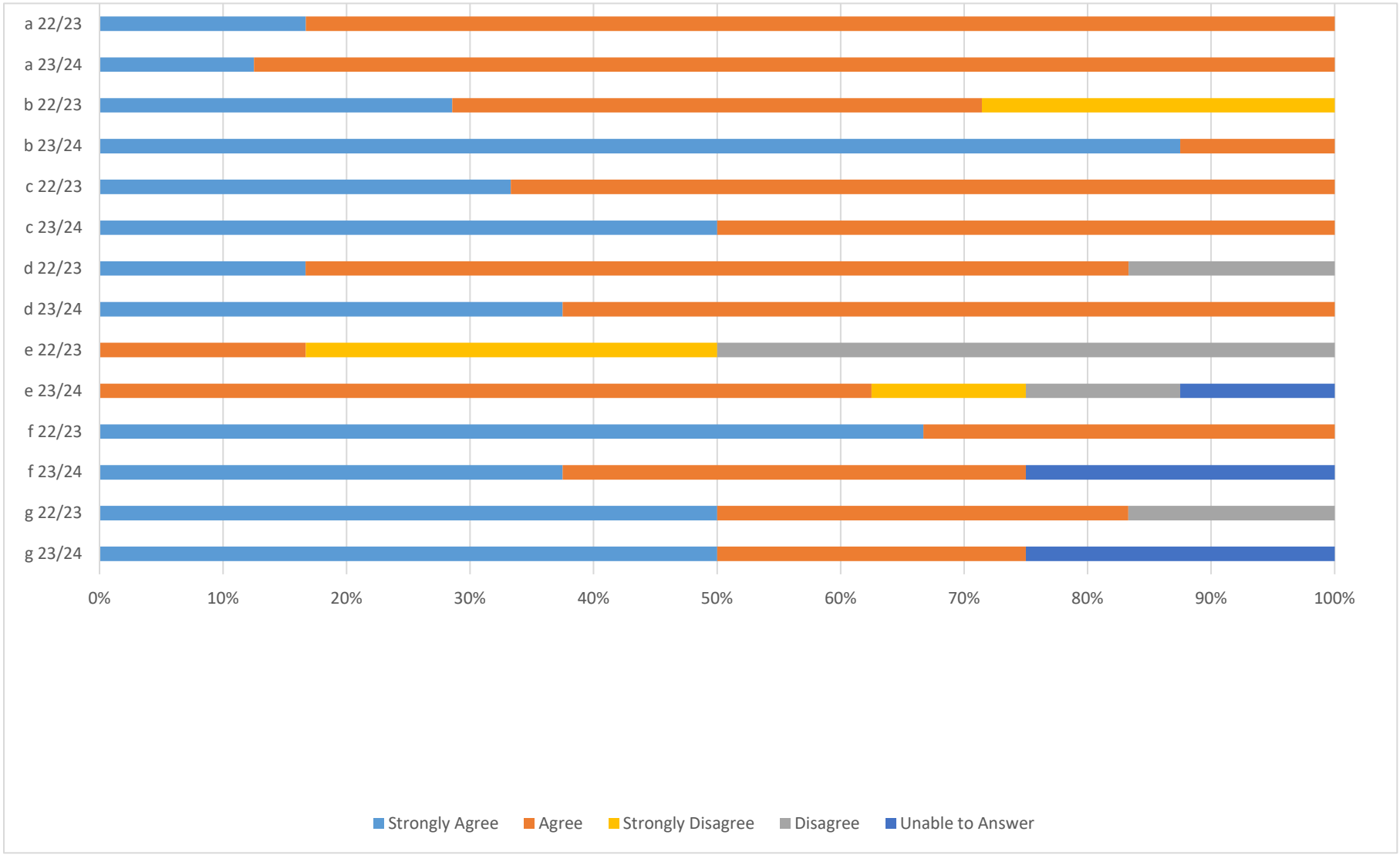
Strongly Agree
Agree
Strongly Disagree
Disagree
Unable to Answer

3. Theme 3 – Effectiveness

	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer
a. The quality of papers received allows members to perform their roles effectively	**12.5%**	**87.5%**			
b. Members provide real and genuine challenge – they do not just seek clarification and/or reassurance	**87.5%**	**12.5%**			
c. The Committee provides appropriate challenge to assurance providers to gain a clear understanding of their findings	**50%**	**50%**			
d. Debate is allowed to flow, and conclusions reached without being cut short or stifled	**37.5%**	**62.5%**			
e. Each agenda item is 'closed off' appropriately so that the Committee is clear on the conclusion; who is doing what, when and how, and how it is being monitored		**62.5%**	**12.5%**	**12.5%**	**12.5%**
f. The Committee provides a written summary report of its meetings to the Trust Board including items for escalation	**37.5%**	**37.5%**			**25%**
g. The Committee has requested 'deep dives' into areas of concern	**50%**	**25%**			**25%**

Additional Comments 22/23
Self-reflection after every meeting becomes mechanical and excessively inward. Annual self-assessment supplemented by periodic self-reflection seems a better approach to adopt.
No formal reflection at the end of committee meetings. However Chair is available to discuss specifics should any member wish. Committee effectiveness report is only formal reflective review
No additional comments received 23/24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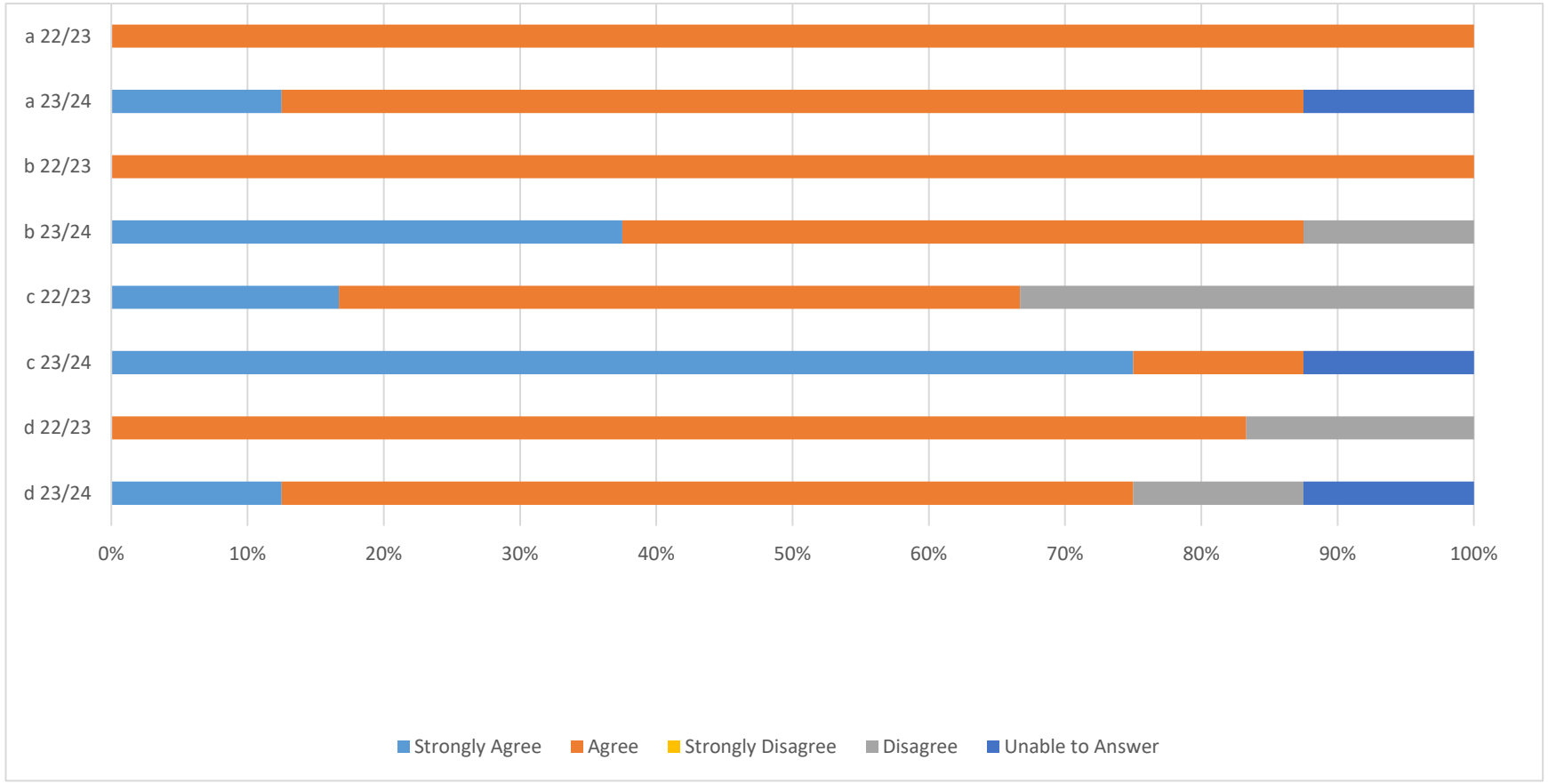
100%
Strongly Agree
Agree
Strongly Disagree
Disagree
Unable to Answer

4. Theme 4 – Engagement

	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer
a. The Committee challenges management and other assurance providers to gain a clear understanding of their findings	**12.5%**	**75%**			**12.5%**
b. The Committee is clear about its role in relationship to other committees that play a role in relation to clinical governance, quality and risk management	**37.5%**	**50%**	**12.5%**		
c. The Chair provides clear and timely reports from other governing bodies which set out the assurances they have received and their impact (either positive or not) on the organisations assurance framework.	**75%**	**12.5%**			**12.5%**
d. We can provide two examples of where we as a Committee have focussed on improvements to the system of internal control as a result of assurance gaps identified.	**12.5%**	**62.5%**	**12.5%**		**12.5%**

Additional Comments 22/23
Two/three areas: Consultant contracts, nursing rosters, Project 86 systems
The Committee has clear Terms of Reference which defines its role I'd suggest as an example the review of P86 / TCP finances requested by the committee has lead to greater transparency and understanding within the committee in this area and an improvement in system controls
No additional comments 23/24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80%
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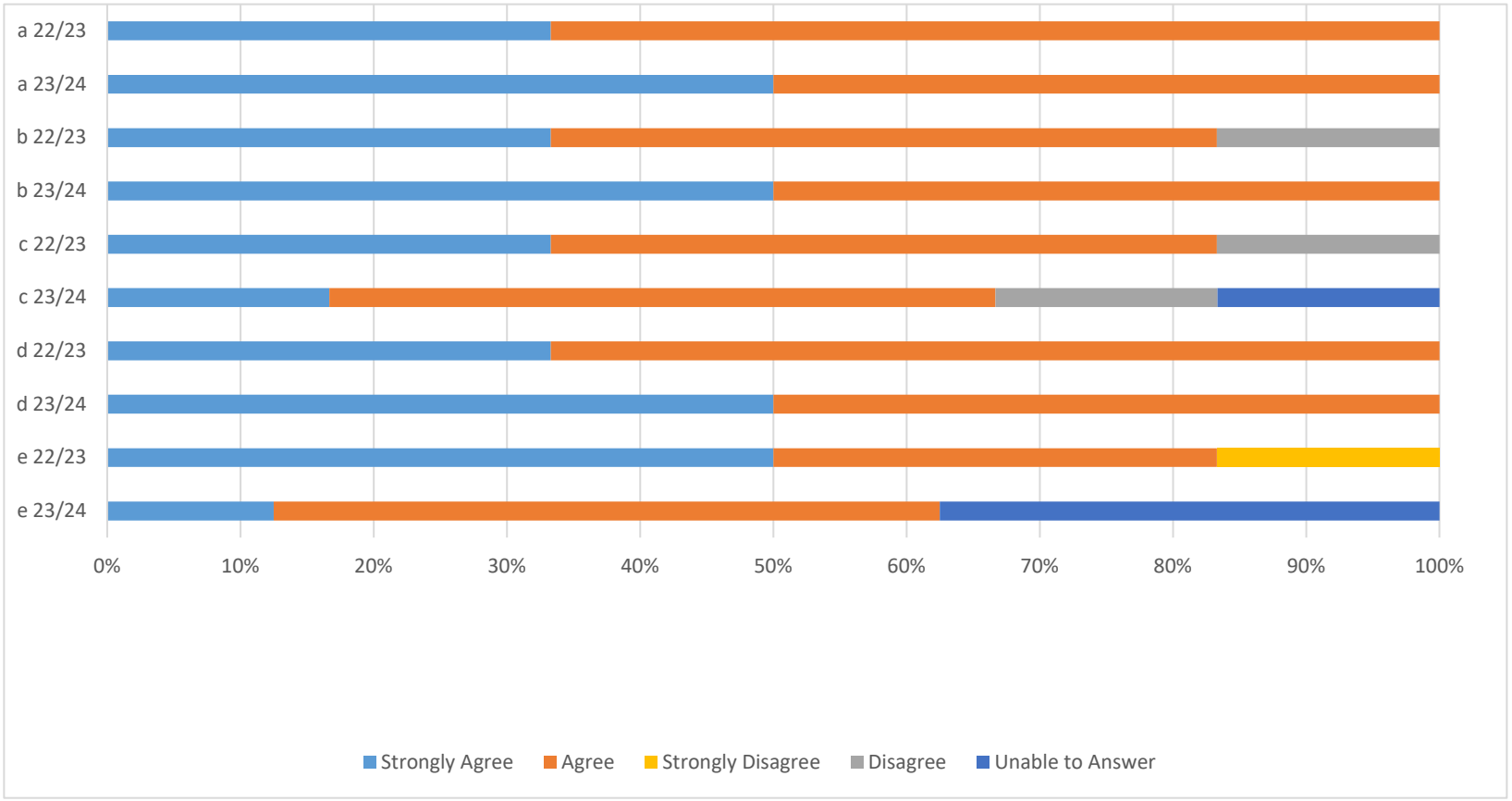
Strongly Agree
Agree
Strongly Disagree
Disagree
Unable to Answer

Theme 5 – Leadership

	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer
a. The Chair has a positive impact on the performance of the Committee	**50%**	**50%**			
b. Committee meetings are chaired effectively	**50%**	**50%**			
c. The Chair is visible within the organisation and is considered approachable	**12.5%**	**37.5%**	**12.5%**		**37.5%%**
d. The Chair allows debate to flow freely and does not assert his/her own views too strongly	**50%**	**50%**			
e. The Chair provides clear and concise information to the Trust Board on group/committee activities and gaps in control	**12.5%**	**50%**			**37.5%**

Additional Comments 22/23
As we all work remotely, the Chair and other NEDs are not visible in the Trust
Lack of Face to Face opportunities has reduced the visibility of all NEDS, not just the Chair within the wider organisation Last minutes changes to the agenda and additional papers resulting in reissue of papers, doesn't help the Chairs ability to run a smooth meeting. However, I recognise that end of year information is often subject to pressures, but delaying the May meeting by a week without changing paper deadlines may help.
No additional comments 23/24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80%
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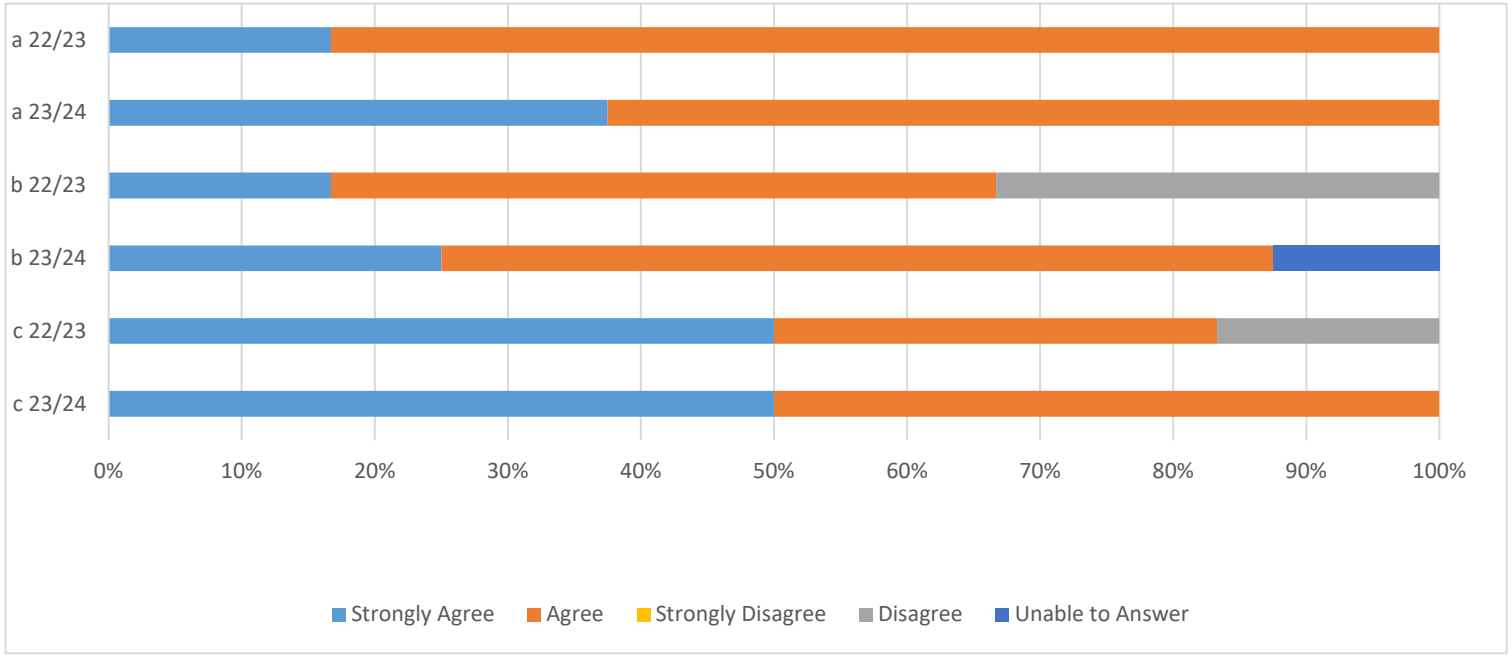
Strongly Agree
Agree
Strongly Disagree
Disagree
Unable to Answer

Theme 6 – Behaviours

	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer
a. Behaviours are always appropriate	**37.5%**	**62.5%**			
b. If behaviours were not appropriate, the Chair addressed this appropriately during the meeting	**25%**	**62.5%**			**12.5%**
c. I would feel empowered to provide feedback to individuals at the time, or afterwards, where inappropriate behaviours were displayed during the meeting	**50%**	**50%**			

Additional Comments 22/23
Committee members whether internal or external are always respectful of each other's positions.
No additional comments 23/24



What works well 22/23 and 23/24?
No Comments received

What does not work well 22/23
2022/23 - Internal and External Audit reports have a lot of "padding" which sometimes makes it difficult to tease out the relevant points despite summaries.
What does not work well 23/24
2023/24 - Need to resolve the duplication of membership of the Audit Committee and F&R

Further suggestions for improvement 22/23
More steps to embed sustainability issues into audit function
Need to review the membership as it can be considered to be not independent as the membership is the same as F&R
Review committee meeting dates relative to required information to ensure all papers are available and that an agenda is only issued once
No further suggestions for improvement 23/24

Areas of attention 22/23:

- More focus on green plan / sustainability issues
- Review membership and attendees to ensure differs from Finance and Resource Committee
- Consider effective ways to reflect at the end of meetings
- When meetings are cancelled or delayed – review paper deadlines
- Consider face to face meetings occasionally
- More succinct summaries from internal and external audit

Areas of attention 23/24:

- More focus on quality and other controls required
- Review membership and attendees to ensure differs from Finance and Resource Committee

Appendix 4

REPORT TO CHARITABLE FUNDS COMMITTEE
Charitable Funds Committee Effectiveness Questionnaire Results –2023/24

Introduction

The report details the findings of the Charitable Committee Effectiveness Review undertaken in March 2024.

Purpose of the Report (Executive Summary)

The Charitable Funds Committee is required to produce an annual assessment of effectiveness, received by Board for assurance. The report reflects on the Committee meetings held during 2023/24.

A data template was populated for 2023/24 which detailed member attendance, adherence to cycle of business, frequency of meetings and paper timeliness. The Committee achieved 47% membership attendance during 2023/24. During 2023/24 70% of items were received in accordance with the Committee Cycle of Business. 40% of all papers were circulated to Committee members within the 1 week standard compared to 20% the previous year. Papers were usually circulated 3 days prior to Committee. No papers during 2023/24 required amending, updating or reissuing. (Appendix 1)

A Self-Assessment questionnaire was not submitted by the Chair given the Chair left the organisation in November 2023 and therefore results provided by the new Chair would not be a true reflection of 2023/24.

Invites to complete questionnaires were circulated to Committee members, of the 11 invites circulated 6 responses were received. (Appendix 2)

Key Recommendations to Consider

The Committee is asked to:

- Receive the report
- Note the areas of attention required
- Review in conjunction with actions from previous committee effectiveness reviews

Background

The review assessed the following areas:

- The Committee had regular attendance from members outlined in the Terms of Reference
- Adherence to cycle of business
- Paper Timeliness
- The Chairs Self –Assessment of composition, establishment, duties, internal control and risk management
- Feedback from members on 6 key themes – Focus of the Committee, team working, effectiveness, leadership and behaviours. What worked well, what did not work well and made suggestions for improvement
- Recommendations and next steps following the review

Recommendations

Areas of attention:

- Review number of Committees per year and membership appropriate to level of funds
- Confirmation of direction and strategy required
- More focus on deliverables and leads for actions
- Staff involvement in Committee

Summary

There is hope that responses can better inform the way the Committee aligns its work with Trust strategy including through engagement with community partners and service users. Staff need to carry out the work agreed by the Committee and help inform and shape objectives for the Committee.

The Committee is a member of NHS Charities Together and needs to utilise this membership better to learn from best practice around the country.

A new Executive Lead has been identified for the Committee lead which provides confidence that there will now be an improvement in taking actions forward between meetings and will be something that the committee will want to prioritise.

Membership is something that the Committee needs to consider going forward in terms of staff and service user representation.

Next Steps (including timeframes)

It is proposed that the committee spend some time reviewing the outcome of the review and look at proposals for improving the functioning of the Committee. A 6 month review has been built into the Committee Effectiveness programme whereby a report will be taken to Committees to review progress against recommendations and actions identified from the March 2024 review.

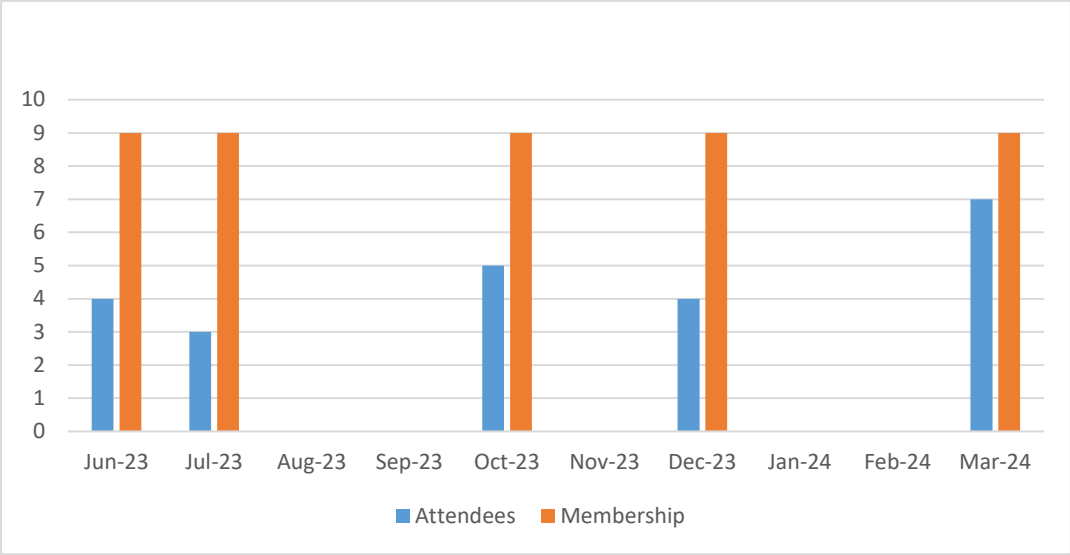
.

Appendix 1 - Committee Effectiveness Data

Attendance:

Has the Committee had regular attendance from members outlined in the Terms of Reference in the last 12 months?

Date	09.06.23	26.07.23	13.10.23	14.12.23	04.03.24
No of attendees	4	3	5	4	5
Total Membership	9	9	9	9	9

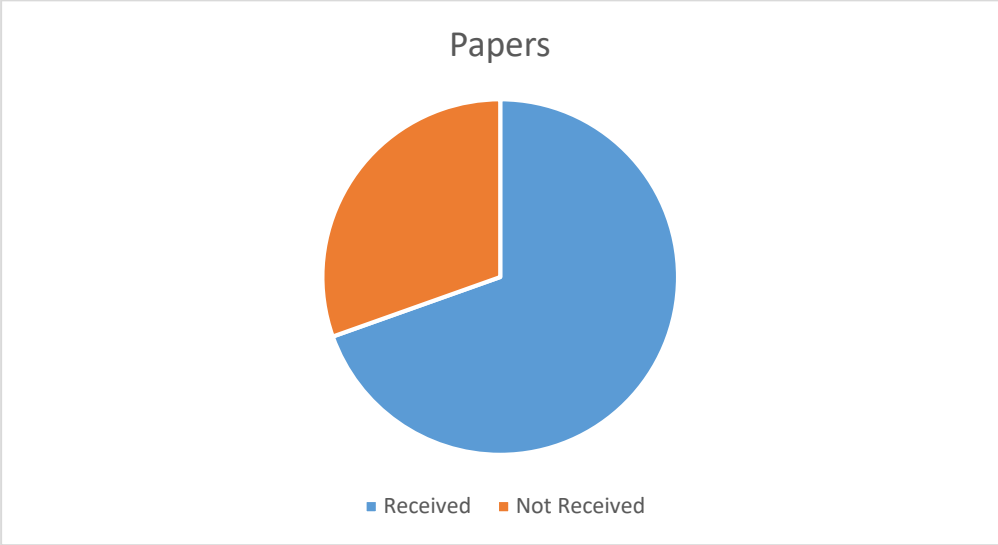


The Committee achieved 47% membership attendance during 2023/24. Compared to 73% the previous year.

Has the Committee / Chair adhered to the Cycle of Business?

*Please note the number of items each month that were scheduled on the cycle of business and how many were not an agenda item

Date	09.06.23	26.07.23	13.10.23	14.12.23	04.03.24
No. of items	4	Extra-ordinary meeting	6	7	6
Not agenda items	1	x	2	4	0



During 2023/24 70% of items were received in accordance with the Committee Cycle of Business

Paper Timeliness

Please advise if the papers were circulated 1 week prior to Committee (yes / no) and if papers were revised / amended after paper deadline

Date	09.06.23	26.07.23	13.10.23	14.12.23	04.03.24
Within 1 week	No	Yes	Yes	No	No
Revised / Amended	No	No	No	No	No

40% of all papers were circulated to Committee members within the 1 week standard compared to 20% the previous year. Papers were usually circulated 3 days prior to Committee. No papers during 2023/24 required amending, updating or reissuing.

Appendix 2 - Results of Chair Self –Assessment

Questions	Response	Comments
1. Does the Committee have written terms of reference and have they been approved by Trust Board?		
2. Are the terms of reference reviewed annually?		
3. Has the Committee formally considered how it integrates with other Committees that are reviewing risk?		
4. Are Committee members independent of the management team? 5.		
6. Are the outcomes of each meeting and any internal control issues reported to the next Trust Board meeting?		
7. Does the Committee prepare an annual report on its work and performance to the Trust Board?		
8. Has the Committee established a plan of matters to be dealt with across the year?		
9. Are Committee papers distributed in sufficient time for members to give them due consideration?		
10. Has the Committee been quorate for each meeting this year?		

11. Has the Committee reviewed the effectiveness of the organisations assurance framework?		
12. Does the Committee receive and review the evidence required to demonstrate compliance with regulatory requirements – for example, as set by the Care Quality Commission?		
13. Does the Committee provide a summary report of its meetings to the next available Board which includes the outcomes of each meeting; the actions taken and the committee's view on the organisation's systems of internal control?		
14. Has the Committee reviewed its performance in the year for consistency with its: • Terms of Reference? • Programme for the year?		

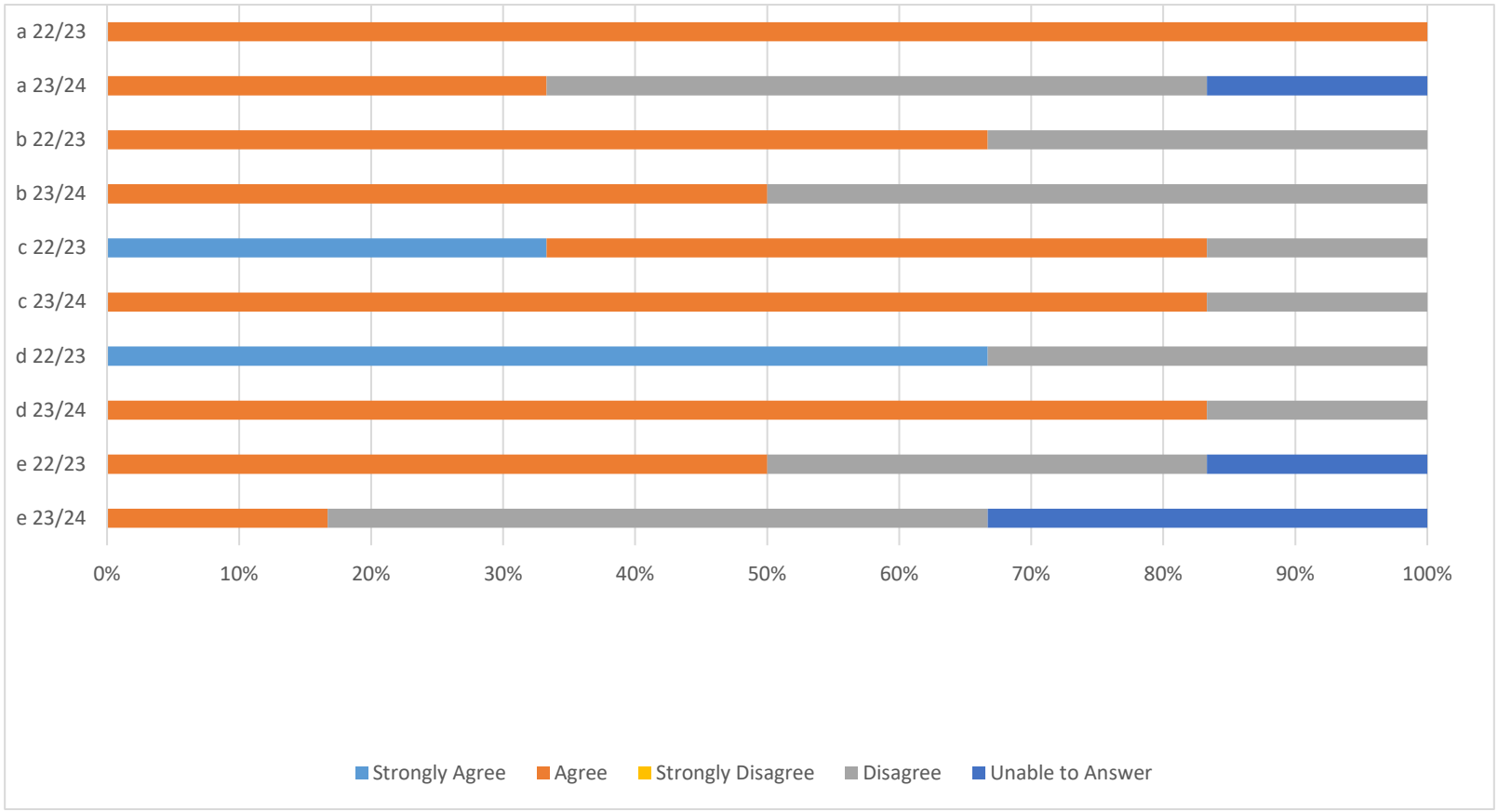
A Self-Assessment was not submitted by the Chair

Appendix 3 - Results of Committee Member Questionnaires

1. Theme 1 – Focus

a. The Committee has set itself a series of objectives for the year		**33.3%**	**50%**		**16.7%**
b. The Committee has made a conscious decision about the information it would like to receive		**50%**	**50%**		
c. Committee members contribute regularly to the issues discussed		**83.3%**	**16.7%**		
d. The Committee is aware of the key sources of assurance and who provides them		**83.3%**	**16.7%**		
e. The Committees focus is appropriately balanced, with items considered for each associated Strategic Priority		**16.7%**	**50%**		**33.3%**

Additional Comments 22/23
There are mixed views from Committee members regarding the specific actions and responsibilities required in making the Charity Committee a positive force
Additional Comments 23/24
I feel this Committee and the Charity is unclear of its direction and strategy.
Committee still in a development phase as it considers the future administration of the funds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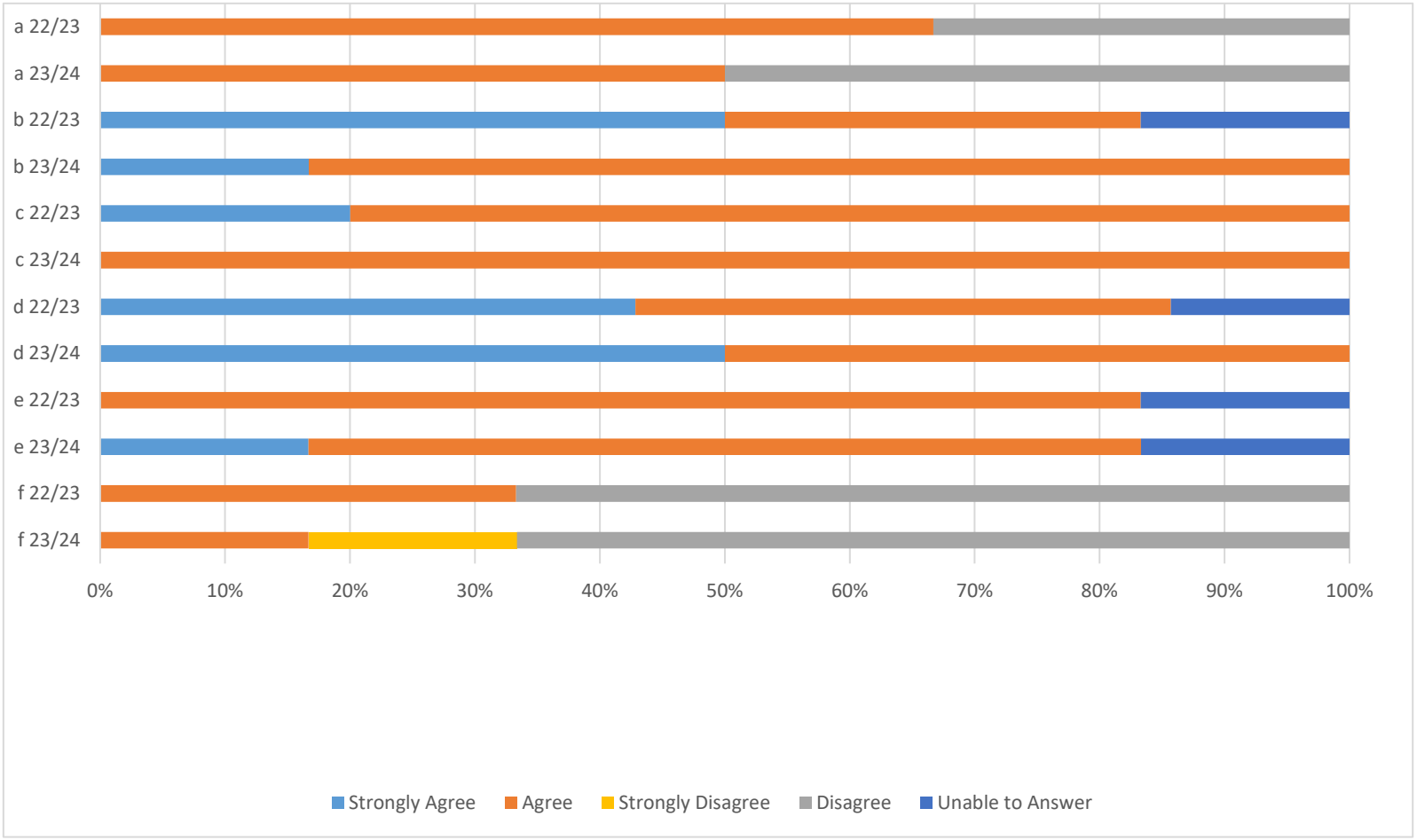
Strongly Agree
Agree
Strongly Disagree
Disagree
Unable to Answer

Theme 2 – Team Working

a. The Committee has the right balance of experience, knowledge and skills to fulfil its role		50%	50%		
b. The Committee ensures that the relevant Executive Director attends meetings to enable it to understand the reports and information it receives	16.7%	83.3%			
c. The Committee is fully briefed on key risks and any gaps in control		100%			
d. The Committee environment enables people to express their views, doubts and opinions	50%	50%			
e. The Chair ensures that assurance providers address issues of late or missing assurances	16.7%	66.7%			16.7%
f. Decisions and actions are implemented in line with the timescale set down		16.7%	66.7%	16.7%	

Additional Comments 22/23
Clearly defined roles and responsibilities are required with time allocated to achieve aims.
There has been, and potentially remains, some confusion about who should be working between meetings to take actions forward.
Additional Comments 23/24
There is no clear direction of the Charity, I believe a part of this is due to not having the correct balance of experience, knowledge and skills in this area.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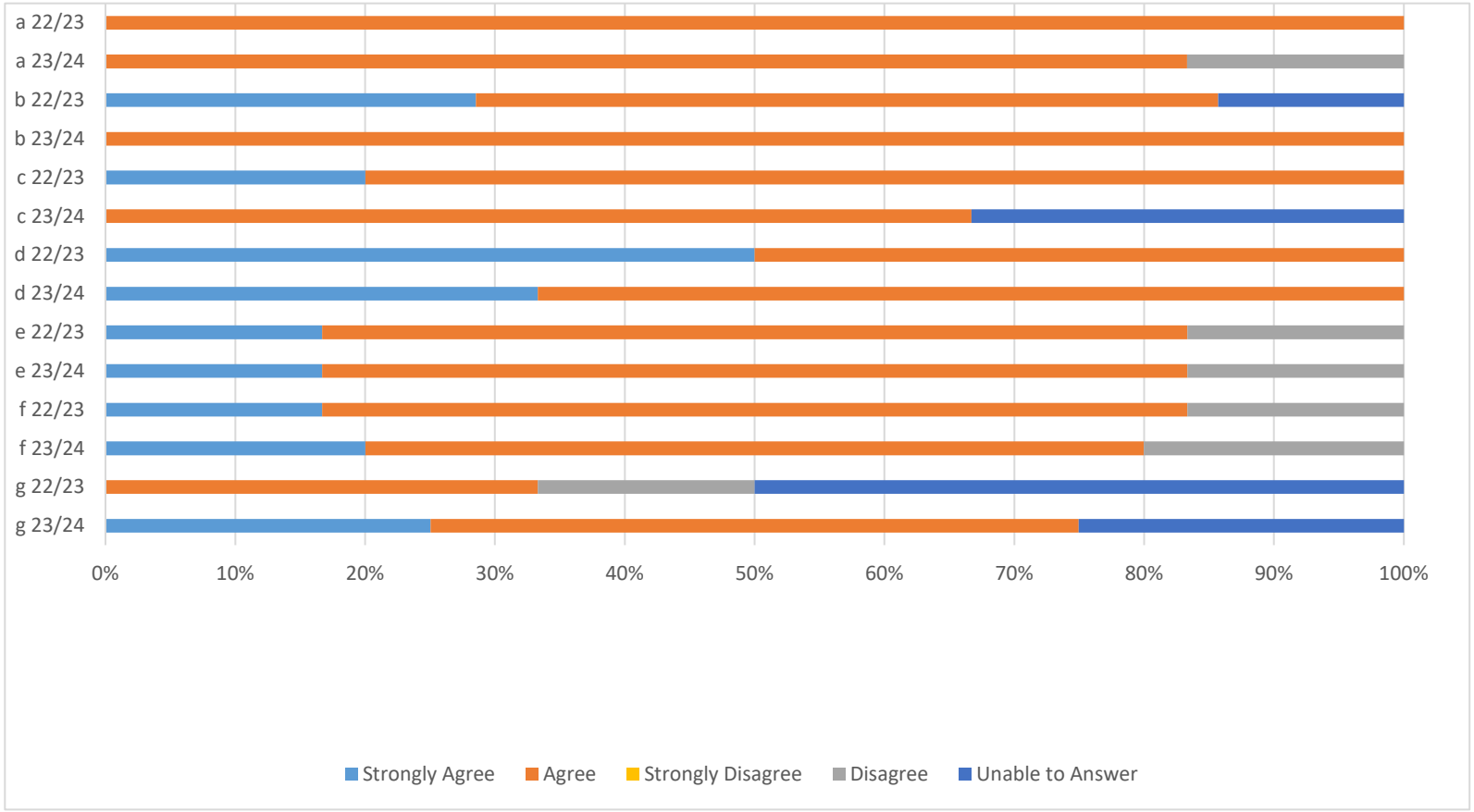
Agree
Strongly Disagree
Disagree
Unable to Answer

Theme 3 – Effectiveness

a. The quality of papers received allows members to perform their roles effectively		83.3%	16.7%		
b. Members provide real and genuine challenge – they do not just seek clarification and/or reassurance		100%			
c. The Committee provides appropriate challenge to assurance providers to gain a clear understanding of their findings		66.7%			33.3%
d. Debate is allowed to flow, and conclusions reached without being cut short or stifled	33.3%	66.7%			
e. Each agenda item is 'closed off' appropriately so that the Committee is clear on the conclusion; who is doing what, when and how, and how it is being monitored	16.7%	66.7%	16.7%		
f. The Committee provides a written summary report of its meetings to the Trust Board including items for escalation	16.7%	50%	16.7%		
g. The Committee has requested 'deep dives' into areas of concern	16.7%	33.3%			16.7%

Additional Comments 22/23
Presently the committee is not effective in developing the Charity as one would wish due to resource constraints
Additional Comments 23/24
Reporting lines to Trustees and Trust Board still evolving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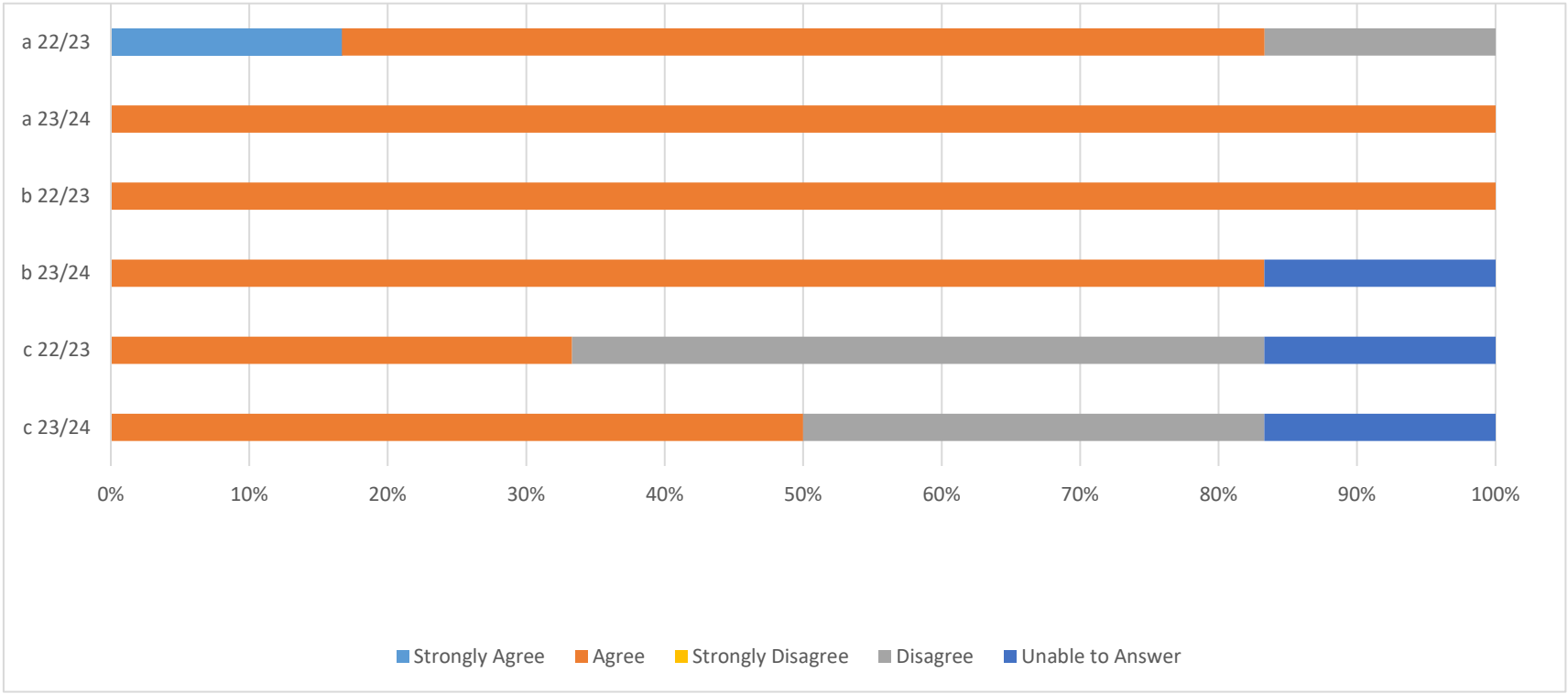
100%
Strongly Agree
Agree
Strongly Disagree
Disagree
Unable to Answer

Theme 4 – Engagement

a. Membership and attendance enables the Committee to cover all aspects of its terms of reference		**100%**			
b. The Committee challenges management and other assurance providers to gain a clear understanding of their findings		**83.3%**			**16.7%**
c. The Committee is clear about its role in relationship to other committees that play a role in relation to clinical governance, quality and risk management		**50%**	**33.3%**		**16.7%**

Additional Comments 22/23
Confusion about the authority of the committee with some issues being suggested they should be escalated to the wider group of Trustees.
Relationship to other committees has never been discussed. Member engagement is mixed
I think there hasn't been any clarity until very recently about how this committee interacts with the rest of the organisation, other than it reports to Corporate Trustees
Additional Comments 23/24
No real relevant fit to this committee
Relationship to other committees not discussed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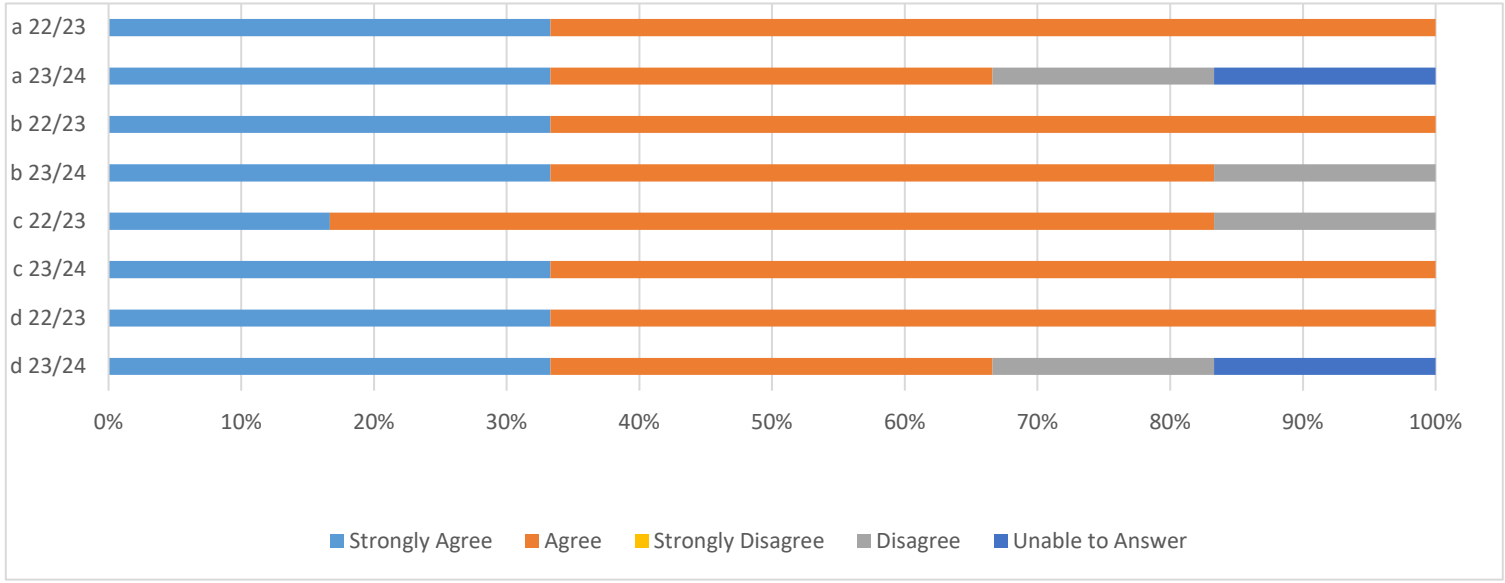
80%
90%
100%
Strongly Agree
Agree
Strongly Disagree
Disagree
Unable to Answer

Theme 5 – Leadership

a. The Chair has a positive impact on the performance of the Committee	**33.3%**	**33.3%**	**16.7%**		**16.7%**
b. Committee meetings are chaired effectively	**33.3%**	**50%**	**16.7%**		
c. The Chair allows debate to flow freely and does not assert his/her own views too strongly	**33.3%**	**66.7%**			
d. The Chair provides clear and concise information to the Trust Board on group/committee activities and gaps in control	**33.3%**	**33.3%**	**16.7%**		**16.7%**

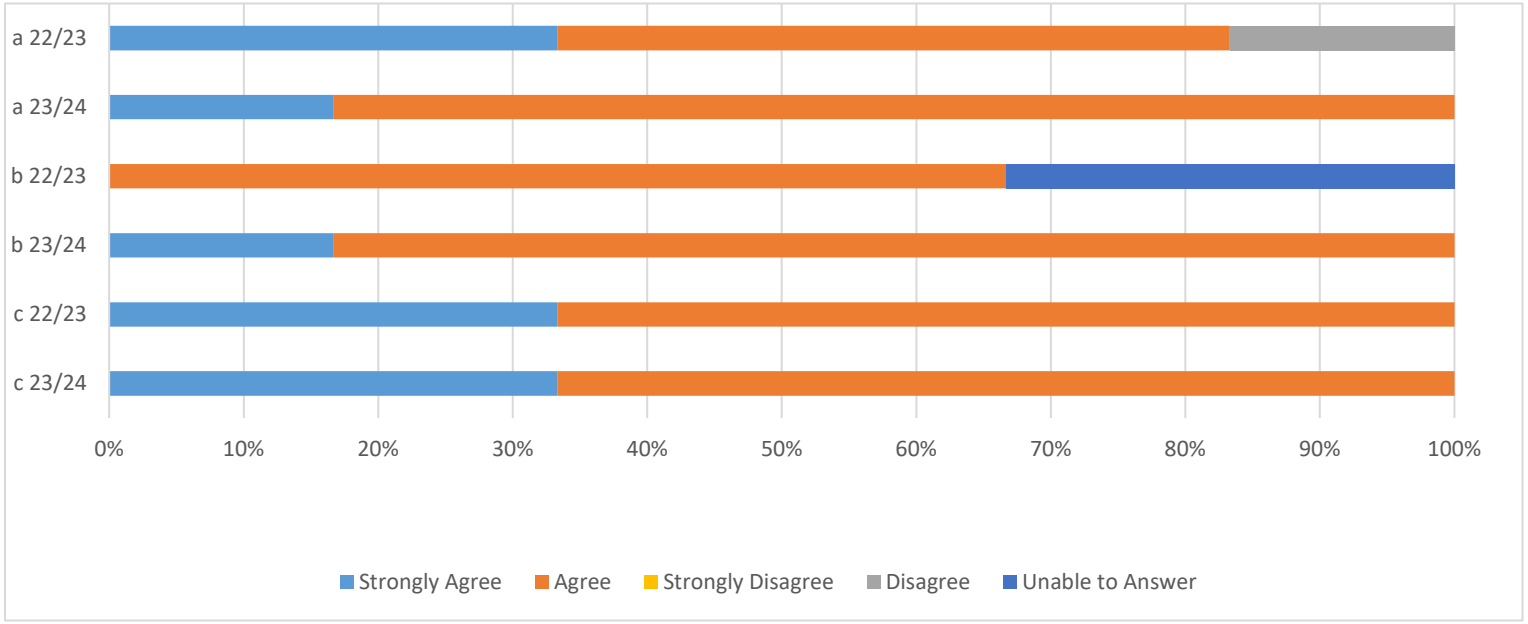
Additional Comments 22/23 – 23/24
No comments



Theme 6 – Behaviours

a. Behaviours are always appropriate	**16.7%**	**83.3%**			
b. If behaviours were not appropriate, the Chair addressed this appropriately during the meeting	**16.7%**	**83.3%**			
c. I would feel empowered to provide feedback to individuals at the time, or afterwards, where inappropriate behaviours were displayed during the meeting	**33.3%**	**66.7%**			

Additional Comments 22/23
Chair has a clear commitment to make the charity a success but is restricted by a lack of clear resource allocation and a mixed view from committee members regarding how to proceed in developing the charity. Recent decisions on alternative ways forward may however create a path to develop the charity provided they are pursued
Additional Comments 23/24
Some questions in the survey to not readily relate to the nature of the Charitable Committee as it operates with a different remit to other parts of the Board governance structure. Also this committee is in transition and the interim chair has been in role since the start of the year. In addition a new Exec Team lead has been assigned and has agreed with the interim chair to undertake a review of the direct of the charity.
This Committee is currently between Chairs, so is difficult to answer.



What works well? 22/23
No Comments received
What works well? 23/24
High quality finance support. Excellent chairing.
There is now a dialogue regarding the future of the committee and an enthusiasm to make it work

What does not work well? 22/23
No clear allocation of resource to take actions forward and no clear direction on what monies raised would be used for.
There hasn't really been SLT ownership of this endeavour and therefore this has made the role of the chair quite difficult. Very recent discussions at Board level may help to resolve this. I think too that the meetings can veer into bureaucracy at times.
What does not work well? 23/24
Too many committees each year ie 4 committees per year. Number of NEDs and Exec membership/attendance excessive for level of funds.
No direction, no strategy, no progression in the 3 years I have been attending this Committee. Too many meetings.
Lack of progress on deliverables
Uncertainty surrounding management of funds and by whom going forward

Suggestions for improvement 22/23
Nothing not currently being reviewed
Let's clarify once and for all what we want to do with the charity.
Suggestions for improvement 23/24
3 committee's per year
Decisions are required on the direction of the Charity. These decisions then need to be endorsed.
Staff involvement on the committee

Areas of attention:

- Review number of Committees per year and membership appropriate to level of funds
- Confirmation of direction and strategy required
- More focus on deliverables and leads for actions
- Staff involvement in Committee

Appendix 5

REPORT TO PEOPLE, CULTURE AND DEVELOPMENT COMMITTEE
People, culture and Development Committee Effectiveness Questionnaire Results –2023/24

Introduction

The report details the findings of the People, Culture and Development Committee Effectiveness Review undertaken in March 2024.

Purpose of the Report (Executive Summary)

The People, Culture and Development Committee is required to produce an annual assessment of effectiveness, received by Board for assurance. The report reflects on the Committee meetings held during 2023/24.

A data template was populated for 2023/24 which detailed member attendance, adherence to cycle of business, frequency of meetings and paper timeliness. The Committee achieved 77% membership attendance during 2023/24. During 2023/24 76% of items were received in accordance with the Committee Cycle of Business. 50% of all papers were circulated to Committee members on time and papers were re-issued on one occasion 3 days prior to the meeting. (Appendix 1)

A Self-Assessment questionnaire of composition, establishment, duties and compliance was completed by the Chair. (Appendix 2)

Invites to complete questionnaires were circulated to Committee members, of the 15 invites circulated 8 responses were received. Low response rates can limit the value of the feedback. (Appendix 3)

Key Recommendations to Consider

The Committee is asked to:

- Receive the report
- Note the areas of attention required
- Review in conjunction with actions from previous committee effectiveness reviews

Background

The review assessed the following areas:

- The Committee had regular attendance from members outlined in the Terms of Reference
- Adherence to cycle of business
- Paper Timeliness
- The Chairs Self –Assessment of composition, establishment, duties, internal control and risk management
- Feedback from members on 6 key themes – Focus of the Committee, team working, effectiveness, leadership and behaviours. What worked well, what did not work well and made suggestions for improvement
- Recommendations and next steps following the review

Recommendations

Consider areas of attention:

- Review Terms of Reference, Agenda and Cycle of Business to allow time to fully debate matters and consider frequency of meetings
- Consideration for staff stories alternate Committee meetings
- Consider the addition of some time out sessions to take the pressure off the regular agendas and otherwise, working with colleagues, feel free to make this committee their own.

Summary

The committee has met regularly throughout the year and meetings have generally been cordial and constructive. It has been much easier to focus on our objectives this year as we have structured the committee to align to our People Plan outcomes. While in post, Paul Draycott brought some very helpful insights into what the committee could achieve and supported our development with external contributors which was positive. We were very sorry to lose him in January and hope that Kerry Smith will support us to carry forward this more outward looking approach if we have time on the agenda.

The cadence of meetings is challenging in terms of long agendas each month. We have considered moving to monthly meetings, but the reality is that people issues move at a relatively slow pace in terms of developing trends (unless there is a crisis of some sort) and monthly meetings are not effective unless we see metrics bi-monthly and look at cyclical items in the alternate months. Six additional meetings would have an impact on executive time to support so have to be considered with care. I would support the addition of a longer time out session twice a year to take a more in depth look at strategy, risk management, special issues and to do some committee development.

Despite the meeting timetable and agendas being available well in advance we still struggle with papers being ready on time which puts pressure on the support teams. I encourage strict enforcement of deadlines to allow sufficient time to consider the papers in advance. The quality of the papers has improved with more analysis and colleagues are much better at taking the papers as read and highlighting key points which really helps with supporting good assurance and meetings staying on time. Other than the Medical Director who is regular in his attendance, operational representation is less predictable although deputies are usually nominated. Staff stories provide great insights into what it feels like to work at the trust and these should be continued. Sometimes it feels like something has been found at the last minute. These stories should be used add value to our understanding. If none is available a particular month this is acceptable rather than filling the time.

I welcome the feedback from those who responded to the survey. I am disappointed that only half of regular attendees were able to complete it and would like to encourage full participation next year so we capture all the opportunities for improvement and more effective meetings.

Thanks go to all those who prepare material for these committees and attend to present them.

Next Steps (including timeframes)

We have welcomed a new NED to the committee as Jennie Koo has joined us from March 2024 and we look forward to having her fresh insights into our people agenda. Our next task is to appoint someone to chair this committee as I take on the board chair role. In common with other committees, we are reviewing our quoracy arrangements to ensure meetings can always be supported. I would

encourage the new chair to consider the addition of some time out sessions to take the pressure off the regular agendas and otherwise, working with colleagues, feel free to make this committee their own.

A 6 month review has been built into the Committee Effectiveness programme whereby a report will be taken to Committees to review progress against recommendations and actions identified from the March 2024 review.

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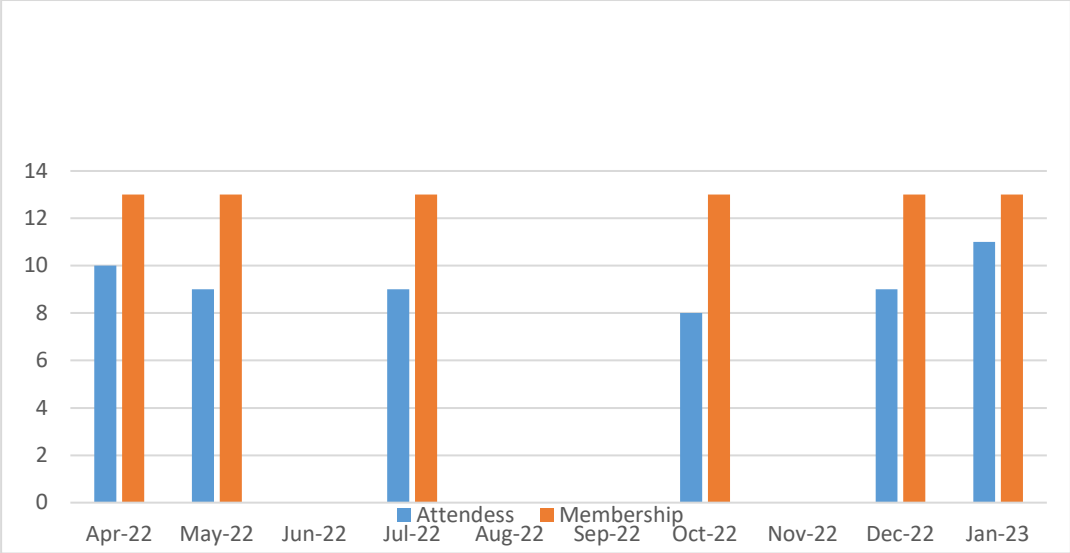
Appendix 1 - Committee Effectiveness Data

Attendance:

Has the Committee had regular attendance from members outlined in the Terms of Reference in the last 12 months?

Date	03/04/23	31/05/23	31/07/23	25/09/23	04/12/23	26/02/24
No of attendees	7	6	6	5	6	7
Total Membership	8	8	8	8	8	8

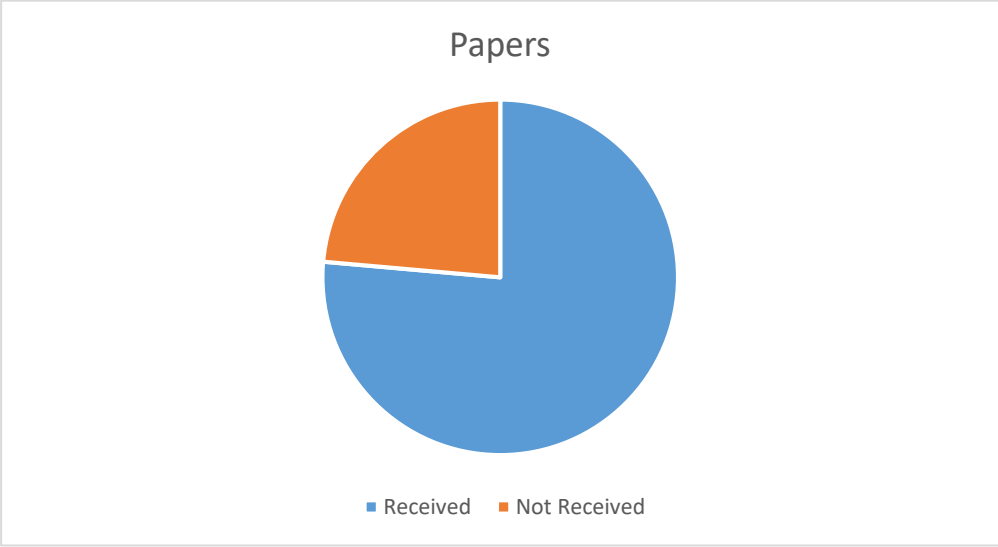


The Committee achieved 77% membership attendance during 2023/24.

Has the Committee / Chair adhered to the Cycle of Business?

*Please note the number of items each month that were scheduled on the cycle of business and how many were not an agenda item

Date	03.04.2023	31.05.2023	31.07.2023	25.09.2023	04.12.2023	26.02.2024
No. of items	**12**	**15**	**12**	**17**	**17**	**16**
Not agenda items	**3**	**5**	**3**	**4**	**3**	**3**



During 2023/24 76% of items were received in accordance with the Committee Cycle of Business a decrease of 10% compared to 2022/23.

Paper Timeliness

Please advise if the papers were circulated 1 week prior to Committee (yes / no) and if papers were revised / amended after paper deadline

Date	03.04.2023	31.05.2023	31.07.2023	25.09.2023	04.12.2023	26.02.2024
Within 1 week	No	Yes	Yes	Yes	No	No
Revised / Amended	No	No	No	No	No	23.02.24

50% of all papers were circulated to Committee members on time. Papers were re-issued on one occasion 3 days prior to the meeting.

Appendix 2 - Results of Chair Self –Assessment

Questions	Response	Comments
1. Does the Committee have written terms of reference and have they been approved by Trust Board?	Yes	
2. Are the terms of reference reviewed annually?	Yes	
3. Has the Committee formally considered how it integrates with other Committees that are reviewing risk?	Yes	Good cross referral between committee chairs
4. Are Committee members independent of the management team?	No	Not all of them. Some are Executive members
5. Are the outcomes of each meeting and any internal control issues reported to the next Trust Board meeting?	Yes	
6. Does the Committee prepare an annual report on its work and performance to the Trust Board?	Yes	Going forward, this will also go to the Audit Committee
7. Has the Committee established a plan of matters to be dealt with across the year?	Yes	Cycle of Business
8. Are Committee papers distributed in sufficient time for members to give them due consideration?	Yes	Some chasing has to be done by the executive PAs but we generally get there
9. Has the Committee been quorate for each meeting this year?	Yes	

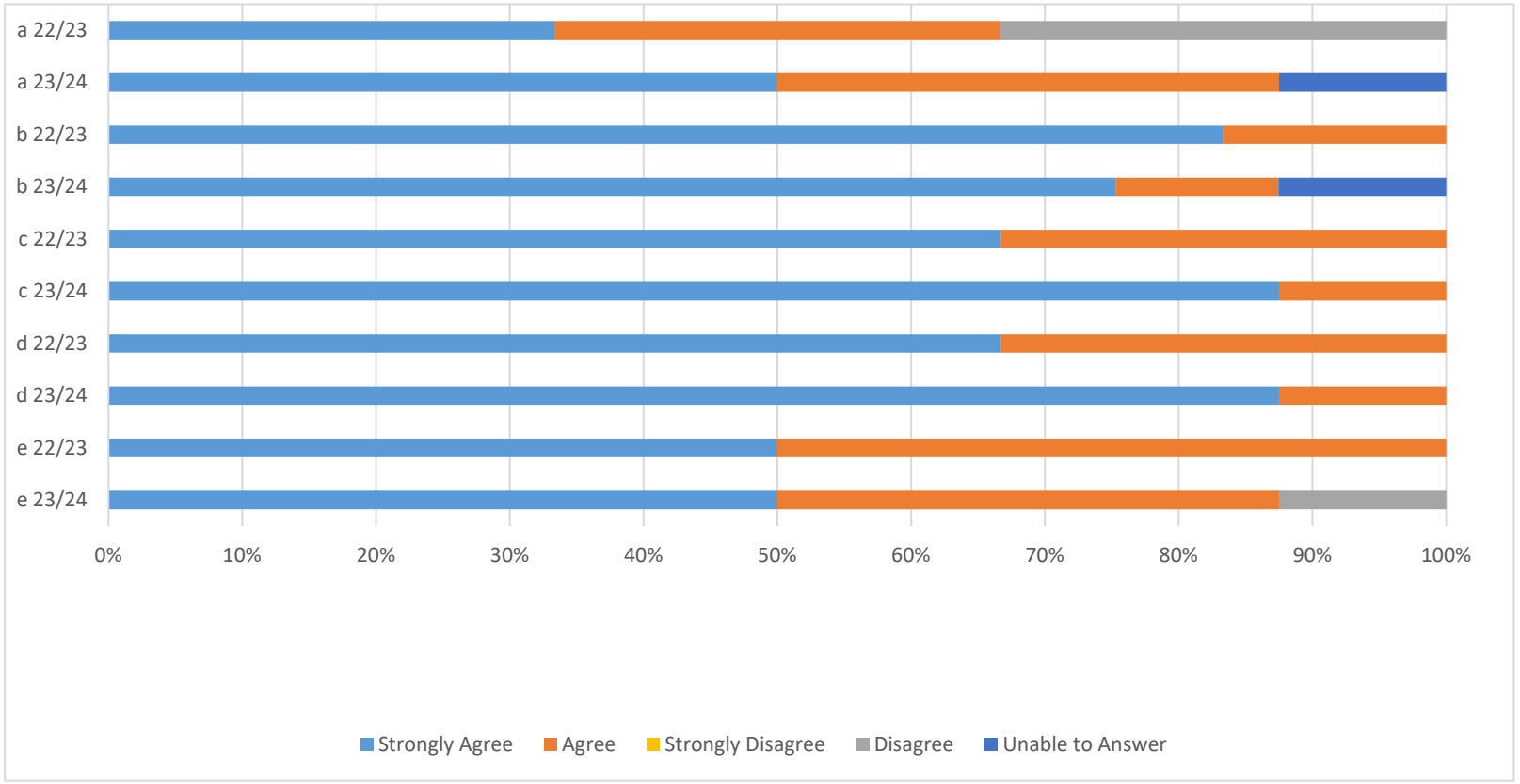
10. Has the Committee reviewed the effectiveness of the organisations assurance framework?	Yes	
11. Does the Committee receive and review the evidence required to demonstrate compliance with regulatory requirements – for example, as set by the Care Quality Commission?	Yes	
12. Does the Committee provide a summary report of its meetings to the next available Board which includes the outcomes of each meeting; the actions taken and the committee's view on the organisation's systems of internal control?	Yes	
13. Has the Committee reviewed its performance in the year for consistency with its: • Terms of Reference? • Programme for the year?	Yes	

Appendix 3 - Results of Committee Member Questionnaires

Theme 1 – Focus

	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer
a. The Committee has set itself a series of objectives for the year	50%	37.5%			12.5%
b. The Committee has made a conscious decision about the information it would like to receive	75%	12.5%			12.5%
c. Committee members contribute regularly to the issues discussed	87.5%	12.5%			
d. The Committee is aware of the key sources of assurance and who provides them	87.5%	12.5%			
e. The Committees focus is appropriately balanced, with items considered for each associated Strategic Priority	50%	37.5%	12.5%		

Additional Comments: 22/23
We have been waiting this year for the conclusion of the people plan on the back of the updated strategy. During 22/23 it was difficult to measure against the key metrics in the strategy as they were not particularly SMART. We have however kept our focus on measuring our impact on the key workforce risks in the IQPR and BAF.
Additional Comments: 23/24
Could possibly err a little more towards strategy but this isn't a significant problem.
The agenda is far too long and considers far too many items of 'interest' rather than focussing on 'assurance'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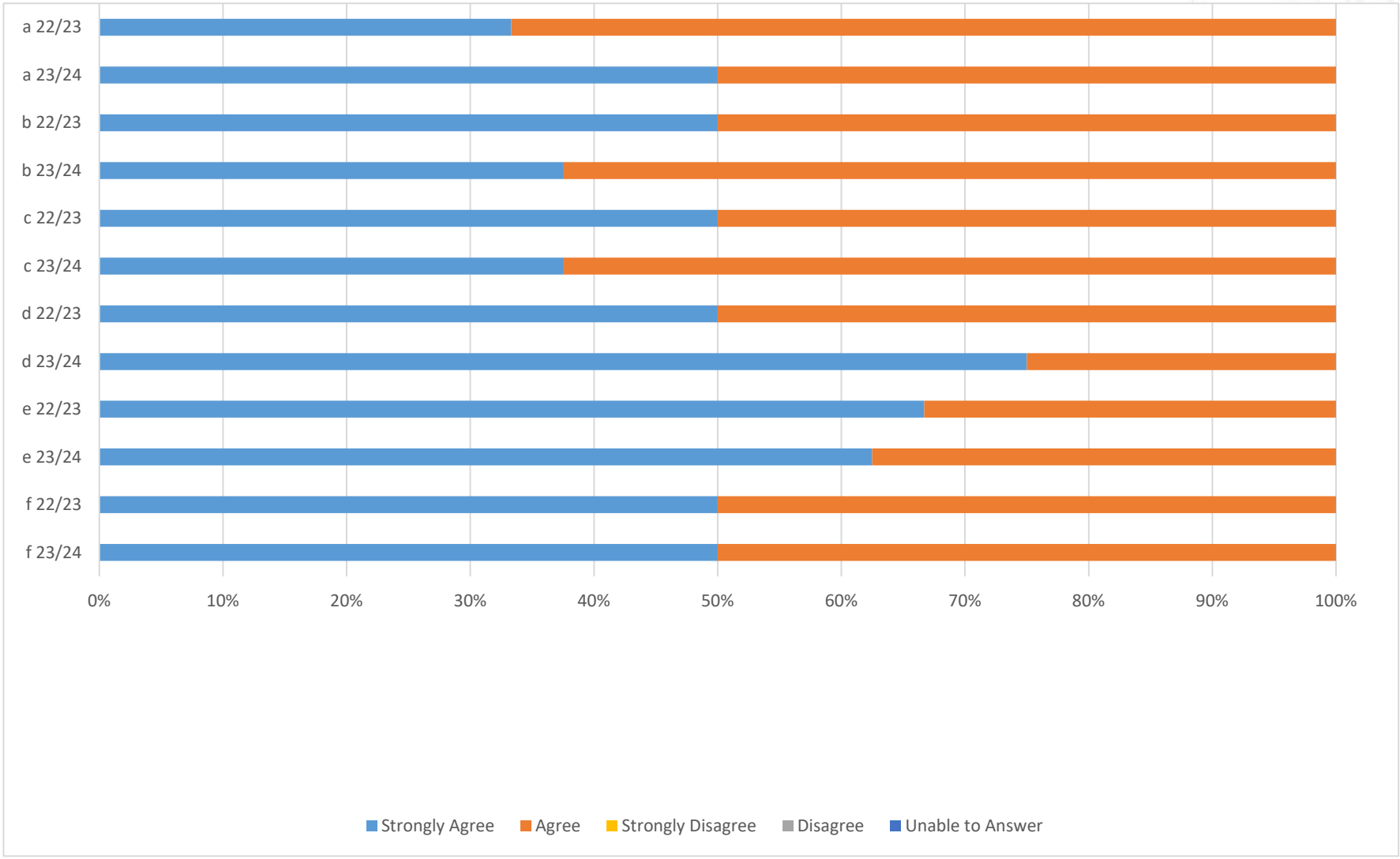
Strongly Agree
Agree
Strongly Disagree
Disagree
Unable to Answer

Theme 2 – Team Working

	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer
a. The Committee has the right balance of experience, knowledge and skills to fulfil its role	**50%**	**50%**			
b. The Committee ensures that the relevant Executive Director attends meetings to enable it to understand the reports and information it receives	**37.5%**	**62.5%**			
c. The Committee is fully briefed on key risks and any gaps in control	**37.5%**	**62.5%**			
d. The Committee environment enables people to express their views, doubts and opinions	**75%**	**25%**			
e. The Chair ensures that assurance providers address issues of late or missing assurances	**62.5%**	**37.5%**			
f. Decisions and actions are implemented in line with the timescale set down	**50%**	**50%**			

Additional Comments 22/23
At times it would be helpful to have the insight of the Trust's Director of Operations to ensure there is triangulation with where the majority of activity/People KPIs.
We sometimes lack the right amount of clinical perspective on the committee
Additional Comments 23/24
Occasionally the Committee cycle of business requires adjustment, this is often as a result of external matters outside of the Trust's control e.g. National operational planning cycle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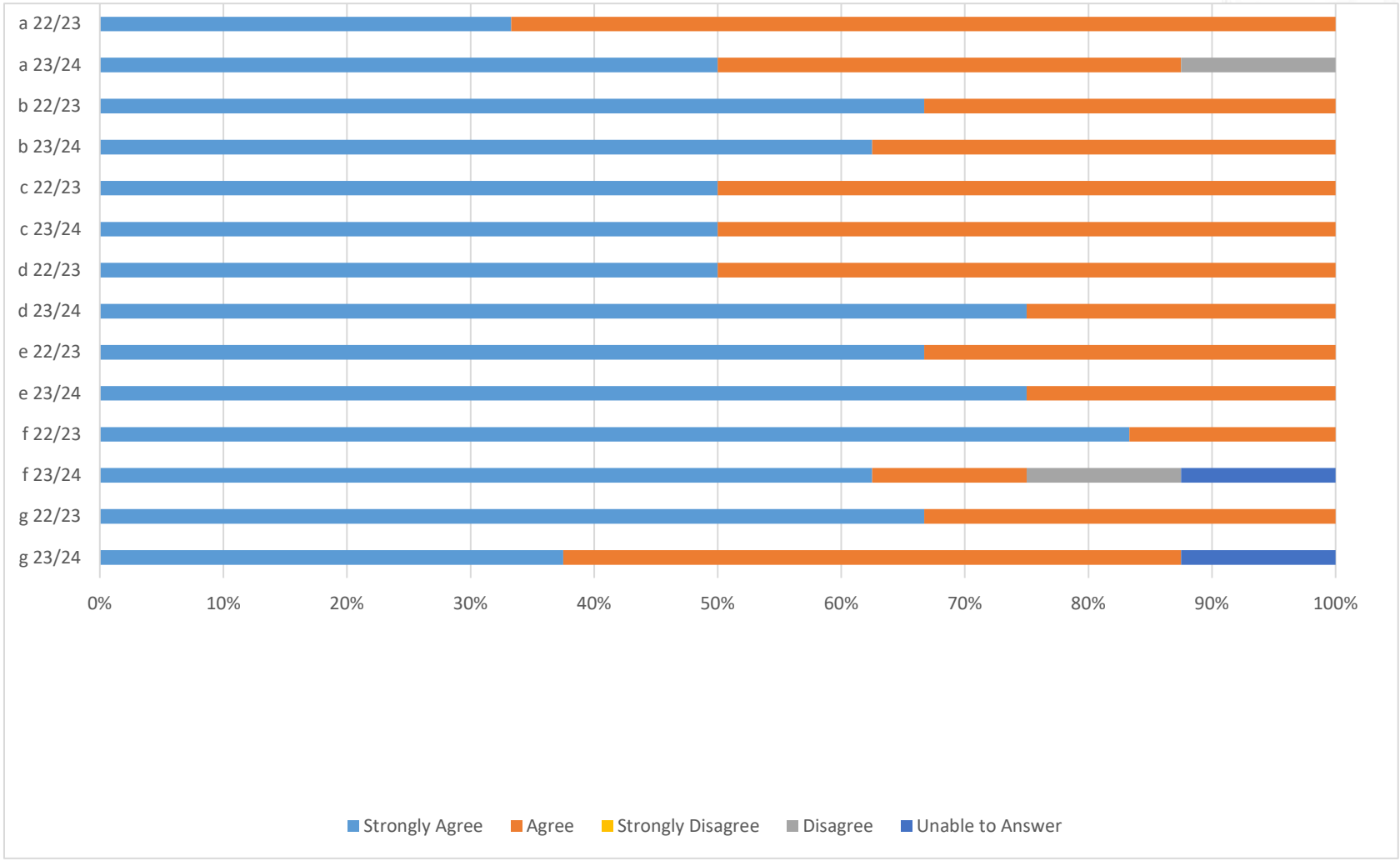
Strongly Agree
Agree
Strongly Disagree
Disagree
Unable to Answer

Theme 3 – Effectiveness

	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer
a. The quality of papers received allows members to perform their roles effectively	50%	37.5%	12.5%		
b. Members provide real and genuine challenge – they do not just seek clarification and/or reassurance	62.5%	37.5%			
c. The Committee provides appropriate challenge to assurance providers to gain a clear understanding of their findings	50%	50%			
d. Debate is allowed to flow, and conclusions reached without being cut short or stifled	75%	25%			
e. Each agenda item is 'closed off' appropriately so that the Committee is clear on the conclusion; who is doing what, when and how, and how it is being monitored	75%	25%			
f. The Committee provides a written summary report of its meetings to the Trust Board including items for escalation	62.5%	12.5%	12.5%		12.5%
g. The Committee has requested 'deep dives' into areas of concern	37.5%	50%			12.5%

Additional Comments 22/23
At times due to the ToR and packed agenda, the ability to fully debate matters can be a challenge.
Additional Comments 23/24
The written summary is too detailed, but this likely reflects the over population of the overall agenda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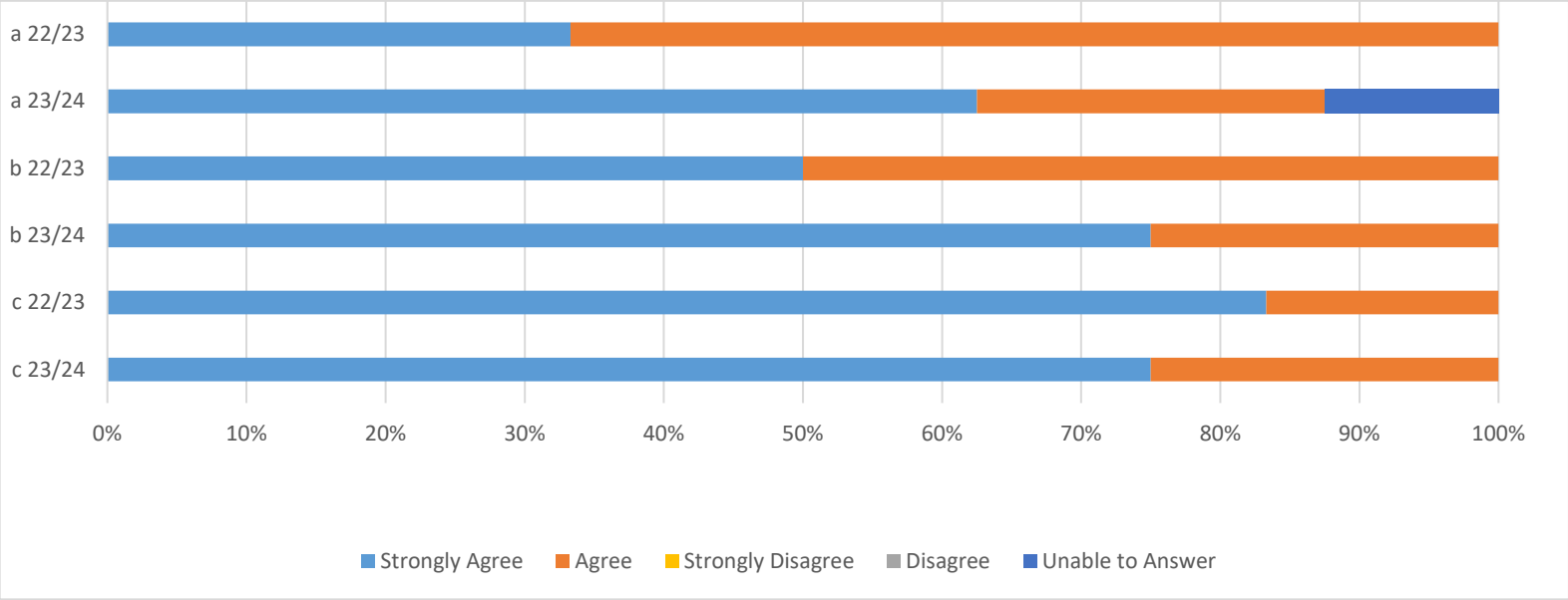
60%
70%
80%
90%
100%
Strongly Agree
Agree
Strongly Disagree
Disagree
Unable to Answer

Theme 4 – Engagement

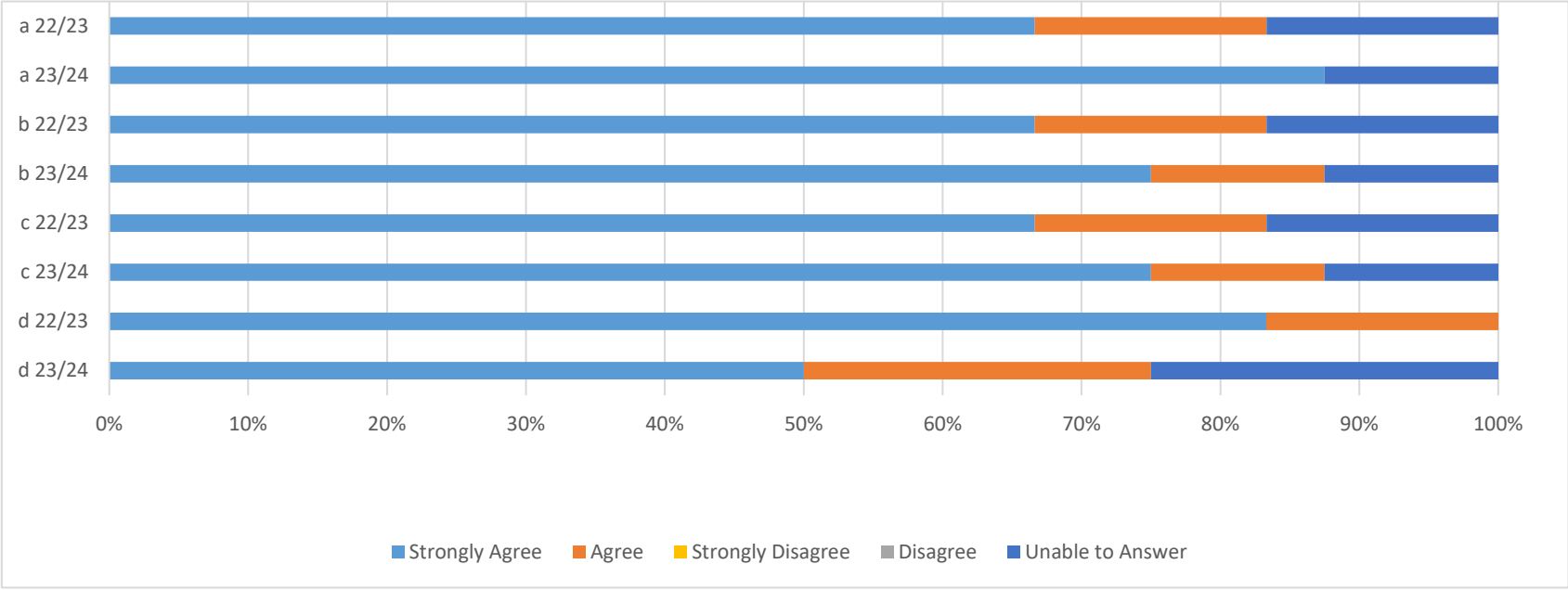
	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer
a. Membership and attendance enables the Committee to cover all aspects of its terms of reference	**62.5%**	**25%**			**12.5%**
b. The Committee challenges management and other assurance providers to gain a clear understanding of their findings	**75%**	**25%**			
c. The Committee is clear about its role in relationship to other committees that play a role in relation to clinical governance, quality and risk management	**75%**	**25%**			

Additional Comments 22/23
Cross committee issues are discussed within each committee and separately by the Chairs.



Theme 5 – Leadership

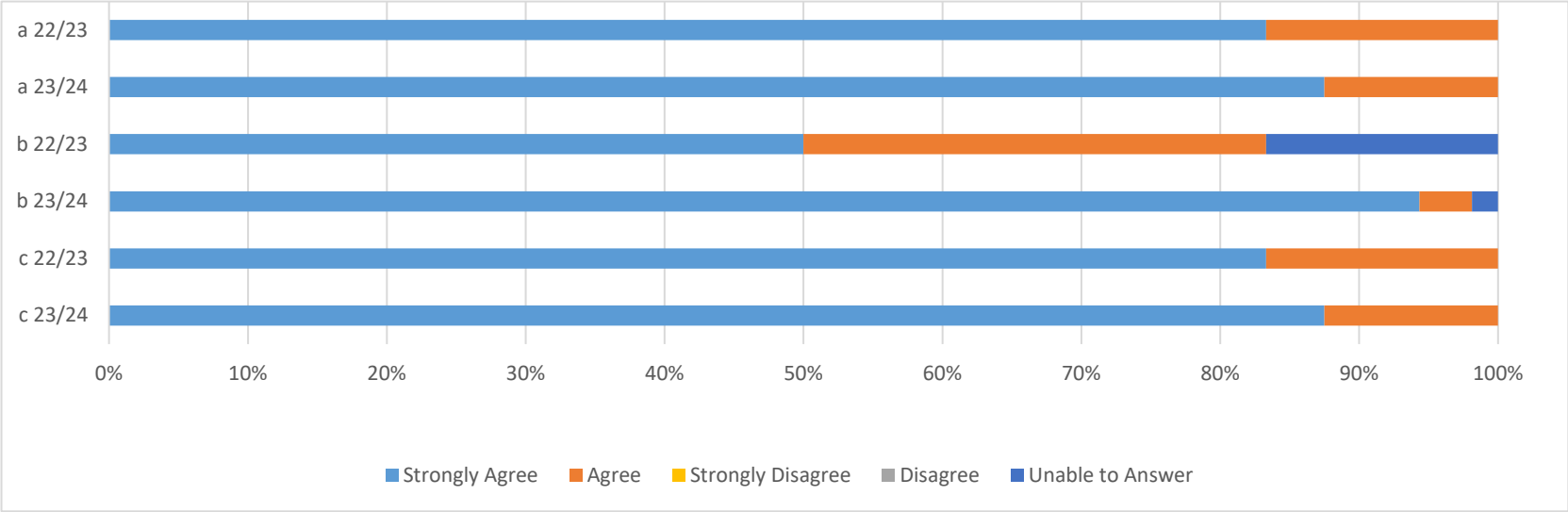
	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer
a. The Chair has a positive impact on the performance of the Committee	87.5%				12.5%
b. Committee meetings are chaired effectively	75%	12.5%			12.5%
c. The Chair allows debate to flow freely and does not assert his/her own views too strongly	75%	12.5%			12.5%
d. The Chair provides clear and concise information to the Trust Board on group/committee activities and gaps in control	50%	25%			25%



Theme 6 – Behaviours

	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer
a. Behaviours are always appropriate	87.5%	12.5%			
b. If behaviours were not appropriate, the Chair addressed this appropriately during the meeting	62.5%	25%			12.5%
c. I would feel empowered to provide feedback to individuals at the time, or afterwards, where inappropriate behaviours were displayed during the meeting	87.5%	12.5%			

Additional Comments 22/23
No comments
Additional Comments 23/24
Membership/attendance appears quite fluid, unclear at times roles of people attending the committee



What works well? 22/23
Cycle of business, continuity, reflections on key topics and staff stories.
This committee enables good communication and encourages openness. People are always polite and kind to one another and positive feedback is a regular feature to individuals
Quality of papers and the contribution by colleagues. Presentation skills have improved dramatically over the past couple of years for example. Colleagues at all levels contribute across most topics. The recent input from external trusts has been very helpful.
Well organised and focused on the right issues.
Janet's chairing is highly effective - she is calm, reflective, and also directive when necessary.

What works well? 23/24
Consistent membership of the committee, tone of the committee is aligned with Trust values.
The meeting continues to be very well chaired.
Participation of attendees and committee members. High quality papers. Presenters getting better at taking papers as read and focussing on key issues.
Well-structured and chaired meeting with praise and recognition for those who put the time in to present and write papers
Structured and well-paced review of key areas

What does not work well? 22/23
The agenda is so full that the ability to fully debate matters can be challenging.
The agenda is long and as meeting are only every other month this can be a long meeting to sit through. We have examined the alternatives and have concluded this is the best approach.
Not sure bimonthly is sufficient for the detailed portfolio of issues considered by the Committee.

What does not work well? 23/24
Due to the diverse nature of the committee's terms of reference, the agenda can often appear full and despite best endeavours some aspects have limited time allocated. A risk approach is taken to address.
There are no specific issues. In line with other board meetings it would be helpful when appropriate for Exec colleagues to ask questions and probe.
Size of the agenda as only every other month.

Suggestions for improvement 22/23
Holding this meeting face to face twice a year would allow relationships to develop further and enhance our discussions.

Suggestions for improvement 23/24
Consideration for staff stories alternate (every other) - often have an impact of capacity and would question the value, purpose and return of investment.
Follow through on our intention to do a couple of half days in addition to the regular meetings to give us some deep dive time.

Areas of attention:

- Review Terms of Reference, Agenda and Cycle of Business to allow time to fully debate matters and consider frequency of meetings
- Consideration for staff stories alternate Committee meetings
- Follow through on our intention to do a couple of half days in addition to the regular meetings to give us some deep dive time.

Appendix 6

REPORT TO QUALITY COMMITTEE
Quality Committee Effectiveness Questionnaire Results –2023/24

Introduction

The report details the findings of the Quality Committee Effectiveness Review undertaken in March 2024.

Purpose of the Report (Executive Summary)

The Quality Committee is required to produce an annual assessment of effectiveness, received by Board for assurance. The report reflects on the Committee meetings held during 2023/24.

A data template was populated for 2023/24 which detailed member attendance, adherence to cycle of business, frequency of meetings and paper timeliness. The Committee achieved 83% membership attendance during 2023/24. 55.5% of items were received in accordance with the Committee Cycle of Business. 100% of all papers were circulated to Committee members on time. During that time there was one occasions where papers were revised and reissued.. (Appendix 1)

A Self-Assessment questionnaire was not submitted by the Chair given the Chair left the organisation in December 2023 and therefore results provided by the new Chair would not be a true reflection of 2023/24.

Invites to complete questionnaires were circulated to Committee members, of the 18 invites circulated 13 responses were received. Low response rates can limit the value of the feedback. (Appendix 3)

Key Recommendations to Consider

The Committee is asked to:

- Receive the report
- Note the areas of attention required
- Review in conjunction with actions from previous committee effectiveness reviews

Background

The review assessed the following areas:

- The Committee had regular attendance from members outlined in the Terms of Reference
- Adherence to cycle of business
- Paper Timeliness
- The Chairs Self –Assessment of composition, establishment, duties, internal control and risk management
- Feedback from members on 6 key themes – Focus of the Committee, team working, effectiveness, leadership and behaviours. What worked well, what did not work well and made suggestions for improvement
- Recommendations and next steps following the review

Recommendations

- Consider tendency for the focus to shift to operational issues going over issues that have been dealt with in performance meetings
- Summary reports to Board could indicate the actual questions raised and subsequent responses
- Ensure areas of concern requiring more actions to gain assurance are not overlooked
- The Committee can be distracted when a focus is placed on issues that are not within the remit of the Committee or the Trust need to ensure Chair brings the focus back to related agenda
- Stay focussed on agenda items
- Strengthen the link with strategic priorities
- Share terms of reference with new Committee members
- Ensure consistency across operational updates

Summary

Committee effectiveness of all Board sub-committees is reviewed on an annual basis. The recent survey completed by committee members and regular attendees has raised some opportunities for review of how the committee operates. This has focused particularly on whether its activity and agenda is focused on obtaining appropriate assurance and if the overall functioning of the committee aligns with the overall strategy of the Trust. The details of the feedback form part of this report and all members are able to review the detail. The key points going forward would appear to be the following.

- The Committee needs to consider tendency for the focus to shift to operational issues going over issues that have been dealt with in performance meetings
- Summary reports to Board could indicate the actual questions raised and subsequent responses and a copy of the report going to Trust Board could be shared with committee members.
- Ensure areas of concern requiring more actions to gain assurance are not overlooked.
- The Committee can be distracted when a focus is placed on issues that are not within the remit of the Committee or the Trust need to ensure Chair brings the focus back to related agenda and stays focussed on agenda items
- The Committee needs to consider how it can strengthen the link with strategic priorities
- The Committee must share terms of reference with new Committee members
- Ensure consistency across operational updates
- Attendance at the committee has generally been good although there have been occasions when certain directorates have not been able to attend the directorate focused meeting and this can be problematic. Generally quoracy is not an issue.
- There is a need for the committee to formally consider how it integrates with other sub-committees of the Board that are considering risk. Chairs of the committees meet regularly but there is a need for the committee to consider what issues may need to input into this forum.
- The committee should spend more time focused on ensuring that all members are fully briefed regarding key risks and gaps in control.

Next Steps (including timeframes)
Overall the committee appears to be functioning with a reasonable level of success. However, a number of issues have been identified in the feedback that require review. These issues are identified in the narrative of the report. It is proposed that the committee spend some time reviewing the outcome of the review and discuss proposals for improving the functioning of the Committee. A 6 month review has been built into the Committee Effectiveness programme whereby a report will be taken to Committees to review progress against recommendations and actions identified from the March 2024 review.

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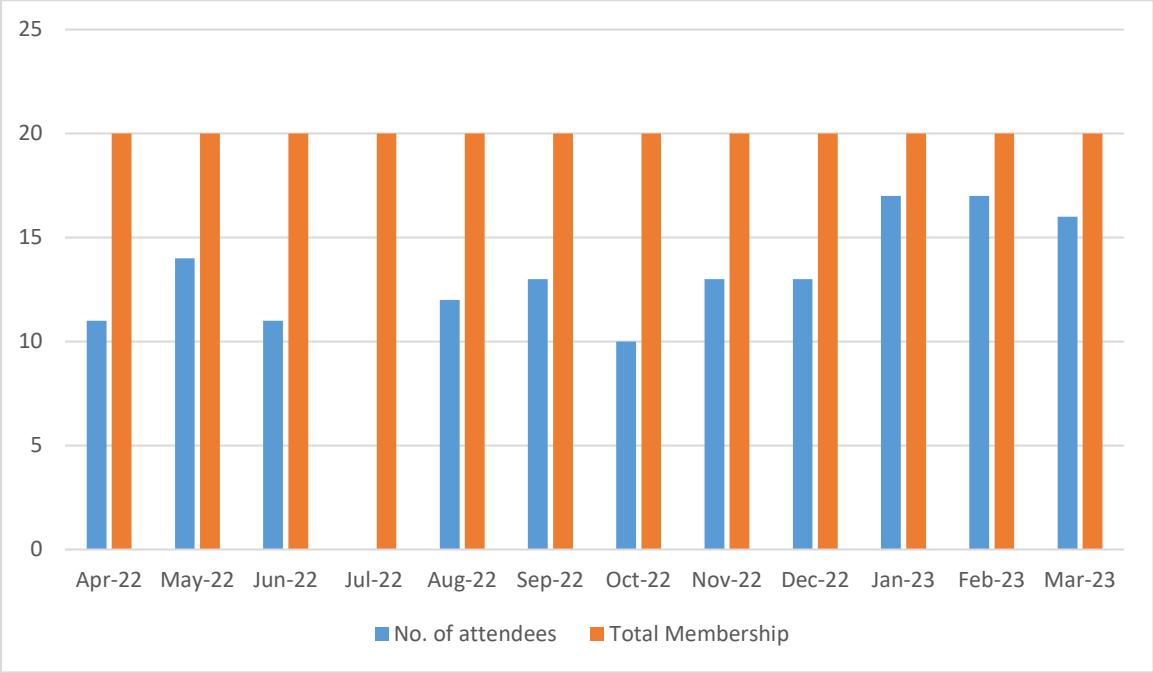
Appendix 1 - Committee Effectiveness Data

Attendance:

Has the Committee had regular attendance from members outlined in the Terms of Reference in the last 12 months?

Date	6.4.23	4.5.23	1.6.23	6.7.23	3.8.23	7.9,23	5.10.23	2.11.23	7.12.23	4.1.24	1.2.24	7.3.24
No of attendees	4	5	4	5	4	5	3	4	4	5	3	4
Total Membership	5	5	5	5	5	5	5	5	5	5	5	5

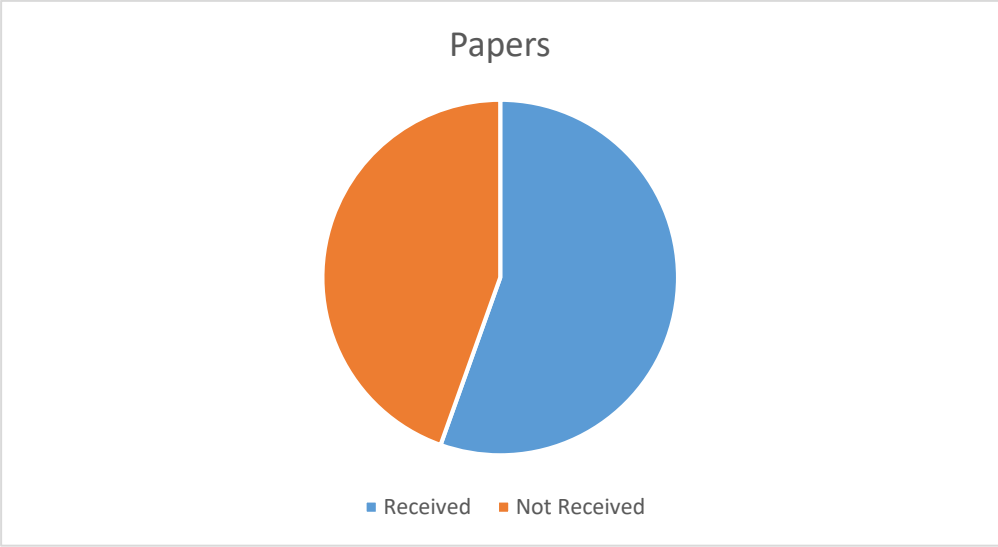


The Committee achieved 83% membership attendance during 2023/24.

Has the Committee / Chair adhered to the Cycle of Business

*Please note the number of items each month that were scheduled on the cycle of business and how many were not an agenda items?

Date	6.4.23	4.5.23	1.6.23	6.7.23	3.8.23	7.9.23	5.10.23	2.11.23	7.12.23	4.1.24	1.2.24	7.3.24
No. of items	10	32	10	17	13	26	13	26	12	17	21	14
Not agenda items	2	17	9	14	7	11	10	8	1	5	7	3



During 2023/24 55.5% of items were received in accordance with the Committee Cycle of Business

Paper Timeliness

Please advise if the papers were circulated 1 week prior to Committee (yes / no) and if papers were revised / amended after paper deadline

Date	6.4.23	4.5.23	1.6.23	6.7.23	3.8.23	7.9.23	5.10.23	2.11.23	7.12.23	4.1.24	1.2.24	7.3.24
Within 1 week	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Revised / Amended								2.11.23 SI report				

100% of all papers were circulated to Committee members on time. During that time there was one occasions where papers were revised and reissued.

Appendix 2 - Results of Chair Self –Assessment

Questions	Response	Comments
1. Does the Committee have written terms of reference and have they been approved by Trust Board?		
2. Are the terms of reference reviewed annually?		
3. Has the Committee formally considered how it integrates with other Committees that are reviewing risk?		
4. Are Committee members independent of the management team?		
5. Are the outcomes of each meeting and any internal control issues reported to the next Trust Board meeting?		
6. Does the Committee prepare an annual report on its work and performance to the Trust Board?		
7. Has the Committee established a plan of matters to be dealt with across the year?		
8. Are Committee papers distributed in sufficient time for members to give them due consideration?		

9. Has the Committee been quorate for each meeting this year?		
10. Has the Committee reviewed the effectiveness of the organisations assurance framework?		
11. Does the Committee receive and review the evidence required to demonstrate compliance with regulatory requirements – for example, as set by the Care Quality Commission?		
12. Does the Committee provide a summary report of its meetings to the next available Board which includes the outcomes of each meeting; the actions taken and the committee's view on the organisation's systems of internal control?		
13. Has the Committee reviewed its performance in the year for consistency with its: • Terms of Reference? • Programme for the year?		

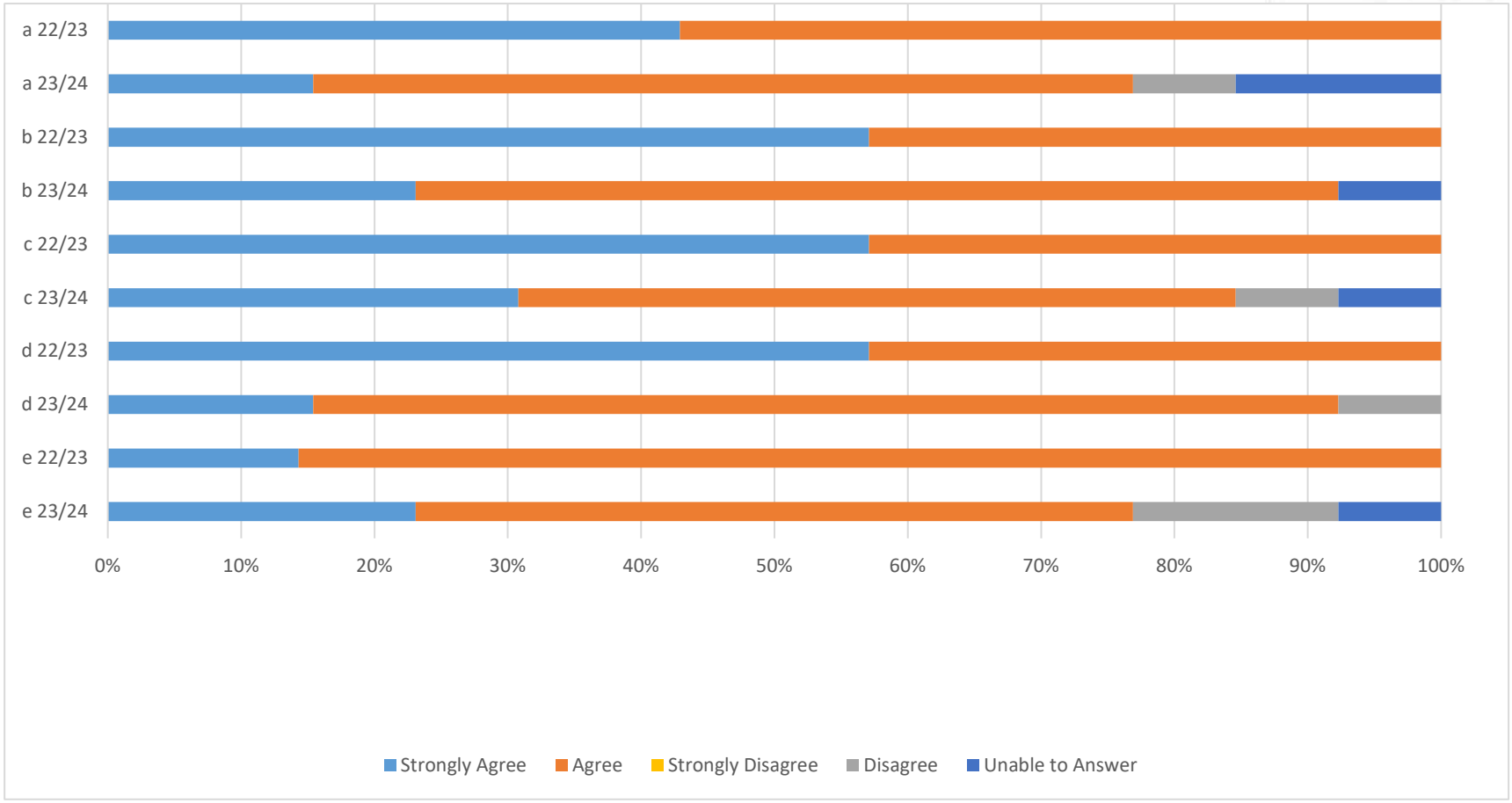
A Self-Assessment was not submitted by the Chair

Appendix 3 - Results of Committee Member Questionnaires

Theme 1 – Focus

a. The Committee has set itself a series of objectives for the year	**15.4%**	**61.5%**	**7.7%**		**15.4%**
b. The Committee has made a conscious decision about the information it would like to receive	**23.1%**	**69.2%**			**7.7%**
c. Committee members contribute regularly to the issues discussed	**30.8%**	**53.8%**	**7.7%**		**7.7%**
d. The Committee is aware of the key sources of assurance and who provides them	**15.4%**	**76.9%**	**7.7%**		
e. The Committees focus is appropriately balanced, with items considered for each associated Strategic Priority	**23.1%**	**53.8%**	**15.4%**		**7.7%**

Additional Comments: 22/23
The link of items considered and the strategic priority could be strengthened.
The Trust has a new strategy and the process for reviewing the business against this strategy as we move forward
Additional Comments 23/24
The tendency for the focus to shift to operational issues going over issues that has been dealt with in performance meetings needs to be checked. It would be better should further assurance be required, that the committee identifies and asks for this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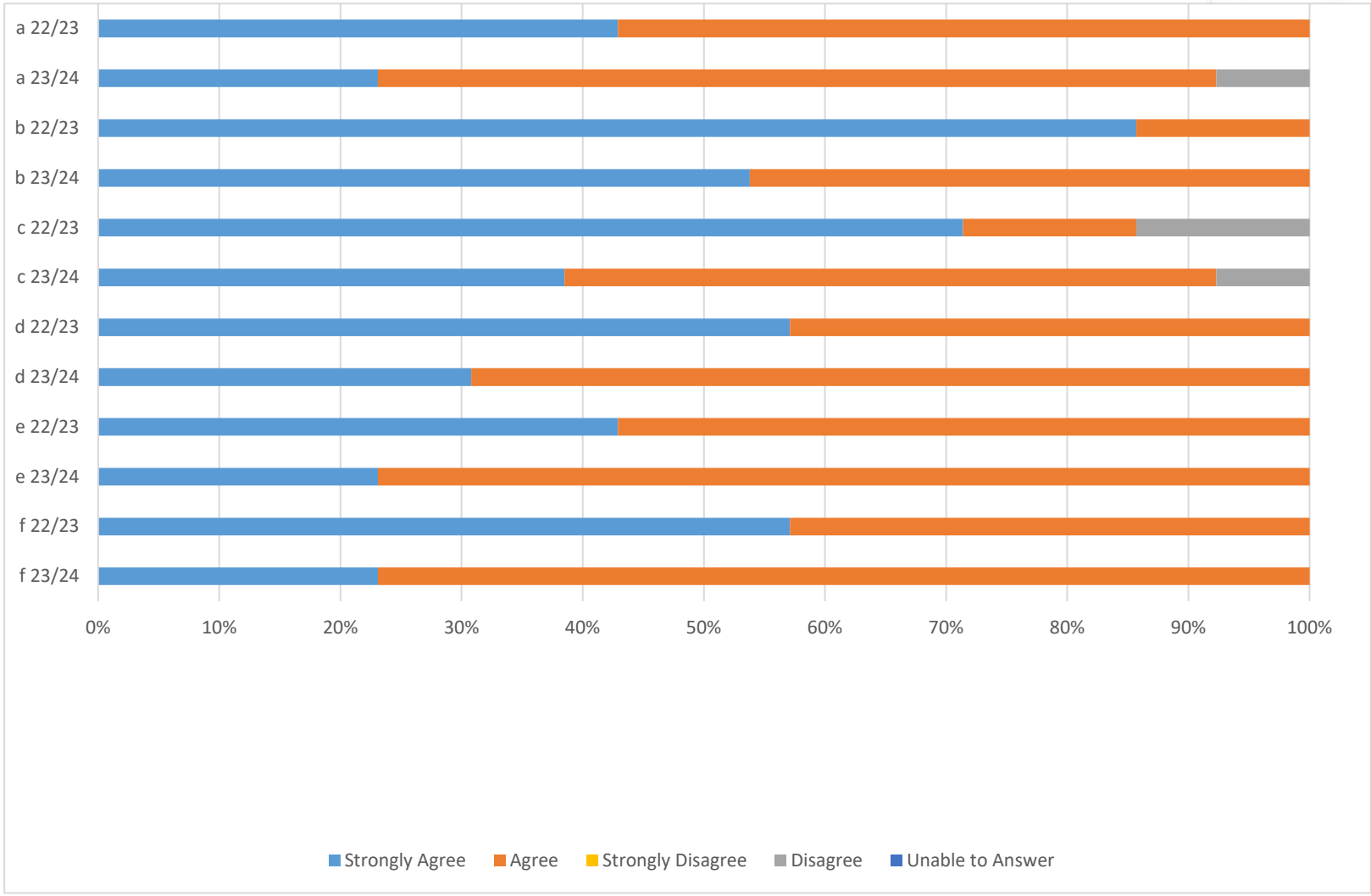
Strongly Agree
Agree
Strongly Disagree
Disagree
Unable to Answer

Theme 2 – Team Working

a. The Committee has the right balance of experience, knowledge and skills to fulfil its role	**23.1%**	**69.2%**	**7.7%**		
b. The Committee ensures that the relevant Executive Director attends meetings to enable it to understand the reports and information it receives	**53.8%**	**46.2%**			
c. The Committee is fully briefed on key risks and any gaps in control	**38.5%**	**53.8%**	**7.7%**		
d. The Committee environment enables people to express their views, doubts and opinions	**30.8%**	**69.2%**			
e. The Chair ensures that assurance providers address issues of late or missing assurances	**23.1%**	**76.9%**			
f. Decisions and actions are implemented in line with the timescale set down	**23.1%**	**76.9%**			

Additional Comments 22/23
The group ask a number of questions for clarity etc which is helpful
Additional Comments 23/24
I have only attended three Quality Committees as a fill-in Chairman for two meetings and a colleague has also attended as a stand-in as a result of two more experienced NEDs (including the well-regarded former Chairman) retired Xmas 2023. We are recruiting new NED capacity and, hopefully, a new NED Chair with clinical background, which will strengthen the relevant skill base. Conclusion from Director of Nursing is that we 'stand-ins' have brought a different perspective.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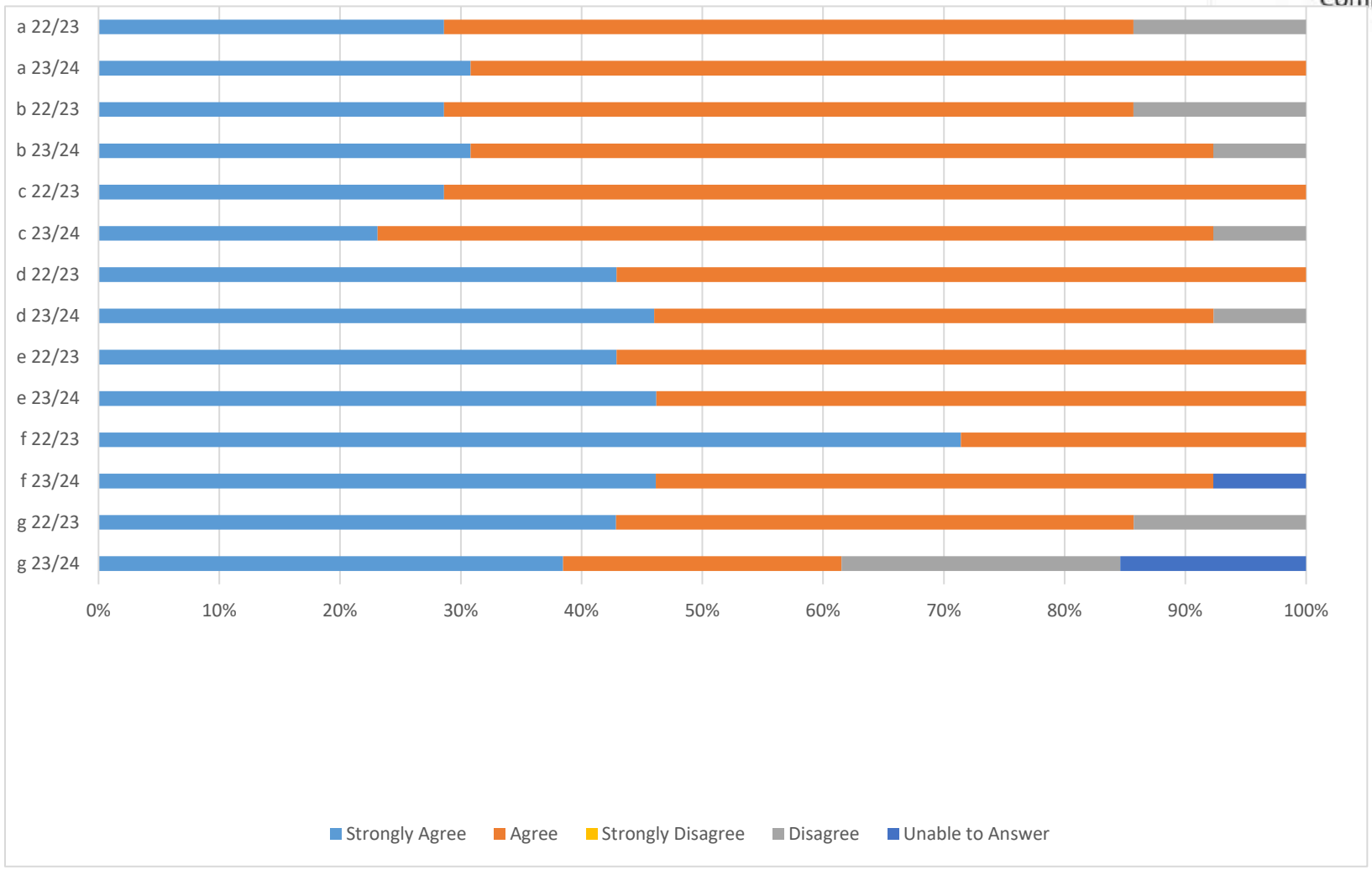
Strongly Agree
Agree
Strongly Disagree
Disagree
Unable to Answer

1. Theme 3 – Effectiveness

a. The quality of papers received allows members to perform their roles effectively	**30.8%**	**69.2%**			
b. Members provide real and genuine challenge – they do not just seek clarification and/or reassurance	**30.8%**	**61.5%**	**7.7%**		
c. The Committee provides appropriate challenge to assurance providers to gain a clear understanding of their findings	**23.1%**	**69.2%**	**7.7%**		
d. Debate is allowed to flow, and conclusions reached without being cut short or stifled	**46.2%**	**46.5%**	**7.7%**		
e. Each agenda item is 'closed off' appropriately so that the Committee is clear on the conclusion; who is doing what, when and how, and how it is being monitored	**46.2%**	**53.8%**			
f. The Committee provides a written summary report of its meetings to the Trust Board including items for escalation	**46.2%**	**46.2%**			**7.7%**
g. The Committee has requested 'deep dives' into areas of concern	**38.5%**	**23.1%**	**23.1%**		**15.4%**

Additional Comments 22/23
The directorate quality element could be strengthened and is an opportunity for us to review this.
There is time for scrutiny and attendance at quality from directorate supports this - the directorate reports need improvement and consistency of reporting across the different specialities
Additional Comments 2023/24
The summary reports to board do not indicate the actual questions raised and subsequent responses to the Trust Board which would be helpful
Sometimes, what areas of concern requiring more actions to gain assurance may be overlooked and focus is placed on an area of less concern with appropriate assurance in place already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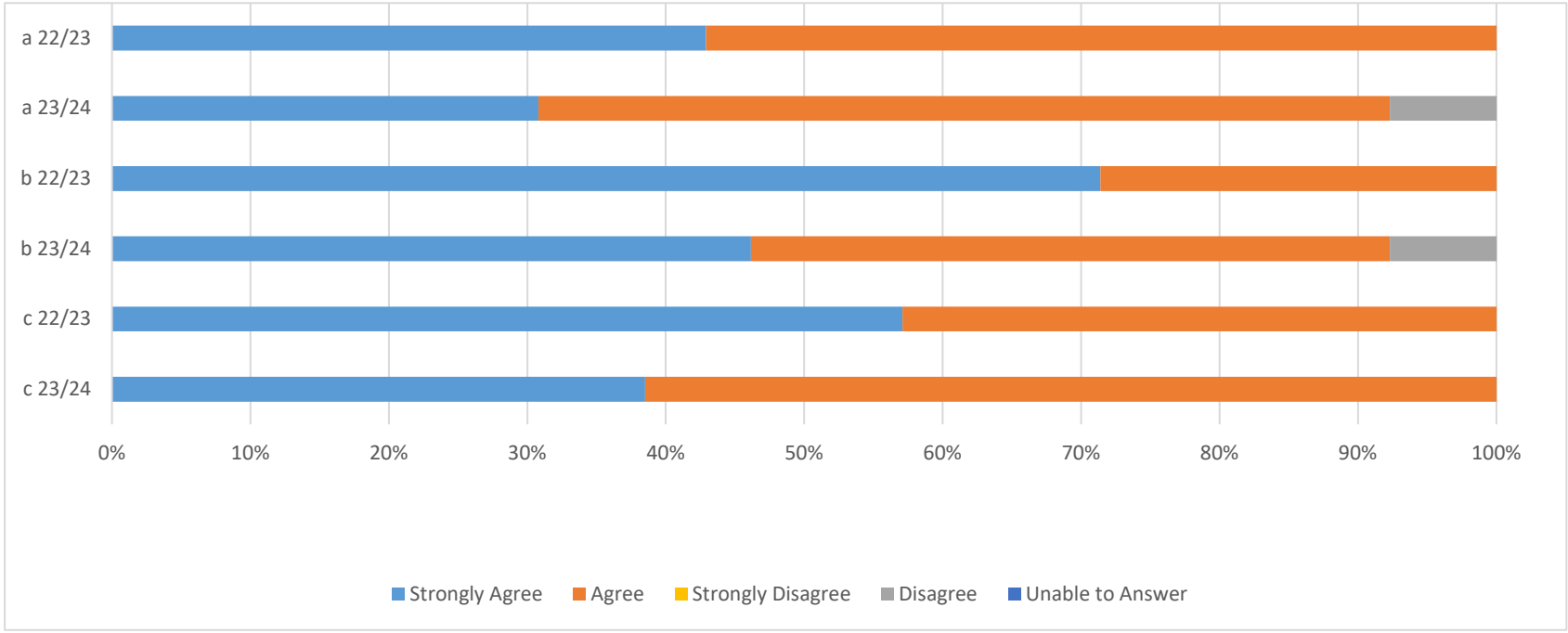
50%
60%
70%
80%
90%
100%
Strongly Agree
Agree
Strongly Disagree
Disagree
Unable to Answer

Theme 4 – Engagement

a. Membership and attendance enables the Committee to cover all aspects of its terms of reference	**30.8%**	**61.5%**	**7.7%**		
b. The Committee challenges management and other assurance providers to gain a clear understanding of their findings	**46.2%**	**46.2%**	**7.7%**		
c. The Committee is clear about its role in relationship to other committees that play a role in relation to clinical governance, quality and risk management	**38.5%**	**61.5%**			

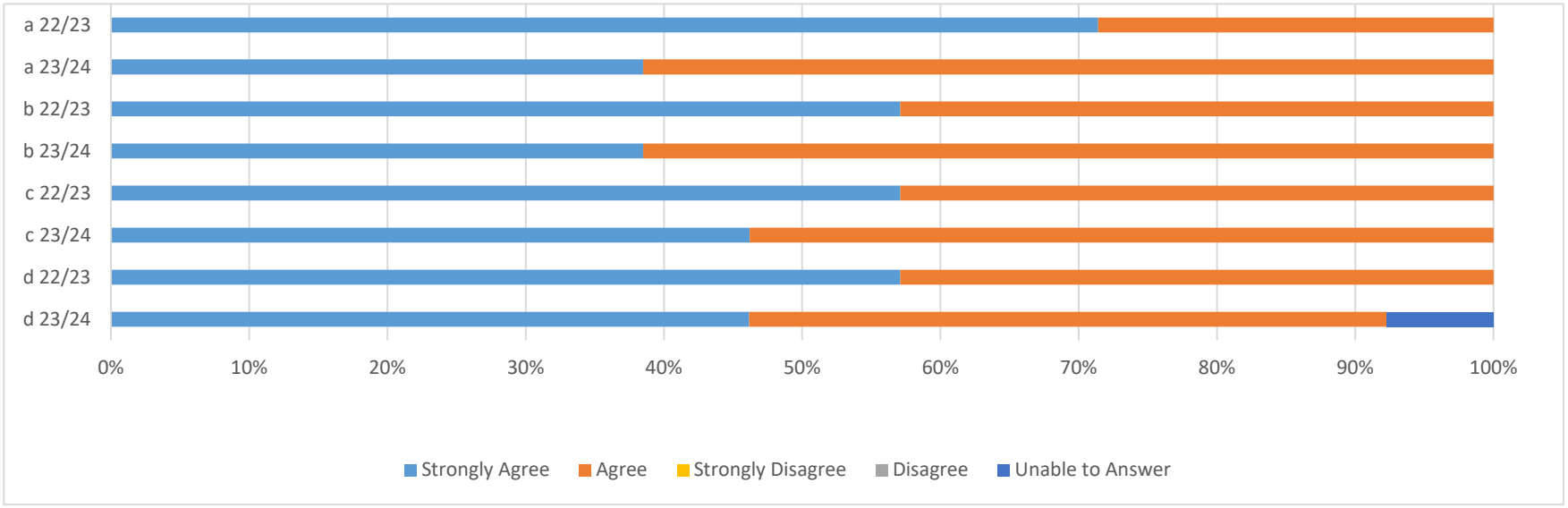
Additional Comments
No additional comments were received 22/23 or 23/24



2. Theme 5 – Leadership

a. The Chair has a positive impact on the performance of the Committee	**38.5%**	**61.5%**			
b. Committee meetings are chaired effectively	**38.5%**	**61.5%**			
c. The Chair allows debate to flow freely and does not assert his/her own views too strongly	**46.2%**	**53.8%**			
d. The Chair provides clear and concise information to the Trust Board on group/committee activities and gaps in control	**46.2%**	**46.2%**			**7.7%**

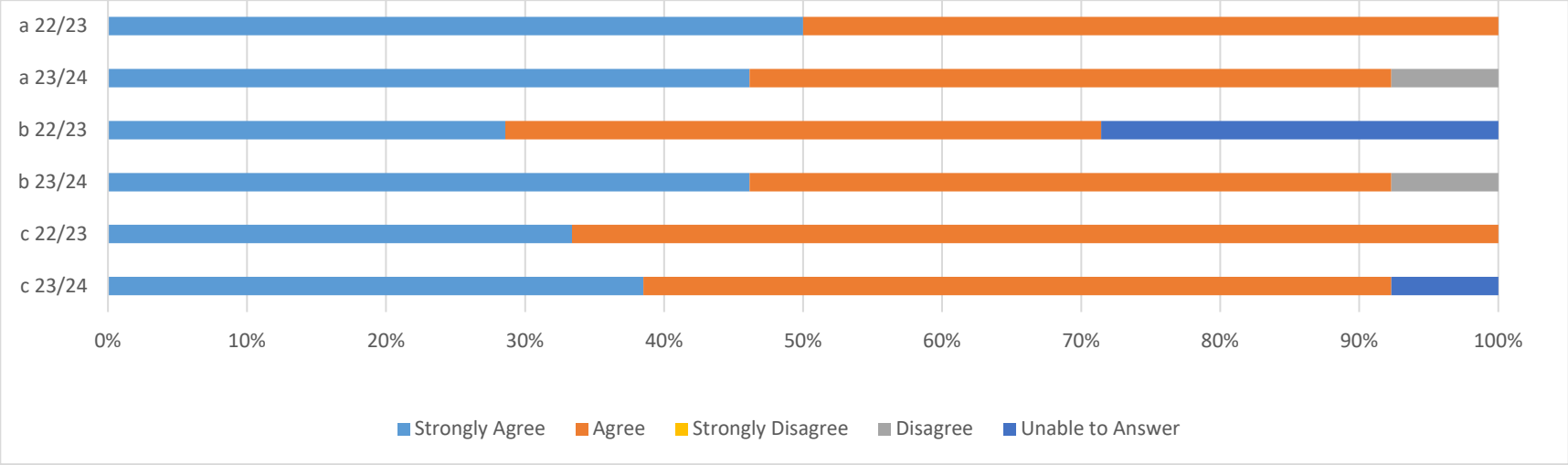
Additional Comments 22/23
The meeting is well chaired and allows for debate and questions
Additional Comments 23/24
Response is based on previous chair who has now retired from the NED role. sometimes, the committee may be distracted when a focus is placed on issues that are not within the remit of the committee or the Trust and Chair struggles to bring the focus back to related committee agenda



Theme 6 – Behaviours

a. Behaviours are always appropriate	46.2%	46.2%	7.7%		
b. If behaviours were not appropriate, the Chair addressed this appropriately during the meeting	46.2%	46.2%	7.7%		
c. I would feel empowered to provide feedback to individuals at the time, or afterwards, where inappropriate behaviours were displayed during the meeting	38.5%	53.8%			7.7%

Additional Comments 22/23
The Cycle of Business requires a review as this is sometimes out of sync. A meeting has been scheduled
Values and behaviours are upheld within the meeting and challenge is seen positively to ensure clarity and assurance.
Additional Comments 23/24
It's difficult to score some items highly because we are in a 'holding position' with this committee - the chair and one other NED are very new to the committee. There is a refresh of chair and membership planned and the committee will benefit from this. That said the committee is, in my view, operating effectively within those constraints and the chair is doing a good job.



What works well? 22/23
Patient Story, Performance dashboards,
The rotation from QIL/CD perspective, I would like to see a better update slide from the CD's so there is consistency. I also expect that CD's utilise there deputies if they are unable to attend. I also feel that the QIL role needs strengthening across directorates and the quality committee could support the direction/expectation of this.
Effective management of the agenda and the meeting
The committee strikes a good balance between openness and being welcoming to members and assurance and accountability
Papers provided with adequate time to read these ahead of the meeting
What works well? 23/24
The split between directorate focus and strategic focus
The chair has always ensured everyone can take part
There is good discussion, particularly as there is typically the right people present to bring context and up to date information to answer questions/expand on reports.
Clarity on purpose and role of the committee, challenge is appropriate.

What does not work well? 22/23
Sometime there is a heavy agenda, on occasion there are no reps for directorates
Conversation can often go off topic, dependent on the drivers to the topic.
It's harder to build working relationships with new members using Teams all the time
There is sometimes variance in the approach from directorates and focus on quality and risk management
What does not work well? 22/24
When particular committee members stray away from the committee agenda
One of the previous NED's (since left) had a tendency to take the QC away from its scope of focus and even that of influence of the organisation which was often unhelpful and limited the time that could be spent on the agenda items. The Chair had to work hard to reign the scope back in. This does not seem to be a problem anymore.
Some queries from NEDS are not always directly related to topic, I think there is an opportunity to strengthen the link with the strategic priorities. I also believe that when you are invited to the group the ToR should be shared as a minimum so you can understand the meeting better.

Suggestions for improvement 22/23
Review of cycle of business as stated above. It would be good to be notified in advance by directorate representatives who is attending the meeting if the CD is not available.
To review report format / structure and content - too much narrative and not much 'challenge; re: next steps / areas of improvement.
Some face to face meetings
Suggestions for improvement 22/23
Refocus all members to the quality committee and Trust business and mutual understanding of assurance required
Consistency across the operational updates

Areas of attention:

- Consider tendency for the focus to shift to operational issues going over issues that have been dealt with in performance meetings
- Summary reports to Board could indicate the actual questions raised and subsequent responses
- Ensure areas of concern requiring more actions to gain assurance are not overlooked
- The Committee can be distracted when a focus is placed on issues that are not within the remit of the Committee or the Trust need to ensure Chair brings the focus back to related agenda
- Stay focussed on agenda items
- Strengthen the link with strategic priorities
- Share terms of reference with new Committee members
- Ensure consistency across operational updates

Appendix 7

REPORT TO REMUNERATION COMMITTEE
Remuneration Committee Effectiveness Questionnaire Results –2023/24

Introduction

The report details the findings of the Remuneration Committee Effectiveness Review undertaken in March 2024.

Purpose of the Report (Executive Summary)

The Remuneration Committee is required to produce an annual assessment of effectiveness, received by Board for assurance. The report reflects on the Committee meetings held during 2023/24.

A data template was populated for 2023/24 which detailed member attendance, adherence to cycle of business, frequency of meetings and paper timeliness. The Committee achieved 81% membership attendance during 2023/24. A Cycle of Business was development in April 2023. 100% of all papers were circulated to Committee members on time (Appendix 1)

A Self-Assessment questionnaire was not submitted by the Chair.

Invites to complete questionnaires were circulated to Committee members, of the 9 invites circulated 5 responses were received. Low response rates can limit the value of the feedback. (Appendix 3)

Key Recommendations to Consider

The Committee is asked to:

- Receive the report
- Note the areas of attention required
- Review in conjunction with actions from previous committee effectiveness reviews

Background

The review assessed the following areas:

- The Committee had regular attendance from members outlined in the Terms of Reference
- Adherence to cycle of business
- Paper Timeliness
- The Chairs Self –Assessment of composition, establishment, duties, internal control and risk management
- Feedback from members on 6 key themes – Focus of the Committee, team working, effectiveness, leadership and behaviours. What worked well, what did not work well and made suggestions for improvement
- Recommendations and next steps following the review

Recommendations

Areas of attention:
- Sometimes difficult to compare to non NHS role
- Sometimes proposals are not fully backed up with data and these get pushed back for more information

Summary

It is unfortunate that due to timing issues we have not captured the thoughts of the chair in this effectiveness review. These are the views of the Vice Chair.

The committee has moved forward in a number of areas including developing a set of reward principles for VSM pay, undertaken and updated its benchmarking material and developed a annual structure of meetings to coincide with the normal timing of pay and performance review. Ad hoc meetings are held as required to authorise for example recruitment salary ranges and deal with exceptional items when they arise. The quality of papers to support the committee has improved although some have to be revised in order to support the business cases, but this is exceptional. It is recommended that in future exceptional items are reviewed in advance by the committee chair to ensure they are sufficient to support committee decisions.

The committee is grateful for the support of the Chief Executive and the CPO for their support to the work of the committee.

Next Steps (including timeframes)

Papers for ad hoc proposals are made available to the committee chair in advance of circulation where possible.

A 6 month review has been built into the Committee Effectiveness programme whereby a report will be taken to Committees to review progress against recommendations and actions identified from the March 2024 review.

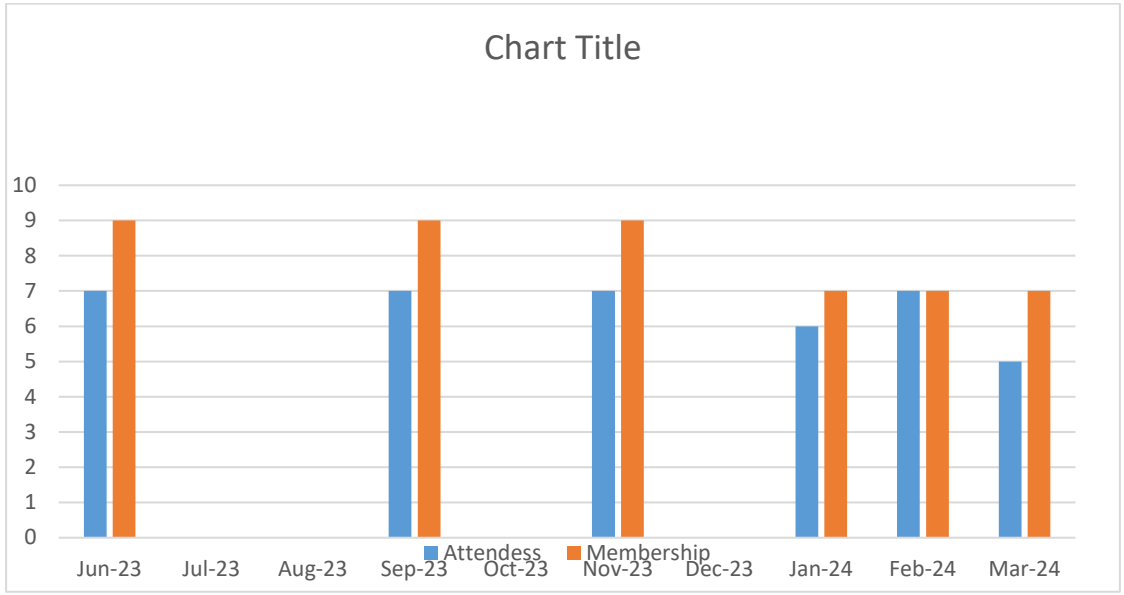
.

Appendix 1 - Committee Effectiveness Data

Attendance:

Has the Committee had regular attendance from members outlined in the Terms of Reference in the last 12 months?

Date	08.06.23	14.09.23	9.11.23	11.1.24	27.2.24	22.3.24
No of attendees	7	7	7	6	7	5
Total Membership	9	9	9	7	7	7



The Committee achieved 81% membership attendance during 2023/24.

Has the Committee / Chair adhered to the Cycle of Business?

*Please note the number of items each month that were scheduled on the cycle of business and how many were not an agenda item

Date	8.6.23	14.9.23	9.11.23	11.1.24	27.2.24	22.3.24
No. of items	5	2	2	2	2	1
Not agenda items	0	0	0	0	0	0

Cycle of Business was development in April 2023. During 2023/24 100% of items were received in accordance with the Committee Cycle

Paper Timeliness

Please advise if the papers were circulated 1 week prior to Committee (yes / no) and if papers were revised / amended after paper deadline

Date	8.6.23	14.9.23	9.11.23	11.1.24	27.2.24	22.3.24
Within 1 week	1.6.23	12.9.23	7.11.23	8.1.24	26.2.24	Virtual 22.3.24
Revised / Amended	N/A	N/A	N/A	N/A	N/A	N/A

100% of all papers were circulated to Committee members on time.

Appendix 2 - Results of Chair Self –Assessment

Questions	Response	Comments
1. Does the Committee have written terms of reference and have they been approved by Trust Board?		
2. Are the terms of reference reviewed annually?		
3. Has the Committee formally considered how it integrates with other Committees that are reviewing risk?		
4. Are Committee members independent of the management team? 5.		
6. Are the outcomes of each meeting and any internal control issues reported to the next Trust Board meeting?		
7. Does the Committee prepare an annual report on its work and performance to the Trust Board?		
8. Has the Committee established a plan of matters to be dealt with across the year?		
9. Are Committee papers distributed in sufficient time for members to give them due consideration?		

10. Has the Committee been quorate for each meeting this year?		
11. Has the Committee reviewed the effectiveness of the organisations assurance framework?		
12. Does the Committee receive and review the evidence required to demonstrate compliance with regulatory requirements – for example, as set by the Care Quality Commission?		
13. Does the Committee provide a summary report of its meetings to the next available Board which includes the outcomes of each meeting; the actions taken and the committee's view on the organisation's systems of internal control?		
14. Has the Committee reviewed its performance in the year for consistency with its: • Terms of Reference? • Programme for the year?		

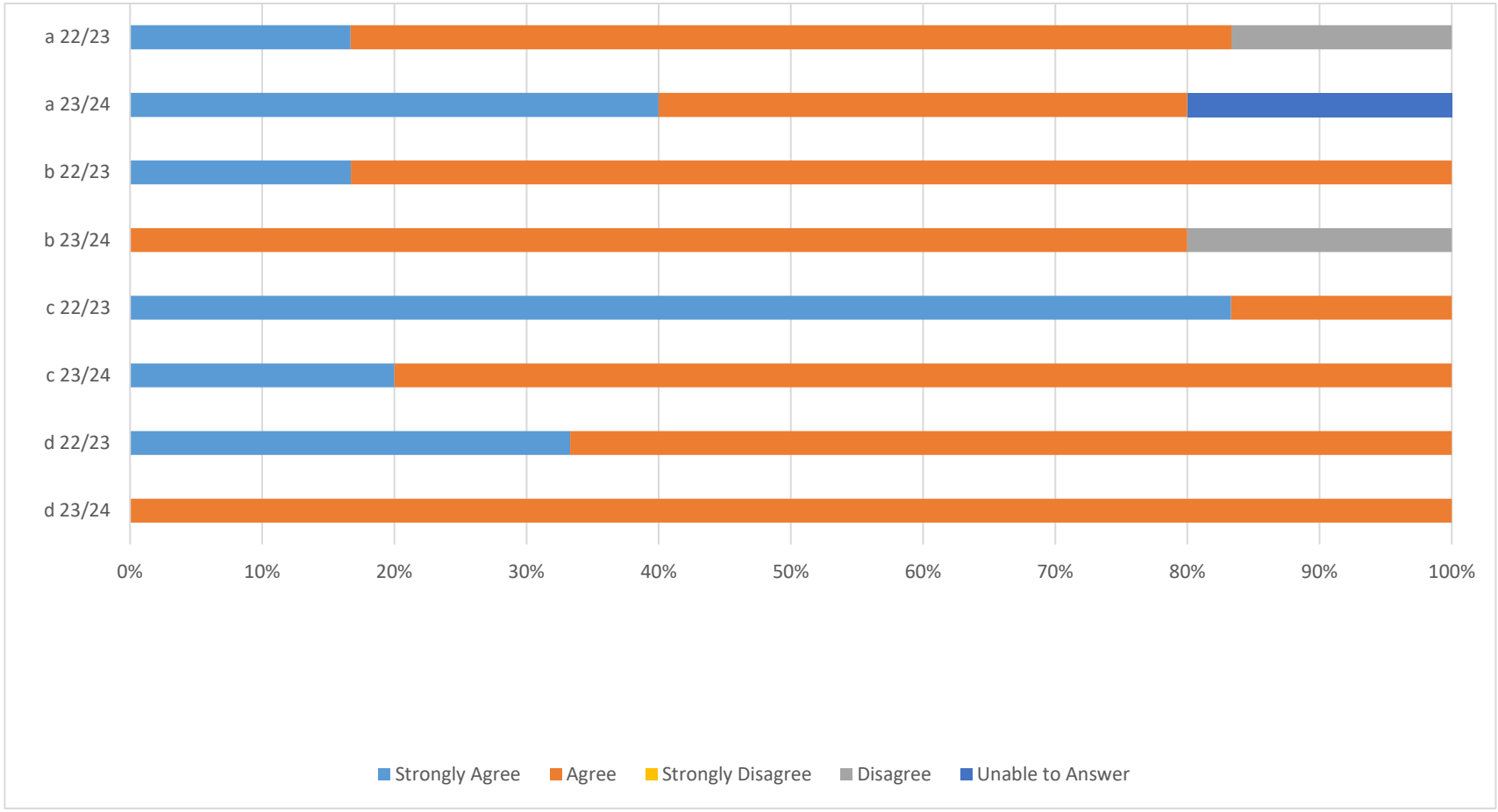
A Self-Assessment was not submitted by the Chair

Appendix 3 - Results of Committee Member Questionnaires

1. Theme 1 – Focus

	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer
a. The Committee has set itself a series of objectives for the year	40%	40%			20%
b. The Committee has made a conscious decision about the information it would like to receive		80%	20%		
c. Committee members contribute regularly to the issues discussed	20%	80%			
d. The Committee is aware of the key sources of assurance and who provides them		100%			

Additional Comments 22/23:
While we have made it clear what we would like to see at this committee it is only recently that this has started to flow through. It will be interesting to see if we also get the long awaited performance and succession material.
We changed and defined the focus of what we wanted to do at the committee.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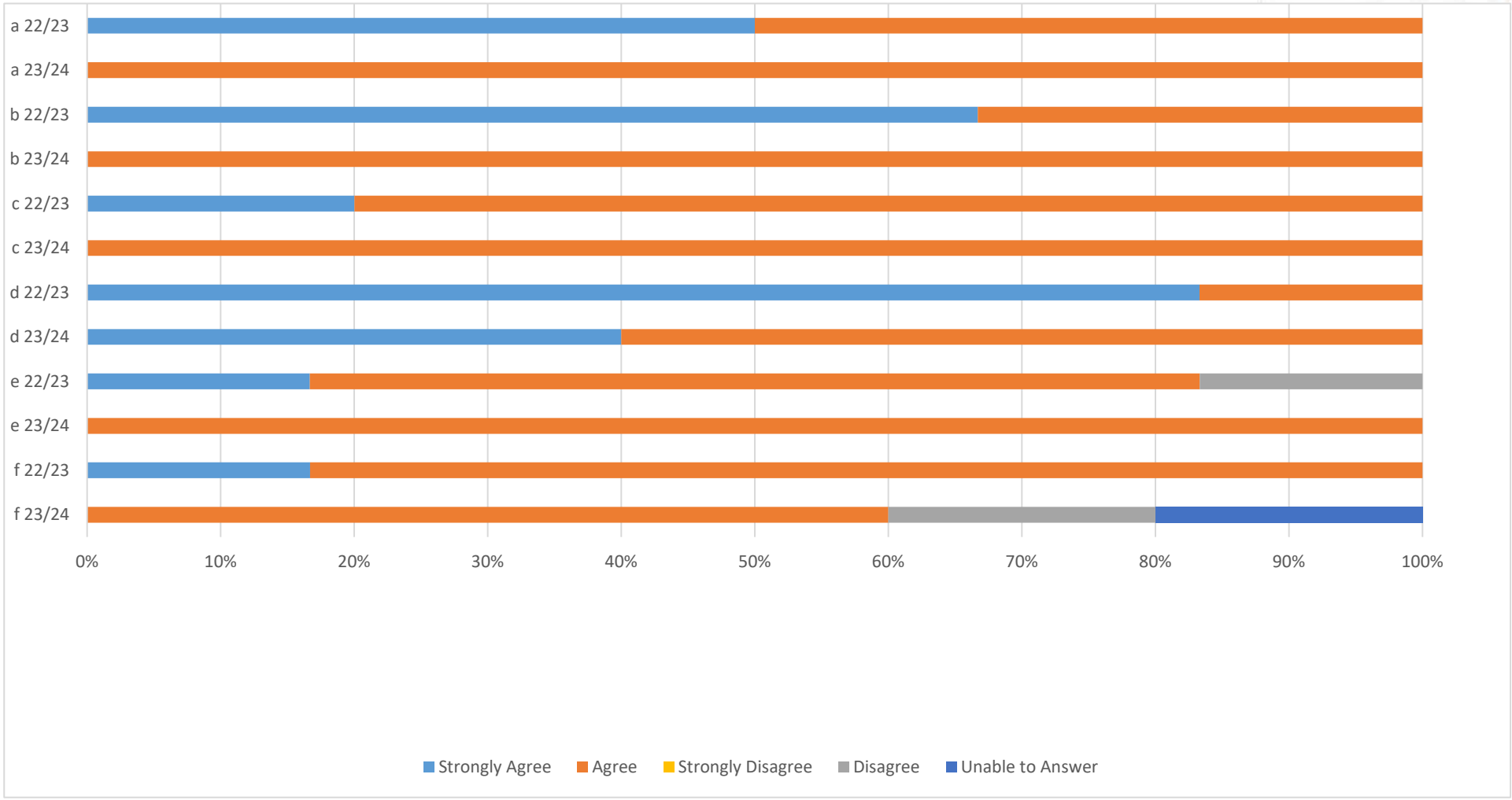
50%
60%
70%
80%
90%
100%
Strongly Agree
Agree
Strongly Disagree
Disagree
Unable to Answer

Theme 2 – Team Working

	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer
a. The Committee has the right balance of experience, knowledge and skills to fulfil its role		**100%**			
b. The Committee ensures that the relevant Executive Director attends meetings to enable it to understand the reports and information it receives		**100%**			
c. The Committee is fully briefed on key risks and any gaps in control		**100%**			
d. The Committee environment enables people to express their views, doubts and opinions	**40%**	**60%**			
e. The Chair ensures that assurance providers address issues of late or missing assurances		**100%**			
f. Decisions and actions are implemented in line with the timescale set down		**60%**	**20%**		**20%**

Additional Comments 23/24
Decisions and actions are implemented in line with the timescale set down - not always.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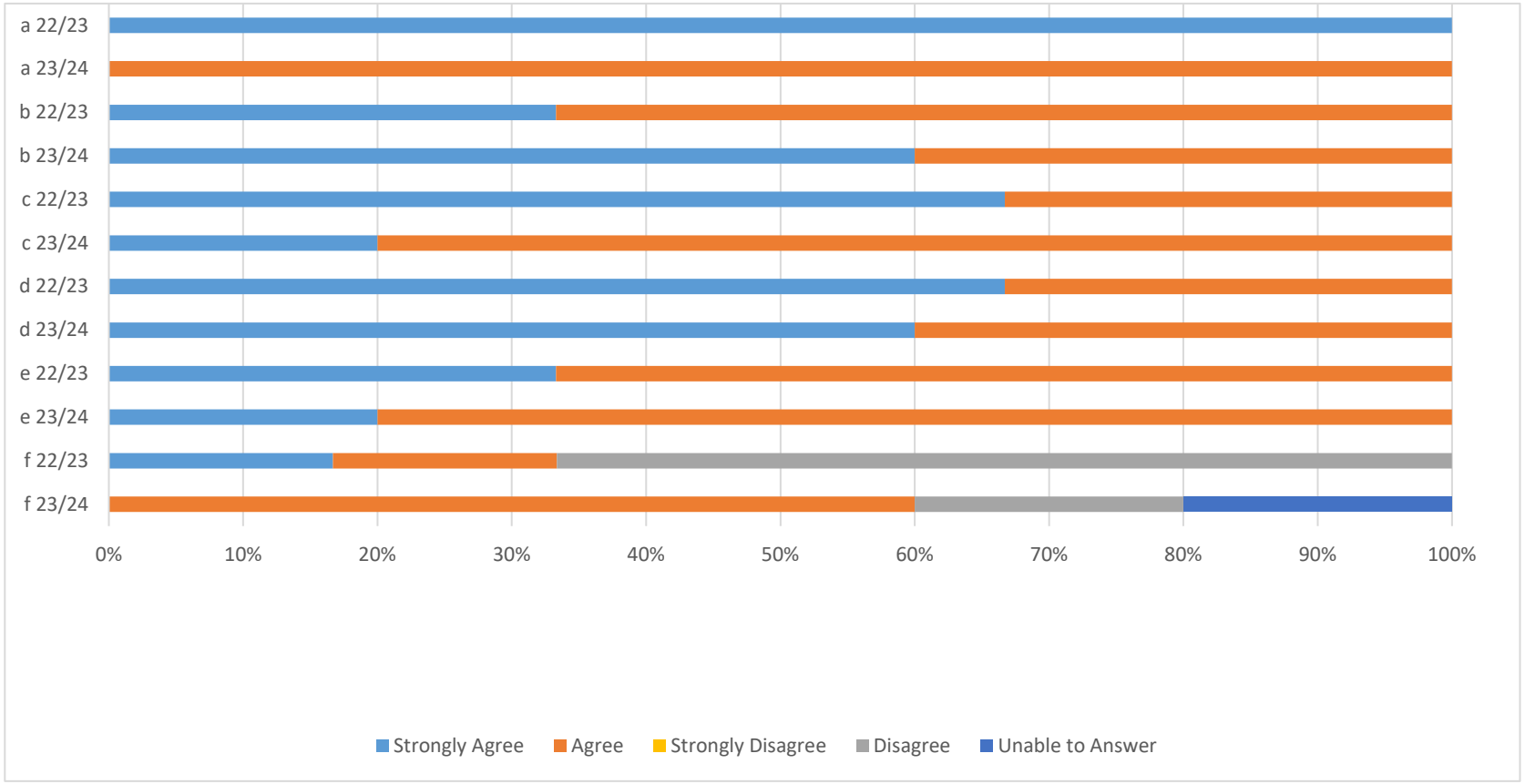
20%
30%
40%
50%
60%
70%
80%
90%
100%
Strongly Agree
Agree
Strongly Disagree
Disagree
Unable to Answer

Theme 3 – Effectiveness

	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer
a. The quality of papers received allows members to perform their roles effectively		100%			
b. Members provide real and genuine challenge – they do not just seek clarification and/or reassurance	60%	40%			
c. The Committee provides appropriate challenge to assurance providers to gain a clear understanding of their findings	20%	80%			
d. Debate is allowed to flow, and conclusions reached without being cut short or stifled	60%	40%			
e. Each agenda item is 'closed off' appropriately so that the Committee is clear on the conclusion; who is doing what, when and how, and how it is being monitored	20%	80%			
f. The Committee provides a written summary report of its meetings to the Trust Board including items for escalation		60%	20%		20%

Additional Comments 22/23
Not aware of any reporting to the board even generic.
Additional Comments 23/24
There is rarely a board report due to confidentiality of the content.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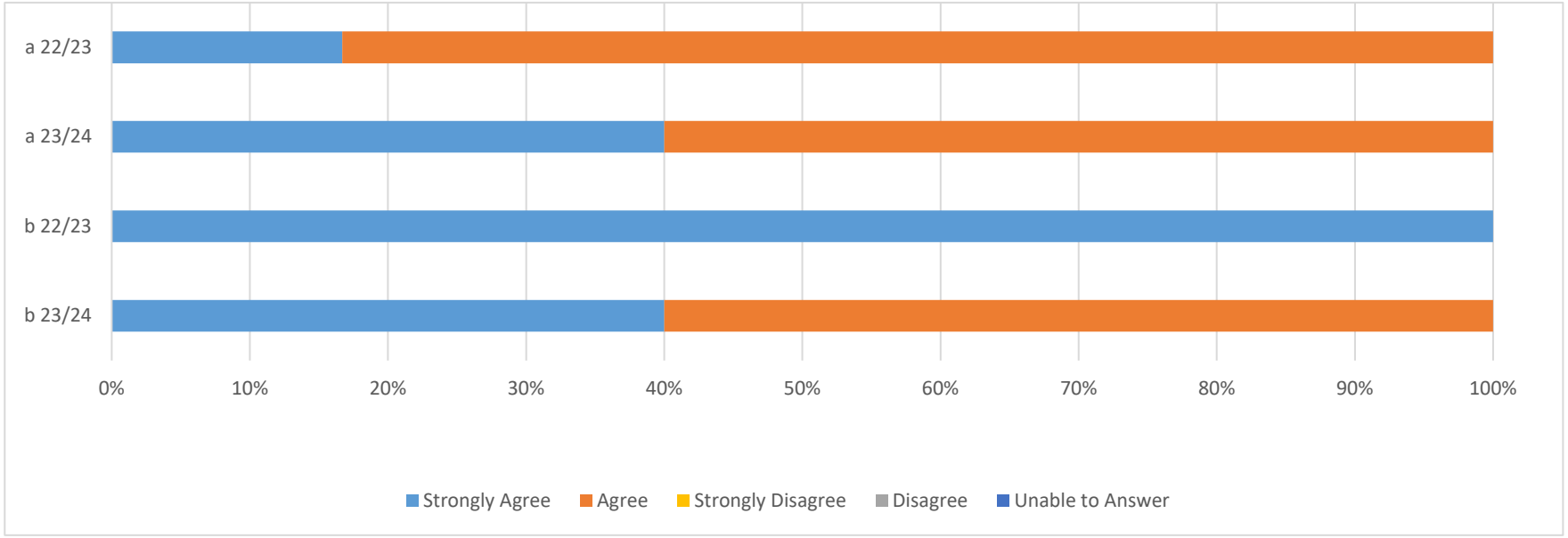
30%
40%
50%
60%
70%
80%
90%
100%
Strongly Agree
Agree
Strongly Disagree
Disagree
Unable to Answer

Theme 4 – Engagement

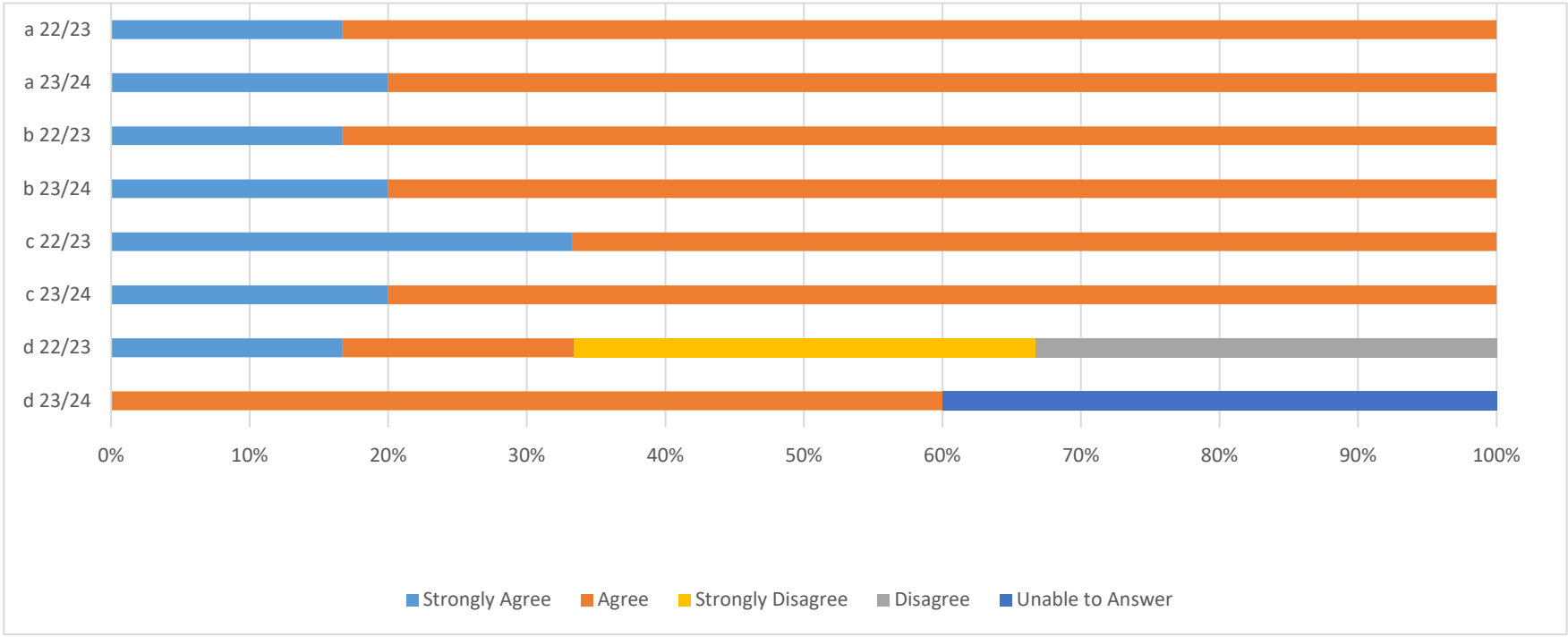
	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer
a. Membership and attendance enables the Committee to cover all aspects of its terms of reference	40%	60%			
b. The Committee challenges management and other assurance providers to gain a clear understanding of their findings	40%	60%			

Additional Comments 22/23
High levels of engagement and participation probably due to the nature of the committee membership.



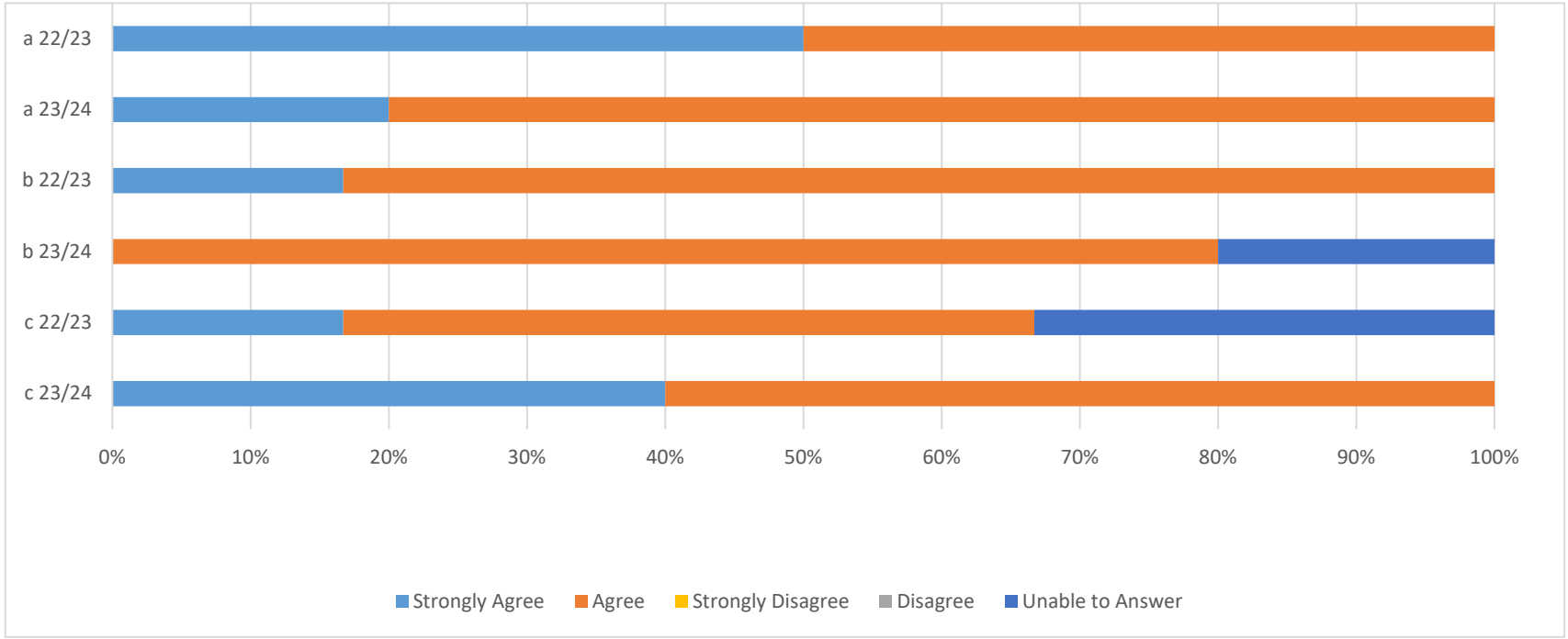
Theme 5 – Leadership

	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer
a. The Chair has a positive impact on the performance of the Committee	**20%**	**80%**			
b. Committee meetings are chaired effectively	**20%**	**80%**			
c. The Chair allows debate to flow freely and does not assert his/her own views too strongly	**20%**	**80%**			
d. The Chair provides clear and concise information to the Trust Board on group/committee activities and gaps in control		**60%**			**40%**



Theme 6 – Behaviours

	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer
a. Behaviours are always appropriate	**20%**	**80%**			
b. If behaviours were not appropriate, the Chair addressed this appropriately during the meeting		**80%**			**20%**
c. I would feel empowered to provide feedback to individuals at the time, or afterwards, where inappropriate behaviours were displayed during the meeting	**40%**	**60%**			



What works well? 22/23
Strong debate and exchange of views, effective arguments and the ability to reach consensus.
The fact that the committee now meets regularly and is more focused.
Well chaired - chair stays on top of their brief and clearly knows and understands the auditing context. has been very helpful.
What works well? 23/24
The workers remit
Has improved massively with the arrival of the Chief People Officer and we need to keep an eye on performance going forward.

What does not work well? 22/23
We have only just had a cycle of business for this committee so time will tell if this helps to get the right information at the right time based on planning. To date, it has been rather reactive.
Sometimes the amount of time necessary to deal with relevant issues is limited due to the meeting following the Trust Board
Sometimes some papers are overlong - particularly in relation to external opinions. This is not a problem unique to Combined but there's some work that could be done to improve accessibility to some papers.
What does not work well? 23/24
Sometimes difficult to compare to non NHS role

Suggestions for improvement 22/23
Clear timetable for what issues have to be reviewed when with the necessary papers issued with sufficient time to consider. Clear rationale for ad hoc meetings and adherence to the new remuneration policy once it is agreed.
Probably needs more structure but this is a work in progress.
Suggestions for improvement 23/24
Sometimes proposals are not fully backed up with data and these get pushed back for more information.

Areas of attention 22/23

- Focus to be given to performance and succession material
- Consider producing a summary to the Board
- Consider allowing more time for the meeting to deal with relevant issues
- Look to condense some papers to improve accessibility
- Clear timetable for what issues have to be reviewed with sufficient time to consider.
- Clear rationale for ad hoc meetings and adherence to the new remuneration policy once it is agreed.

Areas of attention 23/24

- Sometimes difficult to compare to non NHS role
- Sometimes proposals are not fully backed up with data and these get pushed back for more information

REPORT TO PUBLIC TRUST BOARD

Date of Meeting:	9th May 2024		
Title of Report:	Improving Quality & Performance Report (IQPR) Month 12 2023/24		
Presented by:	Eric Gardiner, Chief Finance Officer		
Author:	Victoria Boswell, Associate Director of Performance		
Executive Lead Name:	Eric Gardiner, Chief Finance Officer	**Approved by Exec**	☒

Enc 7

Purpose of the report:								
Approval	☐	**Information**	☒	**Consider for Action**	☐	**Assurance**	☒	

Executive Summary:

Purpose of the report

The Improving Quality and Performance Report [IQPR] provides a Trust summary performance report and a breakdown of areas of under-performance and over-performance by Directorate. The report provides a high degree of assurance to the Finance & Resource Committee and the Trust Board on performance against a balanced scorecard of metrics and standards.

The metrics are reported using SPC methodology and highlight areas where quality improvement is required, help direct efforts in areas where there may be a cause for concern and prompt effective discussion and action planning.

Performance summary

There are 4 special cause variations (orange variation flags) - signifying concern, compared to 2 in M11:

- CAMHS 18 week waits
- MH Liaison 24 hour
- Talking Therapies 6 weeks – target continues to be met
- Risk Assessment Compliance

There are 4 special cause variations (blue variation flags - signifying improvement), compared to 2 in M11:

- 7 day follow up (all patients)
- Service Users in CPA in settled accommodation
- Service Users on CPA in Employment
- Staff Turnover

In addition:

Highlights

- Early Intervention response times continue above standard
- CYP Eating Disorder – Routine response in 4 weeks has met the 95% standard and urgent referral response is 100%
- 18 week RTT is above standard Trust wide in M12
- MH Liaison 1 hour and 4 hour response time standards have been met
- 48 hour follow up, CPA 7 day follow up and 7 day follow up all patients are 100%
- Appraisal and Training performance remains above the 85% standard

Exceptions

- 4 week RTA Trust-wide and CAMHS RTA are below standard. In the Community Directorate CAMHS RTAs have declined in M12, and performance is significantly lower than what is predicted to be required to achieve the target of 95% in May-24
- MH Liaison is marginally below standard at 94.9% during M12
- Talking Therapies for Anxiety and Depression - Service users wait no longer than 90 days between 1st and 2nd treatment: performance has remained the same as M11 at 16%, against a target of <10%.
- CPA 12 month review remains below standard at 89.1% and new Community PIP agreed in M12 sets a new trajectory for achievement in May 2024.
- Care plan compliance has plateaued during the last 3 months, 94.1% M10, 94.3% at M11 and 94.1% M12. New PIPs issued in Community and Specialist Services in M12 for reporting in M1.
- Risk Assessment performance has plateaued during the last 3 months, 92.7% M10, 92.8% M11, 92.7% M12. New PIPs issued in Community and Specialist Services in M12 for reporting in M1.
- There were 14 complaints outside of the 40 working day deadline during M12.
- Agency spend has marginally improved at 5.6% during M12 compared to 5.8% in M11
- Staff Turnover has improved to 12.2% during M12 compared to 12.9% in M11
- The vacancy rate has marginally improved at 11.4% during M12, compared to 11.6% during M11
- Clinical Supervision performance has dipped to 80%

Seen at:	SLT ☐ Execs ☐ Performance Review 16/04/24	Document Version No.	V1
Committee Approval / Review	• Quality Committee ☐ • Finance & Resource Committee ☒ • Audit Committee ☐ • People, Culture & Development Committee ☐ • Charitable Funds Committee ☐		
Strategic Priorities (please indicate)	1. **Growth** - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care ☒ 2. **Access** - We will ensure that everybody who needs our services will be able to choose the way, the time, and the place in which they access them ☒ 3. **Prevention** - To will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce. ☒		
BAF / Risk / legal implications: Risk Register Reference	1. We will provide the highest quality, safe and effective services ☒ 2. We will attract, develop and retain the best people ☒ 3. We will actively promote partnership and integrated models of working ☒ 4. We will increase our efficiency and effectiveness through sustainable development ☐ Performance Improvements Plans (PIPs) may be put in place for those national and contractual measures that have not achieved target. In addition, they may be required for those		

measures showing a special cause variation indicating concern.

PIPs in place in M12

Metric	Directorate	Status
Referral to Assessment within 4 weeks	Community	Trajectories have been reviewed and agreed in M8 - aim for the standard to be met in May 2024 for CYP services and April 2024 for Adult services. In M12 Directorate performance is at 83.1% and is not on track to achieve trajectories • CYP performance is 7.4% against trajectory of 40% • Adult performance is 89.9% against a trajectory of 94% A new PIP has been issued in M12 for Adult and CYP Services and will be reported in M1.
Care Plan Compliance	Community	Community Directorate aimed for achievement of the standard by November 2023. • M12 performance remains consistent at 94% The Community PIP has now expired and has been reissued in M12 and will be reported in M1. A new PIP has been issued for Specialist Services in M12 and will be reported in M1.
Risk Assessment	Community Specialist Services	Community Directorate aimed for achievement of the standard by November 2023 • M12 performance remains consistent at 92.5% Specialist Services has aimed for achievement of the standard by December 2023 • M12 performance is at 93.3% below the 95% standard A new PIP has been issued in M12 for Adult and CYP Services and will be reported in M1.
CPA 12 Month Review	Community	***New PIP in M12*** Community Directorate aimed for achievement of the standard by May 2024. • M12 performance is at 87.6%.
Agency Spend	Community Specialist Services Acute & Urgent Care Primary Care	A PIP has been requested in M12 from all Directorates and will be reported in M1 2024/25.

Sustainability:

1. Reduce the environmental impact of health and social care in Staffordshire and Stoke on Trent ☐
2. Build a network of climate and sustainability champions across Staffordshire and Stoke on Trent ☐
3. Share learning and best practice ☒

Resource Implications: Funding Source:	None directly.	
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	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. Utilising the 2021 census data will support the Heath Equity Assessments being undertaken at PCN level to inform the Mental Health Community Transformation programme to address health inequalities at a local level.	
ICS Alignment / Implications:	N/A	
Recommendations:	Trust Board is asked to: • Receive the report as outlined • Note the Management actions	
Version	Name/group	Date issued
V1	Finance & Resource Committee	24/04/24

North Staffordshire Combined Healthcare NHS Trust

IQPR

Improving Quality & Performance Report

Board Report

Month 12: March 2024

Contents

Balanced Scorecard

Access & Waiting Times

SPC variations signifying concern	Metric	Standard	Performance
	CAMHS 18 weeks	92%	73.9%
	MH Liasion 24 hour	95%	94.9%
	Talking Therapies 6 weeks	75%	88.0%
RAG rated standards	9 met, 5 unmet		
Highlights	RTT 18 weeks MH Liaison 1hr MH Liaison 4hr Talking Therapies 6 weeks Talking Therapies 18 weeks 48 hr FUP CPA 7 day follow up 7 day Follow Up (all) Early Intervention 2 Weeks		

Exceptions	Metric	Standard	Performance
	RTA 4 weeks	95%	94.8%
	CAMHS 4 week	95%	90.5%
	CAMHS 18 week	92%	73.9%
	MH Liaison 24hr	95%	94.9%
	Talking Therapies 90 days	<10%	16.0%

Inpatient & Quality

SPC variations signifying concern	Metric	Standard	Performance
	Nothing significant to note		
RAG rated standards	1 met, 1 not met		
Highlights	Emergency Readmissions		

Exceptions	Metric	Standard	Performance
	Place of Safety	100%	78.0%

Community & Quality

SPC variations signifying concern	Metric	Standard	Performance
	Risk Assessment	95%	92.7%
RAG rated standards	3 Met, 3 unmet		
Highlights	Accommodation Employment Talking Therapies Recovery		

Exceptions	Metric	Standard	Performance
	Care Plan Compliance	95%	94.1%
	Risk Assessment	95%	92.7%
	CPA 12m Review	95%	89.1%

Performance Improvement Plans (PIPs)	Metric	Standard	Performance
Specialist Services	Risk Assessment	95%	93.3%
Specialist Services	Care Plan Compliance	95%	94.6%
Community Directorate	4 week waits	95%	88.6%
Community Directorate	CPA 12 Month Review Compliance	95%	87.6%
Community Directorate	Care Plan Compliance	95%	94.0%
Community Directorate	Risk Assessment	95%	92.5%
Community, Specialist, Acute Directorate	Agency Spend	<3.7%	5.6%

Organisational Health & Workforce

SPC variations signifying concern	Metric	Standard	Performance
	Sickness Absence	<4.95%	5.13%
RAG rated standards	3 met, 7 unmet		
Highlights	Appraisal Stat & Mand Training		

Exceptions	Metric	Standard	Performance
	Complaints	0	14
	Vacancy	<10%	11.4%
	Staff Turnover	<10%	12.2%
	Agency Spend	<3.7%	5.6%
	Clinical Supervision	85.0%	80.0%
	Safe Staffing	100.0%	96.2%
	Sickness Absence	<4.95%	5.13%

Using Statistical Process Control (SPC)

Statistical process control (SPC) is a set of statistical methods based on the theory of variation that can be used to make sense of any process or outcome measured over time, usually with the intention of detecting improvement or maintaining a high level of performance.

Control charts plot historical data and include a central line for the average of the data, an upper line for the upper control limit, and a lower line for the lower control limit. SPC methodology enables the measurement of change from the mean within and beyond the control limits; this change can be positive or negative.

1. Highlights and Exceptions

In Month 12 there are 16 rated measures that have achieved required standard (16 in M11) and 17 that have not met the required standard and highlighted as exceptions (13 in M11). In addititon the CYP Eating Disorder target for response times was achieved in Q4.

There are 5 special cause variations (orange variation flags) - signifying concern, compared to 2 in M11:

1. CAMHS 18 week waits
2. MH Liaison 24 hour
3. Talking Therapies 6 weeks
4. Risk Assessment Compliance
5. Sickness Absence

There are 4 special cause variations (blue variation flags - signifying improvement), compared to 2 in M11:

1. 7 day follow up (all patients)
2. Service Users in CPA in settled accommodation
3. Service Users on CPA in Employment
4. Staff Turnover

2. Long Term Plan and National Mental Health Priorities: Performance against Operational Planning Forecasts 2023/2024

Performance against the forecasts in Q4 are reported as proxy measures in Appendix 1 in advance of publication of MHSDS reported national metrics. All forecasts were achieved with the exception of CYP 1 contact forecast that was not achieved in Q4.

With the CYP 1 contact metric being a 12 month rolling measure, quarter on quarter variances are driven by the previous reported quarter's first 3 months being removed and the new reported quarters latest 3 months being introduced.

Between January-23 to March-23, 3,132 distinct patients received a contact in accordance with the metrics methodology, this has reduced to 2,853 between January-24 to March-24.

Essentially between January-23 to March-23 more distinct patients received a contact than between January-24 to March-24 which negatively impacted the CYP 1 Contact Metric. This is being reviewed with the Community Directorate.

4. Performance Improvement Plans (PIPs)

Performance Improvements Plans (PIPs) may be put in place for those national and contractual measures that have not met the target. In addition, they may be required for those measures showing a special cause variation indicating concern.

The new PIP process takes into account the wider context such as demand and capacity considerations and more granular team level data to enable Directorates to set out the issues, actions and a realistic and achievable trajectory for improvement, and to mitigate any risks in achieving compliance and maintain the standard required.

The PIPs are reviewed in light of performance achieved for each team and updated in light of the latest activity data prior to being reported to the monthly Executive Performance Review meetings.

The PIPs are monitored on a monthly basis through these meetings until the standard has been achieved for 3 consecutive months, or otherwise agreed. This will ensure that the actions outlined by the Associate Directors are embedded and performance levels are sustained.

PIP trajectories have not been achieved in the last Quarter and all PIPs are being reissued for review with realistic and achievable trajectories to be provided in M1. These will be subject to more rigorous review through Executive Directorate Performance Review meetings. The IQPR will contain more information from Operational Services on mitigations and actions to be taken.

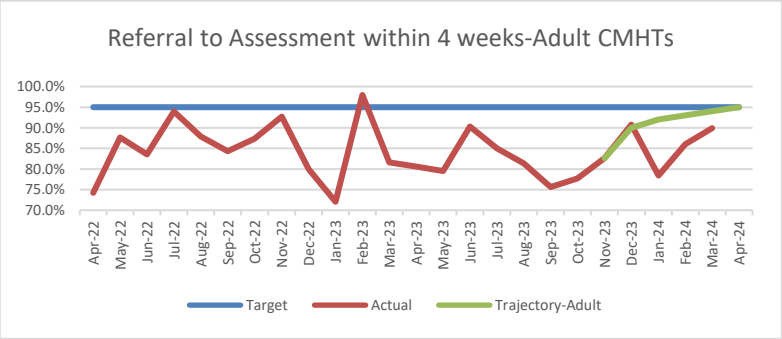
PIPs for Agency spend have been issued in M12 and will be reported in M1 2024/25 IQPR.

PIPs currently in place

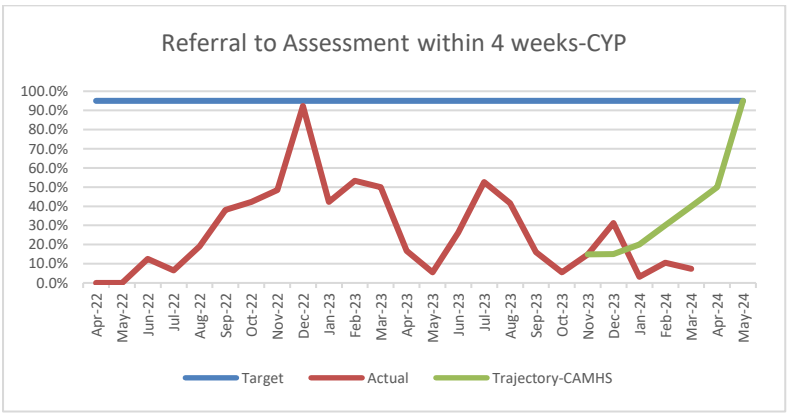
Metric	Directorate	Status
Referral to Assessment within 4 weeks	**Community**	Trajectories have been reviewed and agreed in M8 - aim for the standard to be met in May 2024 for CYP services and April 2024 for Adult services. In M12 Directorate performance is at 83.1% and is not on track to achieve trajectories • CYP performance is 7.4% against trajectory of 40% • Adult performance is 89.9% against a trajectory of 94% A new PIP has been issued in M12 for Adult and CYP Services and will be reported in M1.
Care Plan Compliance	**Community** **Specialist Services**	Community Directorate aimed for achievement of the standard by November 2023. • M12 performance remains consistent at 94% The Community PIP has now expired and has been reissued in M12 and will be reported in M1. A new PIP has been issued for Specialist Services in M12 and will be reported in M1.
Risk Assessment	**Community** **Specialist Services**	Community Directorate aimed for achievement of the standard by November 2023 • M12 performance remains consistent at 92.5% Specialist Services has aimed for achievement of the standard by December 2023 • M12 performance is at 93.3% below the 95% standard The PIP has now expired and has been reissued in M12 and will be reported in M1.
CPA 12 Month Review	**Community**	Community Directorate aimed for achievement of the standard by May 2024.

		• M12 performance is at 87.6% against a 90% trajectory
Agency Spend	**Community Specialist Services Acute & Urgent Care Primary Care**	A PIP has been requested in M12 and will be reported in M1 2024/25.

Community Directorate: Adult - Referral to Assessment



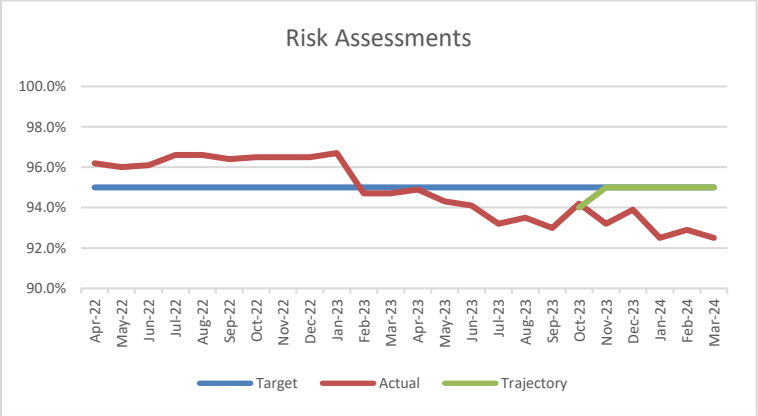
Community Directorate CYP - Referral to Assessment



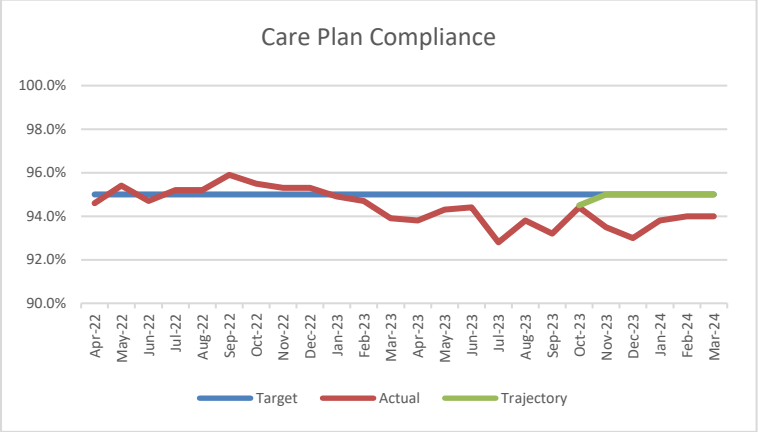
Community Directorate - CPA 12 month Review

- The Directorate is underperforming at 88.6% during M12, against a target of 95%.
- Adult CMHTs performance has improved to 89.9% which is 4% less of the planned 94% trajectory and 5% less of the standard.
- CYP CMHTs performance is 7.4% and significantly adrift of both the trajectory (40%) and the standard (95%).

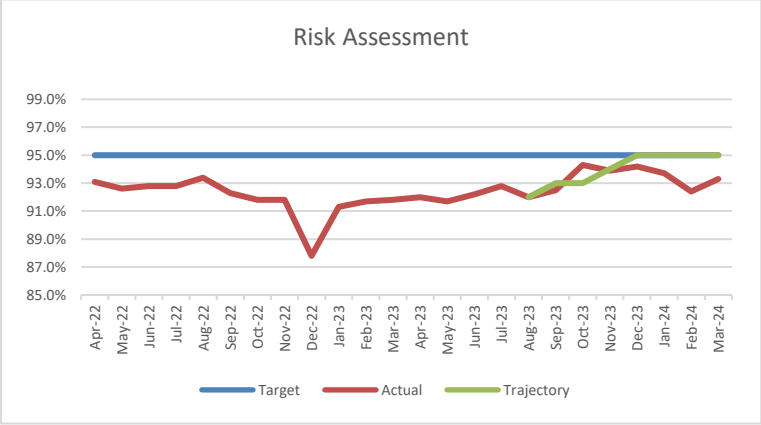
Community Directorate - Risk Assessment



Community Directorate - Care Plan Compliance



Specialist Services – Risk Assessment



5. Performance Summary

Measure	Met/Not Met	Assurance	Variation	Exception	Narrative
1 - Referral to Assessment within 4 weeks	Not Met			*	Performance is at 94.8% and has not met the required standard during M12. ***A PIP is in place for Community Directorate for Adult and CYP and has been reissued in M12 for review***
2 - Referral to Treatment within 18 weeks	Met				Performance is at 94.5% and is just under the 95% standard during M12
3 - CAMHS Compliance within 4 week waits (Referral to Assessment)	Not Met			*	Performance is not meeting the required standard and is currently at 90.5% during M12. ***A PIP is in place for Community Directorate for CYP and has been reissued in M12 for review***
4 - CAMHS Compliance within 18 week waits (Referral to Treatment)	Not Met			*	Performance is at 73.9% during M12 and is not meeting the required standard.
5 - Access Service Waiting Times: 1 hour					Performance is at 94.8% during M12.
6 - Access Service Waiting Times: 24 hour					Performance is at 80.7% during M12.
7 - Access Service Waiting Times: 4 hour					Performance is at 91.3% at M12.
8 - MH Liaison 1 Hour Response (Emergency)	Met				Performance is at 95.2% during M12 and is meeting the required standard.
9 - MH Liaison 4 Hour Response (Urgent)	Met				Performance is at 96.6% during M12 and is meeting the required standard.
10 - MH Liaison 24 Hour Response (Urgent from General Hospital Ward)	Not Met			*	Performance is at 94.4% during M12 and is not meeting the required standard. A special cause variation suggests there is a trend requiring action.
11 - Talking Therapies for Anxiety and Depression Referral to Treatment (6 weeks)	Met				Performance is at 88% during M12. A special cause variation of concern has remained in place for some time, suggesting there is a trend.
12 - Talking Therapies for Anxiety and Depression Referral to Treatment (18 weeks)	Met				Performance is at 99% during M12.
13 - Talking Therapies for Anxiety and Depression Patients wait no longer than 90 days between 1st and 2nd treatment	Not Met			*	Performance is declining in excess of 16% during M12 against a target of <10%
14 - Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment	Met				Performance is at 91% during M12.
15 - 48 Hour Follow Up	Met				Performance is at 100% during M12.
16 - Care Programme Approach (CPA) 7 day Follow Up	Met				Performance is at 100% during M12.
17 - 7 day follow up (All Patients)	Met				Performance is at 100% during M12 signifying a special cause of improvement.

Measure	Met/Not Met	Assurance	Variation	Exception	Narrative
18 - Average Length of Stay - Adult					The average length of stay for inpatients on an adult ward has increased to 41 days in M12 compared to an average 25 days.
19 - Average Length of Stay - Older Adult					The average length of stay for inpatients on an older adult ward has increased to 66 days in M12 compared to an average 42 days.
20 - Emergency Readmissions rate (30 days)	Met				The emergency readmission rate is 3.5% and remains within the threshold.
21 - Place of Safety assessment carried out within 3 hours (where clinically appropriate)	Not Met			*	Performance is at 78% below the required 100% standard.
22 - Clinically Ready for Discharge (CRFD)					There are 26 patients identified as clinically ready for discharge at M12.
23 - Care Plan Compliance	Not Met			*	Performance is at 94.1% during M12 and is not meeting the required standard across all directorates. ***A PIP is in place for Community Directorate and has been reissued in M12 for review. A new PIP has been issued in Specialist Services in M12.***
24 - Risk Assessment Compliance	Not Met			*	Performance is at 92.7% during M12 and remains below the required standard. A special cause variation remains in place suggesting a trend in under performance. ***PIPs are in place for Community and Specialist Services directorates and have been reissued in M12.***
25 - CPA 12 Month Review Compliance	Not Met			*	Performance is at 89.1% during M12 and continues to remain below standard. ***A PIP is in place for Community Directorate and has been updated in M12.***
26 - Service Users on CPA in settled accommodation	Met				Performance has improved to 76.2% during M12 and continues to exceed the required standard.
27 - Service Users on CPA in Employment	Met				Performance has improved to 27.2% during M12 and continues to exceed the required standard.
28 - Talking Therapies for Anxiety and Depression Recovery	Met				Performance remains consistent at 56.3% during M12.
29 - Serious Incidents					There are 0 serious incidents Trust wide reported during M12.
30 - Complaints Open Beyond Agreed Timescale	Not Met			*	There were 14 complaints outside of the 40 working day deadline.
31 - DQMI					DQMI Score for December (latest published data) is 95.4%.
32 - Friends and Family Test - Recommended					88% rated the Trust as good.
33 - Safe Staffing	Not Met			*	There was an overall staffing fill rate of 96.2% in M12.

Measure	Met/Not Met	Assurance	Variation	Exception	Narrative
34 - Vacancy Rate	Not Met			*	The vacancy rate is at 11.4% in M12.
35 - Staff Turnover	Not Met			*	Performance is consistently above the 10% threshold at 12.2% in M12.
36 - Agency Spend	Not Met			*	Agency spend rate is 5.6% for M12. ***PIPs have been issued in M12 for all Directorate and will be reported in M1.***
37 - Sickness Absence	Not Met			*	Sickness Absence is at 5.13% during M12 and is exceeding the required standard.
38 - Clinical Supervision	Not Met			*	Performance is at 80% during M12 and is not meeting the required standard.
39 - Appraisal	Met				Performance is at 89% during M12 and is meeting the required standard.
40 - Statutory & Mandatory Training	Met				Performance is maintaining at 91% during M12.

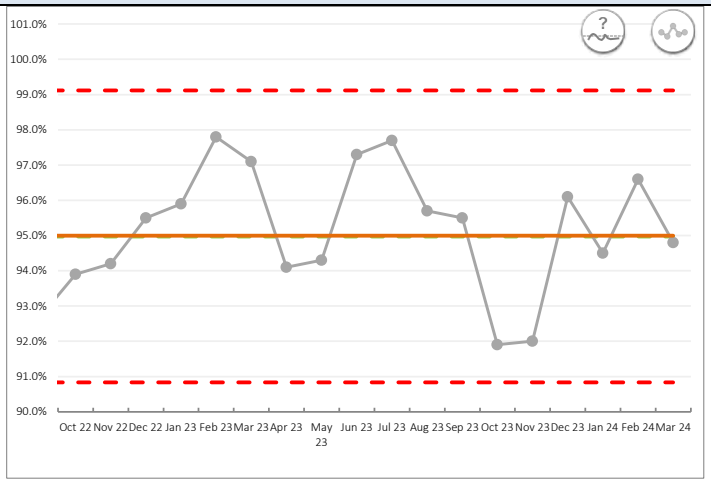
- There are no under 18 admissions to adult wards during M12.
- There are no inappropriate out of area admissions during M12 outside Staffordshire.

Access & Wait Times

Not Met - Referral to Assessment within 4 weeks ↘

A Higher Value Is Better

Actual	94.8%	M12	**Chief Operating Officer**	Responsive
Target:	95.0%	Monthly	Trust Measure	



12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
94.1%	94.3%	97.3%	97.7%	95.7%	95.5%	91.9%	92.0%	96.1%	94.5%	96.6%	94.8%

Trust	Community	Specialist Services	Acute and Urgent Care
✗	✗	✓	✓
94.8%	88.6%	96.8%	97.9%

-- Context --
Trust indicator to ensure that service users referred receive a timely assessment and access to services - based on time between referral and first successful contact for current service users with an incomplete pathway

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 94.8% and is just under the 95% standard during M12.

A PIP is in place for Community directorate;

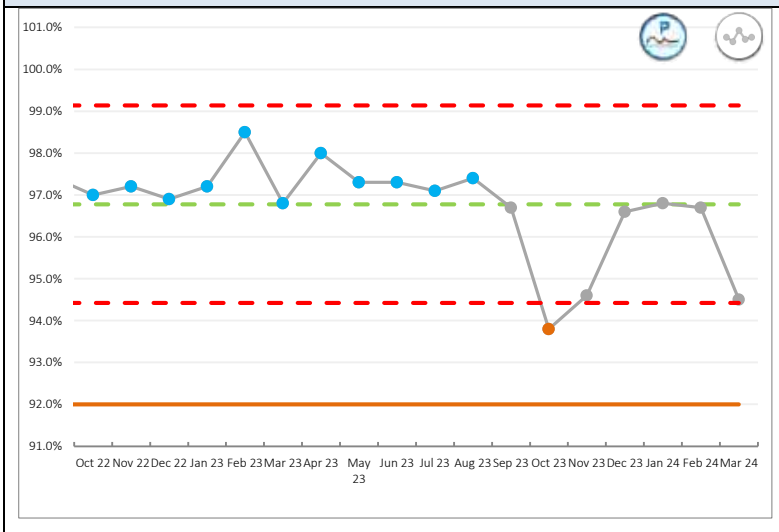
- ***For Adult Community a trajectory has been set for achievement of the standard by April 2024. Performance is not on track in M12 at 89.9%.***
- ***For CYP a trajectory has been set for achievement by May 2024. Performance is significantly below the trajectory and standard in M12 at 7.4%***

1

Met - Referral to Treatment within 18 weeks ↘

A Higher Value Is Better

Actual	94.5%	M12	**Chief Operating Officer**	Responsive
Target:	92.0%	Monthly	Trust Measure	



12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
98.0%	97.3%	97.3%	97.1%	97.4%	96.7%	93.8%	94.6%	96.6%	96.8%	96.7%	94.5%

Trust	Community	Specialist Services	Acute and Urgent Care
✓	✗	✓	✓
94.5%	91.3%	94.1%	97.0%

-- Context --
ICB and Trust measure to ensure that service users referred receive timely treatment - based on time between referral and 2nd successful contact in current service users with an incomplete pathway.

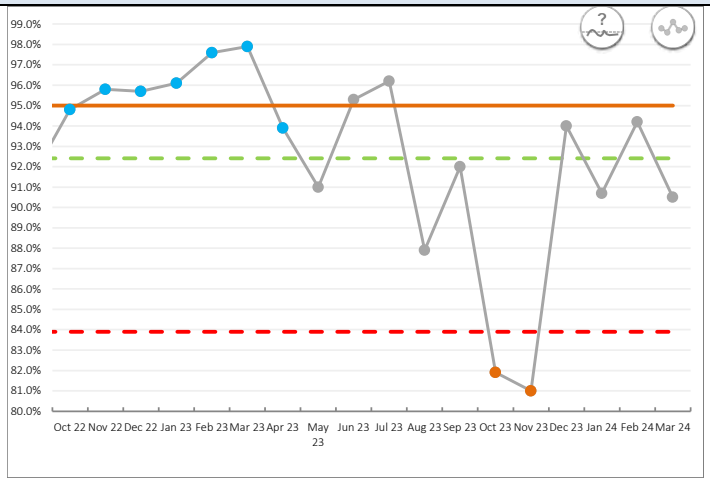
-- Monthly Narrative (Key Issues and Actions) --
Performance is at 94.5% during M12 and is just under the 95% standard during M12.

2

Not Met - CAMHS Compliance within 4 week waits (Referral to Assessment) ↘

A Higher Value Is Better

Actual	90.5%	M12	**Chief Operating Officer** Responsive
Target:	95.0%	Monthly	Trust Measure



-- Context --
Trust measure to ensure that service users referred receive a timely assessment and access to services - based on time between referral and first successful contact for current service users with an incomplete pathway

-- Monthly Narrative (Key Issues and Actions) --
Performance is not meeting the required standard at 90.5% in M12.

A PIP is in place for Community CYP with a trajectory for achievement of the standard by May 2024. Performance is not on track.

12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
93.9%	91.0%	95.3%	96.2%	87.9%	92.0%	81.9%	81.0%	94.0%	90.7%	94.2%	90.5%

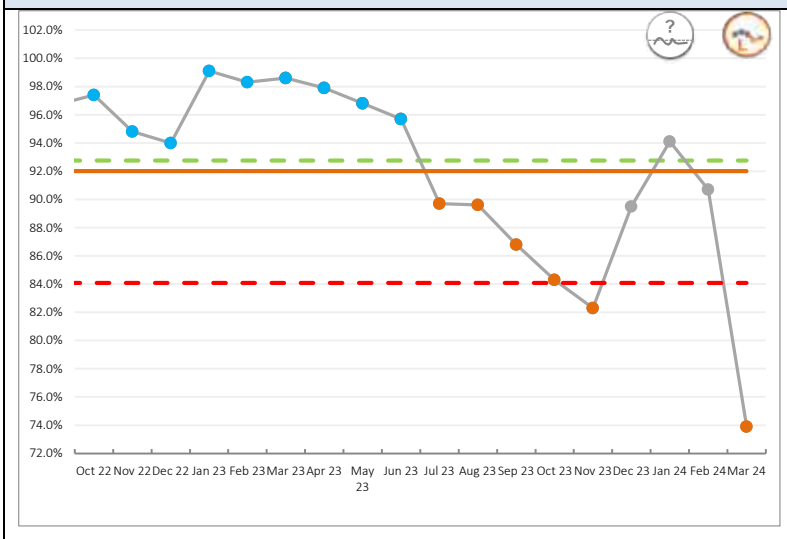
Trust	Community	Specialist Services	Acute and Urgent Care
✖	✖		✓
90.5%	7.4%	#N/A	96.9%

3

Not Met - CAMHS Compliance with 18 week waits (Referral to Treatment) ↘

A Higher Value Is Better

Actual	73.9%	M12	**Chief Operating Officer** Responsive
Target:	92.0%	Monthly	Trust Measure



-- Context --
ICB and Trust indicator to ensure that service users referred receive timely treatment - based on time between referral and second successful contact in current service users with an incomplete pathway.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 73.9% during M12 and is not meeting the required standard. A special cause variation has been triggered for the significant under performance.

82/111 patients who had their second appointments with CAMHS service were seen within 18 weeks.

12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
97.9%	96.8%	95.7%	89.7%	89.6%	86.8%	84.3%	82.3%	89.5%	94.1%	90.7%	73.9%

Trust	Community	Specialist Services	Acute and Urgent Care
✖	✖		✖
73.9%	55.6%	#N/A	86.4%

4

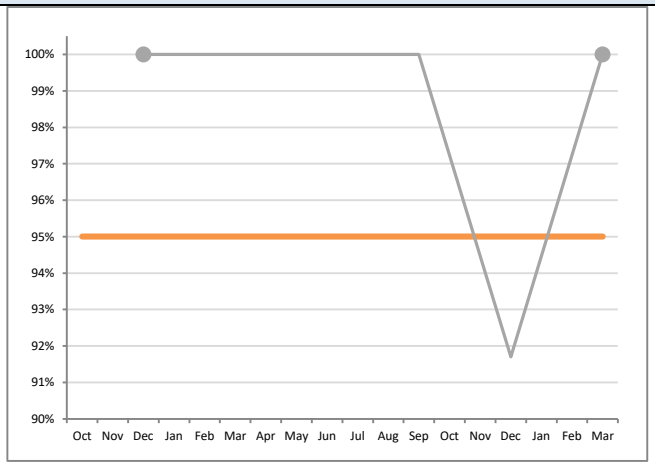
Supporting Data for Community 4 Week Referral to Assessment - Waited (first contact) – CYP Services

Supporting Data for Community 4 Week Referral to Assessment - Waited (first contact) – Adult Services

Adult CMHT services are a main driver for the RTA performance, making up 30.8% of the total directorate RTAs.

The number of RTAs completed in M12 are the fourth highest over the last 13 months, due to demand. We have however, seen an increase in the number of patients waiting for an RTA.

Met - CYP: Eating Disorders - Referral to Assessment (Urgent) 1 Week	Actual 100.0% M12	Chief Operating Officer Responsive
A Higher Value Is Better	Target: 95.0% Quarterly	Trust Measure



12 Month Trend

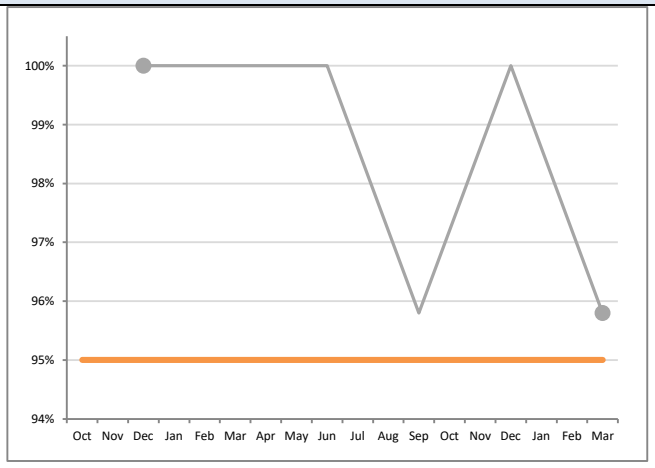
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
		100.0%			100.0%			91.7%			100.0%

Trust
✓
100.0%

-- Context --
National target - 1 week or less from referral to entering a course of treatment under urgent ED cases is considered the benchmark due to the time sensitive nature of the service and the link between clinical outcomes and timeliness of service. Treatment is classed as second successful contact.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 100% during quarter 4.

Met - CYP: Eating Disorders - Referral to Assessment (Routine) 4 Weeks	Actual 95.8% M12	Chief Operating Officer Responsive
A Higher Value Is Better	Target: 95.0% Quarterly	Trust Measure



12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
		100.0%			95.8%			100.0%			95.8%

Trust
✓
95.8%

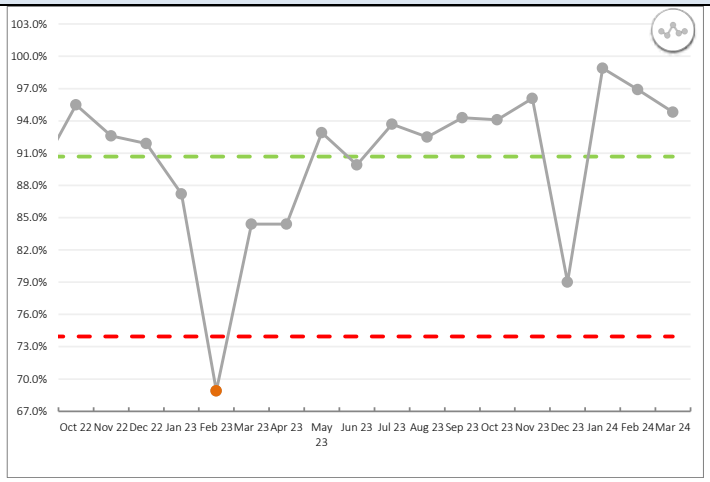
-- Context --
National target - 4 weeks or less from referral to entering a course of treatment under routine ED cases is considered the benchmark due to the time sensitive nature of the service and the link between clinical outcomes and timeliness of service. Treatment is classed as second successful contact.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 95.8% during quarter 4.

Not Met - Access Service Waiting Times: 1 hour ↘

A Higher Value Is Better

Actual	94.8%	M12	**Chief Operating Officer**	Responsive
Target:		Monthly	Trust Measure	



-- Context --
One hour crisis response is for those whose referral is designated as emergency. This metric is a contractual metric in the ICB Contract and not proposed as a national measure for Crisis response standards

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 94.8% during M12.

12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
84.4%	92.9%	89.9%	93.7%	92.5%	94.3%	94.1%	96.1%	79.0%	98.9%	96.9%	94.8%

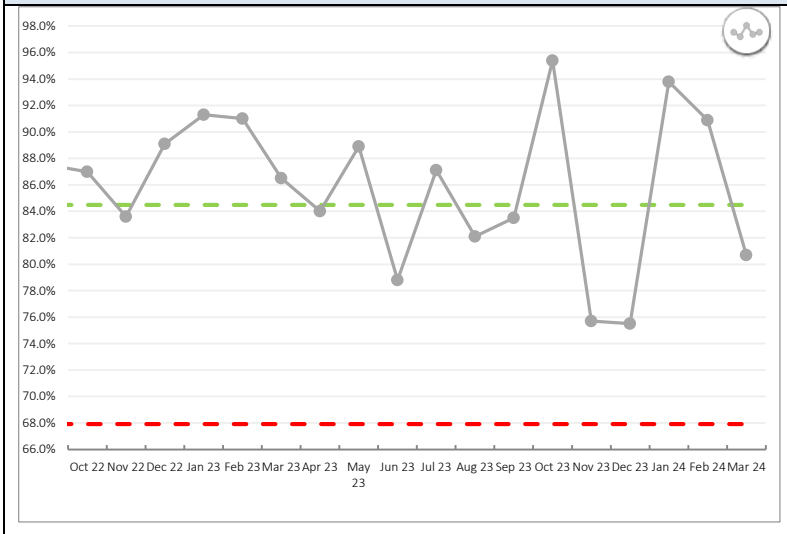
Trust
94.8%

5

Not Met - Access Service Waiting Times: 24 hour ↘

A Higher Value Is Better

Actual	80.7%	M12	**Chief Operating Officer**	Responsive
Target:		Monthly	Trust Measure	



-- Context --
This target aims to ensure that patients requiring urgent care will be seen by community mental health crisis teams within 24 hours of referral. This is shadow reporting in advance of anticipated reporting against a national standard for Crisis Care and conforms to contractual targets

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 80.7% during M12.

12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
84.0%	88.9%	78.8%	87.1%	82.1%	83.5%	95.4%	75.7%	75.5%	93.8%	90.9%	80.7%

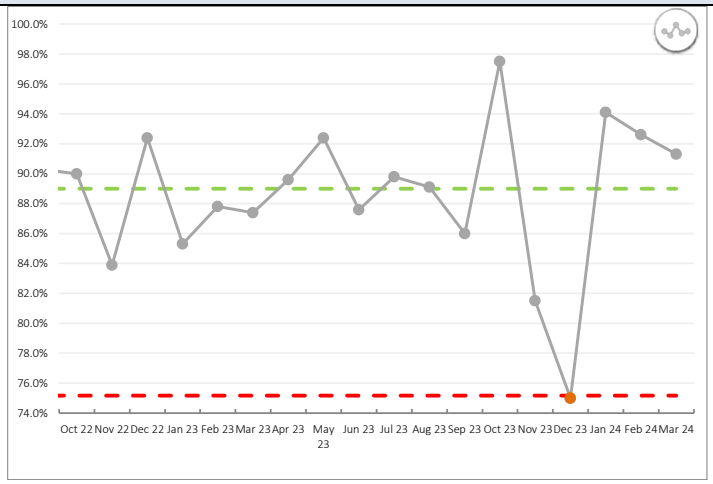
Trust
80.7%

6

Not Met - Access Service Waiting Times: 4 hour ↘

A Higher Value Is Better

Actual	91.3%	M12	**Chief Operating Officer** Responsive
Target:		Monthly	Trust Measure



-- Context --
This standard aims to ensure that those in need of the most urgent support receive help within four hours. This is shadow reporting in advance of anticipated reporting against a national standard for Crisis Care and conforms to contractual targets.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 91.3% during M12.

12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
89.6%	92.4%	87.6%	89.8%	89.1%	86.0%	97.5%	81.5%	75.0%	94.1%	92.6%	91.3%

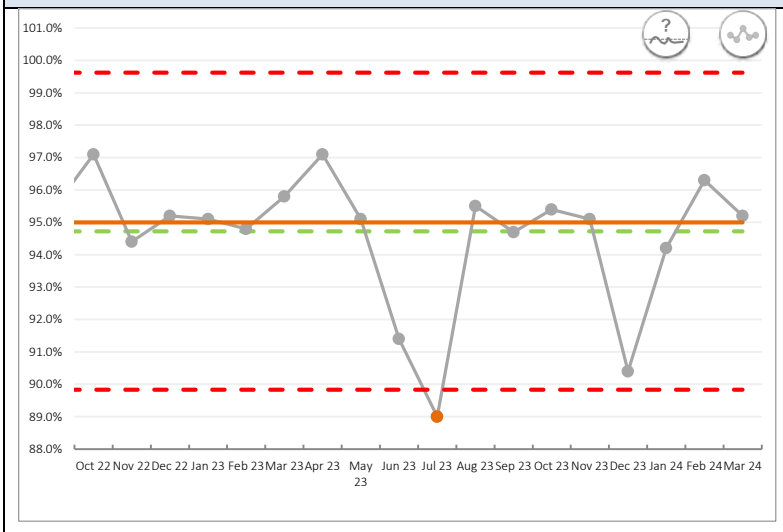
Trust
91.3%

7

Met - MH Liaison 1 Hour Response (Emergency) ↘

A Higher Value Is Better

Actual	95.2%	M12	**Chief Operating Officer** Responsive
Target:	95.0%	Monthly	Trust Measure



-- Context --
ICB measure - Of those who are emergency referrals, the percentage of which where the referral is assessed and care plan in place, transferred, discharged or MHA commenced within 1 hour - emergency is classified as an unexpected, time critical situation that may threaten life, long-term health, or safety of an individual or others.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 95.2% in M12 and is achieving the required standard.

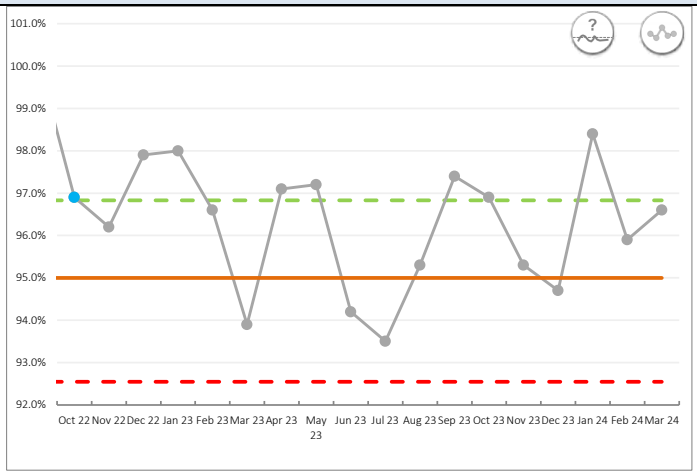
12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
97.1%	95.1%	91.4%	89.0%	95.5%	94.7%	95.4%	95.1%	90.4%	94.2%	96.3%	95.2%

Trust
✓
95.2%

8

Met - MH Liaison 4 Hour Response (Urgent) ↗ A Higher Value Is Better	**Actual** 96.6% M12 **Target:** 95.0% Monthly	**Chief Operating Officer** Trust Measure	Responsive



12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
97.1%	97.2%	94.2%	93.5%	95.3%	97.4%	96.9%	95.3%	94.7%	98.4%	95.9%	96.6%

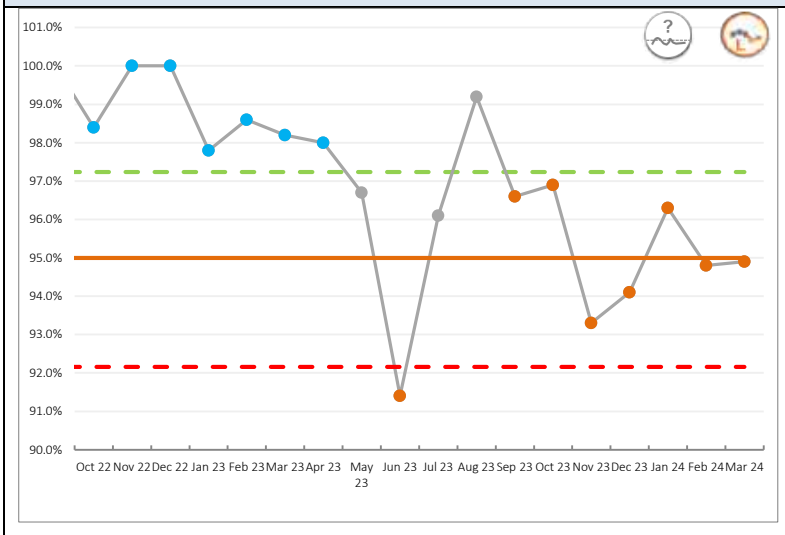
Trust
✓
96.6%

-- Context --
ICB measure - Of those who are urgent referrals, the percentage of which where the referrals is assessed and care plan in place, transferred, discharged or MHA commenced within 4 hours - urgent is classified as when a situation is serious and an individual may need timely attendance but it is not immediately life threatening.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 96.6% and is meeting the required standard.

9

Not Met - MH Liaison 24 Hour Response (Urgent from General Hospital Ward) ↗ A Higher Value Is Better	**Actual** 94.9% M12 **Target:** 95.0% Monthly	**Chief Operating Officer** Trust Measure	Responsive



12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
98.0%	96.7%	91.4%	96.1%	99.2%	96.6%	96.9%	93.3%	94.1%	96.3%	94.8%	94.9%

Trust
✘
94.9%

-- Context --
ICB measure - Of referrals, the percentage of which where the referral is assessed and care plan in place, transferred, discharged or MHA commenced within 24 hours. This target increased from 90% last year (as reported in the PQMF) to 95% in 2019/20.

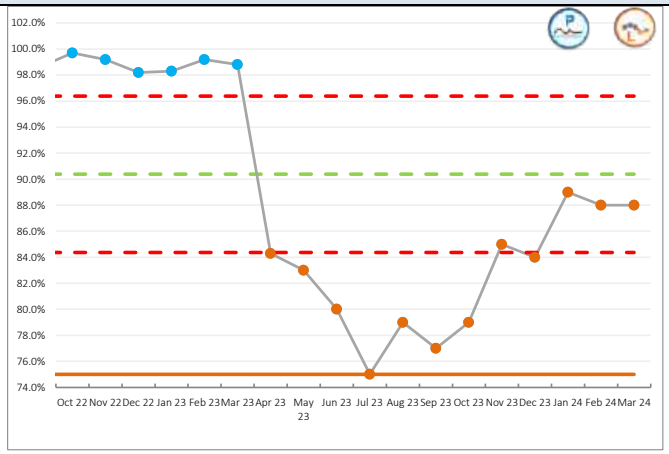
-- Monthly Narrative (Key Issues and Actions) --
Performance is at 94.9% and is under the required standard at M12. A special cause variation remains in place as an average trend of under-performance remains.

10

Met - Talking Therapies for Anxiety and Depression Referral to Treatment (6 weeks) ↔

A Higher Value Is Better

Actual	88.0%	M12	**Chief Nursing Officer**	Safe
Target:	75.0%	Monthly	Trust Measure	



-- Context --
National indicator - 6 weeks or less from referral to entering a course of talking treatment under IAPT - treatment is defined as the2nd successful contact.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 88% in M12 and has continually achieved the 75% standard. A special cause variation remains in place due to the control limits no longer accurately representing performance levels. This will be updated in M1.

12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
84.3%	83.0%	80.0%	75.0%	79.0%	77.0%	79.0%	85.0%	84.0%	89.0%	88.0%	88.0%

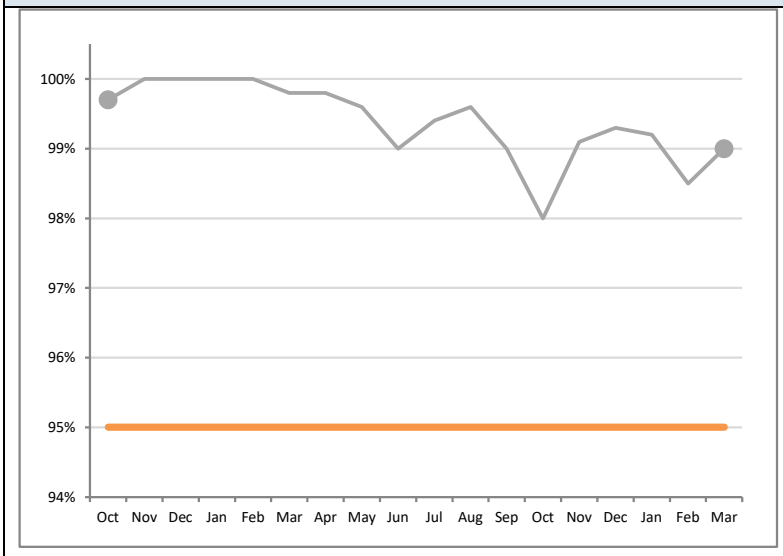
Trust
✓
88.0%

11

Met - Talking Therapies for Anxiety and Depression Referral to Treatment (18 weeks) ↗

A Higher Value Is Better

Actual	99.0%	M12	**Chief Nursing Officer**	Safe
Target:	95.0%	Monthly	Trust Measure	



-- Context --
National indicator - 18 weeks or less from referral to entering a course of talking treatment under IAPT - treatment is defined as the2nd successful contact.

-- Monthly Narrative (Key Issues and Actions) --
Performance is 99% during M12 and is meeting the required 95% standard.

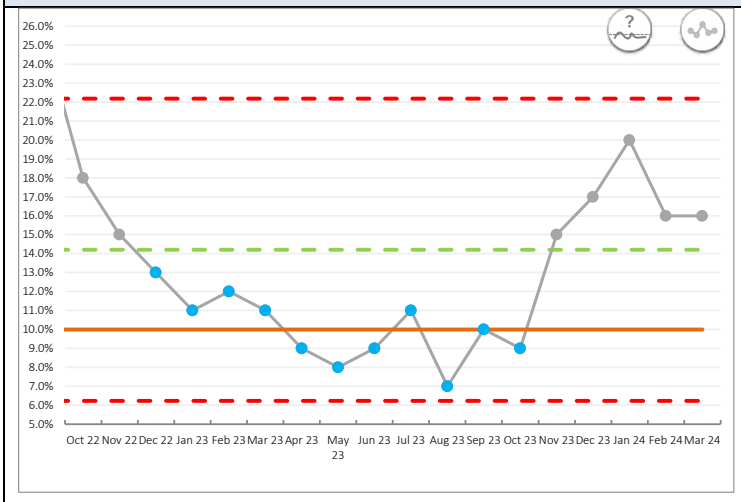
12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
99.8%	99.6%	99.0%	99.4%	99.6%	99.0%	98.0%	99.1%	99.3%	99.2%	98.5%	99.0%

Trust
✓
99.0%

12

Not Met - Talking Therapies for Anxiety and Depression Patients wait no longer than 90 days between 1st and 2nd treatment ↔	**Actual**	16.0%	M12	**Chief Operating Officer** Safe
A Lower Value Is Better	**Target:**	10.0%	Monthly	Trust Measure



12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
9.0%	8.0%	9.0%	11.0%	7.0%	10.0%	9.0%	15.0%	17.0%	20.0%	16.0%	16.0%

Trust
✖
16.0%

-- Context --
National indicator-IAPT services provide support for adults with depression and anxiety disorders that can be managed effectively. Services are delivered using a stepped-care model.

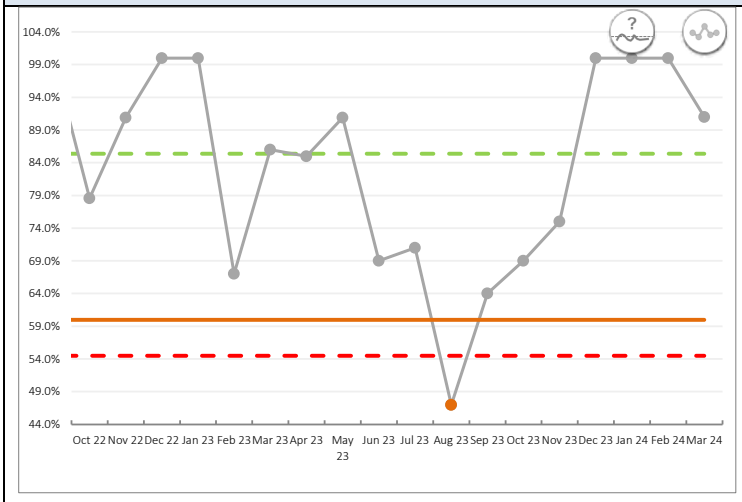
-- Monthly Narrative (Key Issues and Actions) --
Performance is at 16% during M12. The service has workforce pressures that are impacting on this metric.

There have been no Graduate PWP University training places in the October 23 cohort and there are no trainee Post Graduate CBT places allocated by MPFT on the January 24 University course to replace the predicted churn in the service. As it takes a year to train a CBT therapist, there is a predicted further shortfall of staff which will impact on meeting the quality metrics/contract.

In addition, there is also a reduced number of CBT therapists.

13

Met - Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment ↘	**Actual**	#N/A	M12	**Chief Operating Officer** Responsive
A Higher Value Is Better	**Target:**	60.0%	Monthly	Trust Measure



12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
85.0%	90.9%	69.0%	71.0%	47.0%	64.0%	69.0%	75.0%	100.0%	100.0%	100.0%	91.0%

Trust
✓
91.0%

-- Context --
National target - 2 weeks or less from referral to entering a NICE compliant course of treatment under EIP is considered the benchmark due to the time sensitive nature of the service and the link between clinical outcomes and timeliness of service. Treatment is classed as second successful contact.

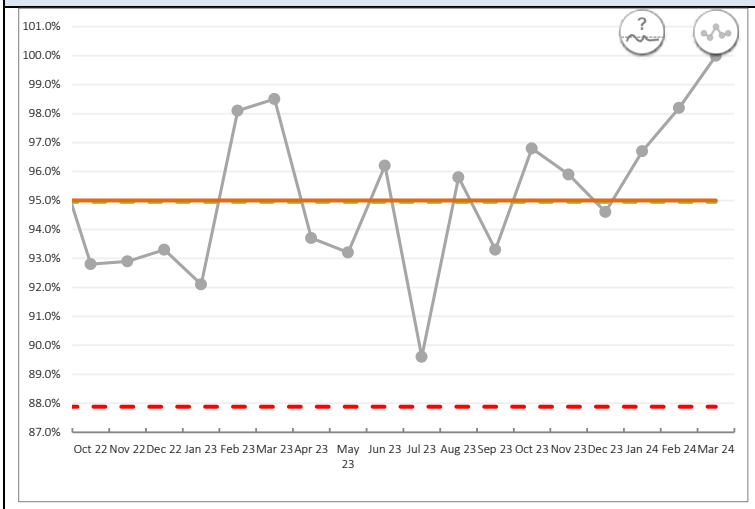
-- Monthly Narrative (Key Issues and Actions) --
Performance is at 91% during M12 and continues to exceed the standard.

14

Met - 48 Hour Follow Up

A Higher Value Is Better

Actual	100.0%	M12	**Chief Medical Officer**		Safe
Target:	95.0%	Monthly	Trust Measure		



-- Context --
This is an important safety measure showing the link between inpatient and community teams, as the immediate period after discharge is a time of significant suicide and self-harm risk.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 100% during M12 and is meeting the standard.

12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
93.7%	93.2%	96.2%	89.6%	95.8%	93.3%	96.8%	95.9%	94.6%	96.7%	98.2%	100.0%

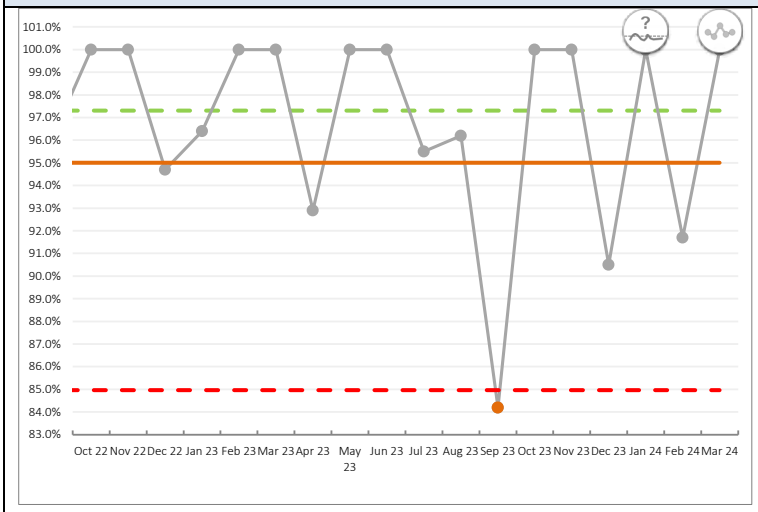
Trust	Community	Specialist Services	Acute and Urgent Care
✓	✓		✓
100.0%	100.0%	#N/A	100.0%

15

Met - Care Programme Approach (CPA) 7 day follow up

A Higher Value Is Better

Actual	100.0%	M12	**Chief Medical Officer**		Safe
Target:	95.0%	Monthly	Trust Measure		



-- Context --
National target - This is an important safety measure, showing the link between inpatient and community teams, as the immediate period after discharge is a time of significant suicide and self-harm risk.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 100% during M12.

12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
92.9%	100.0%	100.0%	95.5%	96.2%	84.2%	100.0%	100.0%	90.5%	100.0%	91.7%	100.0%

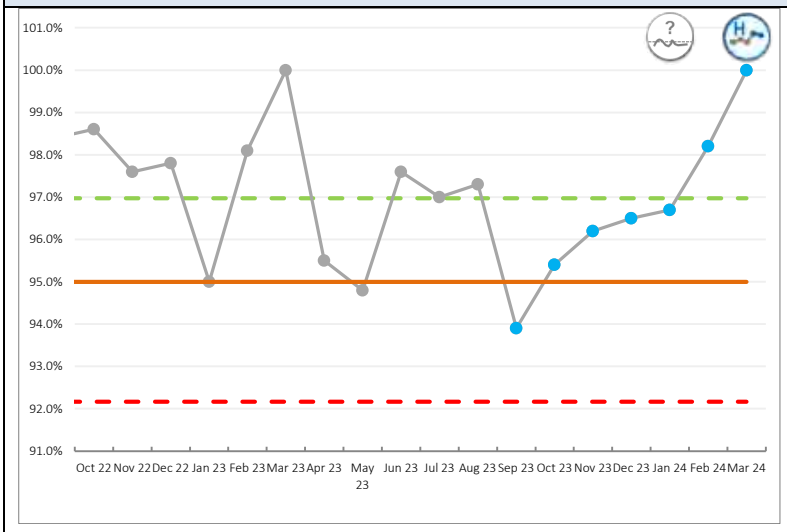
Trust	Community	Specialist Services	Acute and Urgent Care
✓	✓		✓
100.0%	100.0%	#N/A	100.0%

16

Met - 7 Day Follow Up (All Patients) ↗

A Higher Value Is Better

Actual 100.0% M12	**Chief Medical Officer**	Safe
Target: 95.0% Monthly	Trust Measure	



12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
95.5%	94.8%	97.6%	97.0%	97.3%	93.9%	95.4%	96.2%	96.5%	96.7%	98.2%	100.0%

Trust	Community	Specialist Services	Acute and Urgent Care
✓	✓	✓	✓
100.0%	100.0%	100.0%	100.0%

-- Context --
ICB target - This is an important safety measure, showing the link between inpatient and community teams, as the immediate period after discharge is a time of significant suicide and self-harm risk.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 100% during M12 and continuous improvements have been made during the last 7 months. .

17


Inpatient & Quality

Met - Average Length of Stay - Adult ↘

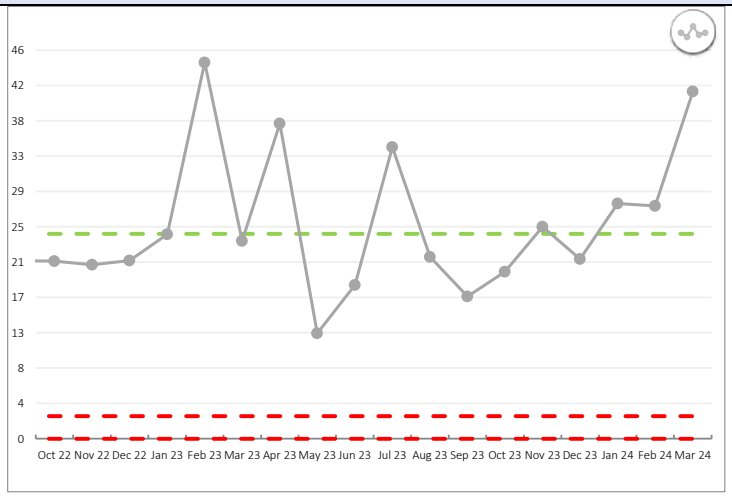
A Lower Value Is Better

Actual 41.10 M12

Target: Monthly

Chief Operating Officer Responsive

Trust Measure



-- Context --

Trust measure- Reducing the length of stay aims to provide patients with a better care experience by ensuring they are discharged from hospital without unnecessary delay

-- Monthly Narrative (Key Issues and Actions) --

The average length of stay for inpatients on an adult ward is 41 days during M12.

12 Month Trend

37	12	18	35	22	17	20	25	21	28	28	41
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

Trust
41.10

18

Met - Average Length of Stay - Older Adult ↘

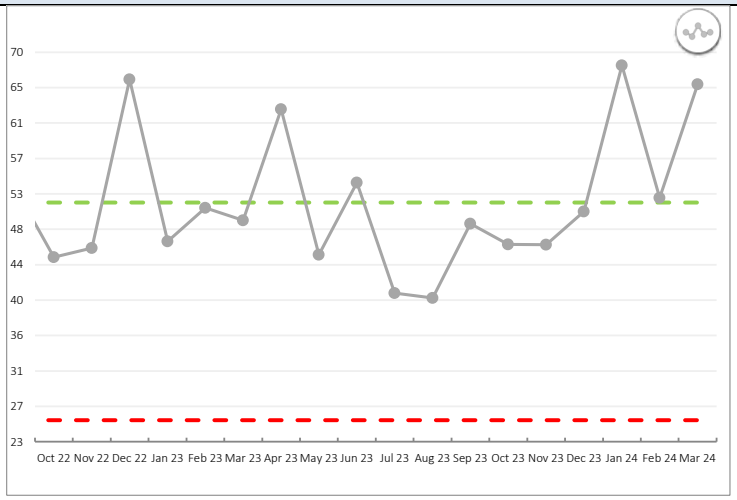
A Lower Value Is Better

Actual 65.80 M12

Target: Monthly

Chief Operating Officer Responsive

Trust Measure



-- Context --

Trust measure - Reducing the length of stay aims to provide patients with a better care experience by ensuring they are discharged from hospital without unnecessary delay

-- Monthly Narrative (Key Issues and Actions) --

The average length of stay of inpatients on an older adult ward is 66 days during M12.

12 Month Trend

63	45	54	41	40	49	47	47	51	68	52	66
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

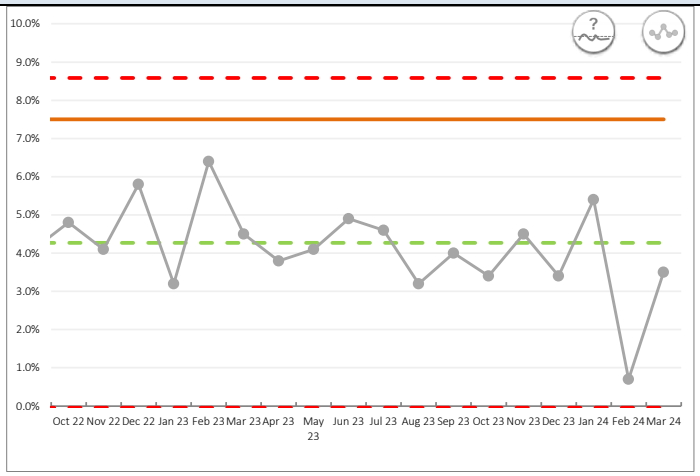
Trust
65.80

19

Met - Emergency Readmissions rate (30 days) ↘

A Lower Value Is Better

Actual	3.5%	M12	**Chief Medical Officer**	Responsive
Target:	7.5%	Monthly	Trust Measure	



-- Context --
To measure the prevalence of emergency readmissions - linked to patient outcomes and use of resources

-- Monthly Narrative (Key Issues and Actions) --
The emergency readmission rate during M12 is 3.5% and remains within the threshold.

12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
3.8%	4.1%	4.9%	4.6%	3.2%	4.0%	3.4%	4.5%	3.4%	5.4%	0.7%	3.5%

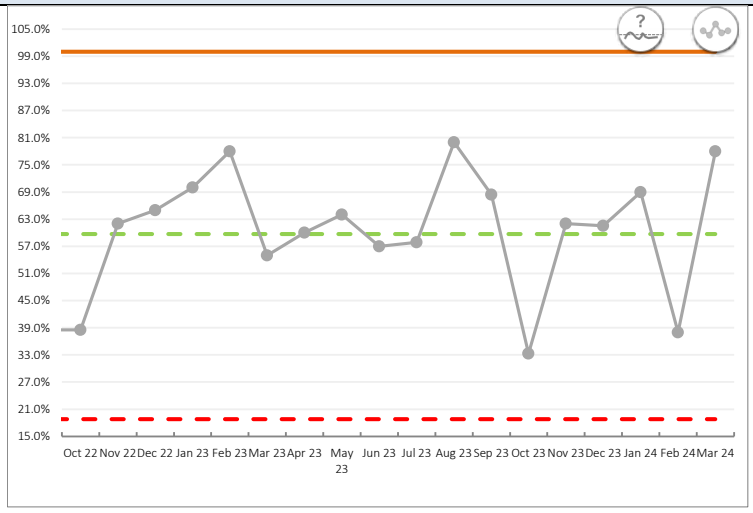
Trust	Specialist Services	Acute and Urgent Care
✓	✓	✓
3.5%	0.0%	3.7%

20

Not Met - Place of Safety assessment carried out within 3 hours (where clinically appropriate) ↗

A Higher Value Is Better

Actual	78.0%	M12	**Chief Medical Officer**	Safe
Target	100.0%	Monthly	Trust Measure	



-- Context --
The recommendation that PoS assessments are carried out within 3 hours is driven by service user experience and clinical outcomes, as well as availability of PoS for other service users.

-- Monthly Narrative (Key Issues and Actions) --
Out of 18 assessments in M12 (15 at Harplands POS, 1 at custody, 2 at RSUH) 5 assessments occurred within the 3 hour target plus 9 which had agreed clinical grounds for delay therefore not to be classed as breaches.

Which leaves 4 assessments which occurred outside of 3 hours with no agreed clinical grounds for delay.

This results in 78% overall compliance.

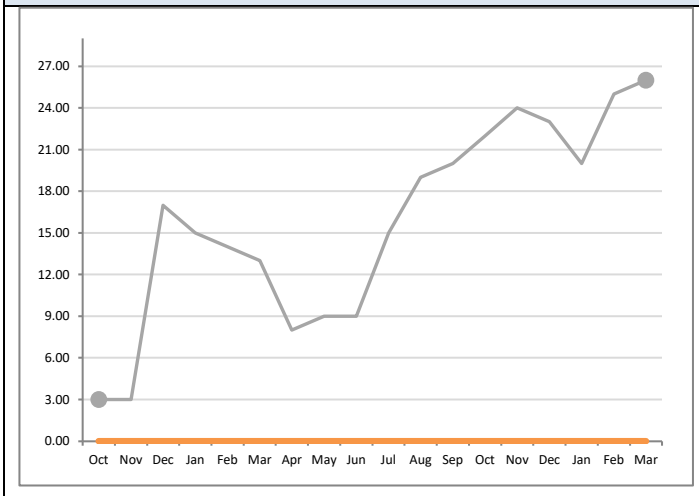
12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
60.0%	64.0%	57.0%	57.9%	80.0%	68.4%	33.3%	62.0%	61.5%	69.0%	38.0%	78.0%

Trust
✘
78.0%

21

Met - Clinically Ready for Discharge (CRFD) ↘	**Actual** 26.00 M12	**Chief Operating Officer** Responsive
A Lower Value Is Better	**Target:** Monthly	Trust Measure



12 Month Trend

8	9	9	15	19	20	22	24	23	20	25	26
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

Trust
26.00

-- Context --
Trust measure - To understand the number of patients who have been declared clinically ready for discharge but remain in inpatient services.

-- Monthly Narrative (Key Issues and Actions) --
During M12 there are 26 patients identified as clinically ready for discharge across inpatient areas.

The main reasons given for discharge delay are shown in the table below:

Ward	Reasons for Delay
WARD 1	Awaiting care coordinator allocation Awaiting care package in own home Awaiting further non-acute (including PCT and mental health) NHS care (including intermediate care, rehabilitation services etc) Awaiting nursing home placement or availability Housing - Awaiting supported accommodation
Ward 2	Awaiting multi-disciplinary care planning meeting/Case conference Awaiting residential home placement or availability Housing - Awaiting supported accommodation Lack of social care support Patient or Family choice - CYP awaiting social care or family placement
Ward 3	Awaiting transfer within the Trust Lack of social care support No Reason for Delay Recorded
Ward 4	Awaiting care package in own home Awaiting nursing home placement or availability Awaiting residential home placement or availability
Ward 5	Awaiting residential home placement or availability
Ward 6	Awaiting nursing home placement or availability
Ward 7	Awaiting care package in own home Awaiting nursing home placement or availability

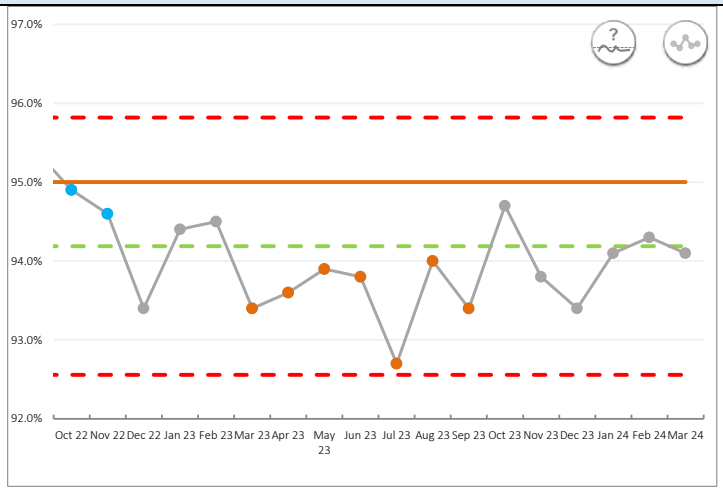
22

Community and Quality

Not Met - Care Plan Compliance ↘

A Higher Value Is Better

Actual	94.1%	M12	**Chief Nursing Officer**	Safe
Target:	95.0%	Monthly	Trust Measure	



-- Context --
Service users are entitled to have a care plan that's regularly reviewed. A care plan sets out what support will be provided day to day and who will provide it. The care plan should include details of what should happen in an emergency or crisis.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 94.1% during M12 and is not meeting the required standard.

A PIP is in place for Community directorate, with a trajectory for the standard to be achieved by November 2023. Performance is below standard at 94%. The PIP has now expired, has been reissued and will be reported in M1.

12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
93.6%	93.9%	93.8%	92.7%	94.0%	93.4%	94.7%	93.8%	93.4%	94.1%	94.3%	94.1%

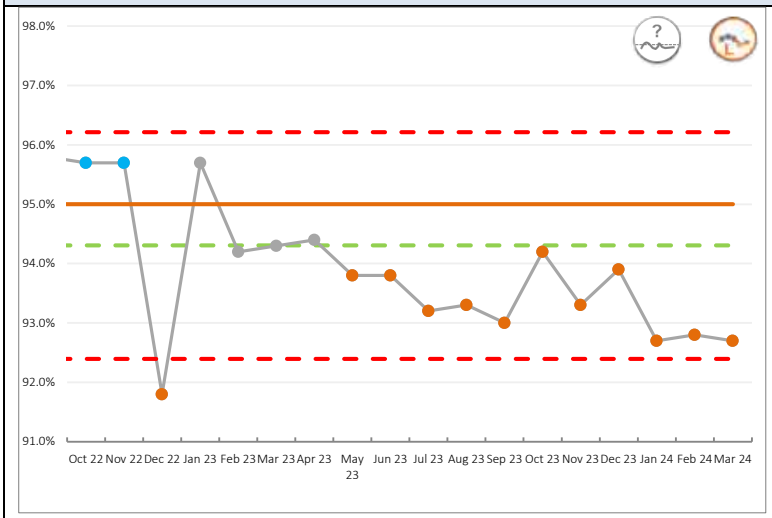
Trust	Community	Specialist Services	Acute and Urgent Care
✗	✗	✗	✗
94.1%	94.0%	94.6%	91.8%

23

Not Met - Risk Assessment Compliance ↘

A Higher Value Is Better

Actual	92.7%	M12	**Chief Nursing Officer**	Safe
Target:	95.0%	Monthly	Trust Measure	



-- Context --
To measure availability of risk assessments for all service users - patients who have been accepted into service and had a first contact are expected to have a risk assessment (exception is Memory Clinic where it is expected after second appointment) - intended to minimise harm to service users and others.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 92.7% during M12 and is below the required standard. A special cause variation remains in place.

A PIP is in place for Community Directorate, with a trajectory for the standard to be achieved by November 2023. Performance is at 92.5%. The PIP has now expired.

For Specialist Services a trajectory for the standard to have been achieved by December 2023. Performance is at 93.3%. The PIP has now expired, has been reissued and will be reported in M1.

12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
94.4%	93.8%	93.8%	93.2%	93.3%	93.0%	94.2%	93.3%	93.9%	92.7%	92.8%	92.7%

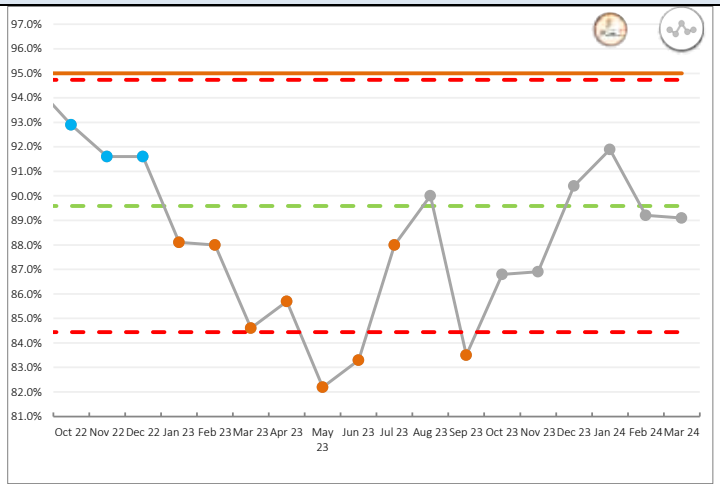
Trust	Community	Specialist Services	Acute and Urgent Care
✗	✗	✗	✓
92.7%	92.5%	93.3%	95.9%

24

Not Met - CPA 12 Month Review Compliance ↘

A Higher Value Is Better

Actual	89.1%	M12	**Chief Nursing Officer** Safe
Target:	95.0%	Monthly	Trust Measure



-- Context --
National indicator - There is a requirement for all services users on a CPA pathway to receive a review of their care plan as a minimum within 12 months of the care plan being agreed.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 89.1% during M12. 277/311 patients on CPA have had a review within 12 months which remains below the required standard.

The numbers of patients in the count on CPA are relatively low so small changes can impact the performance percentage more dramatically. The teams that show the lowest performance are Newcastle CMHT (13/25 – 52%), NAOP City CMHT (1/2-50%), NOAP County CMHT (1/2-50%), North Stoke CAMHS (1/3-33.3%).

A PIP is in place for Community Services with a trajectory for the standard to be achieved by May 2024. Performance is at 87.6%.

12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
85.7%	82.2%	83.3%	88.0%	90.0%	83.5%	86.8%	86.9%	90.4%	91.9%	89.2%	89.1%

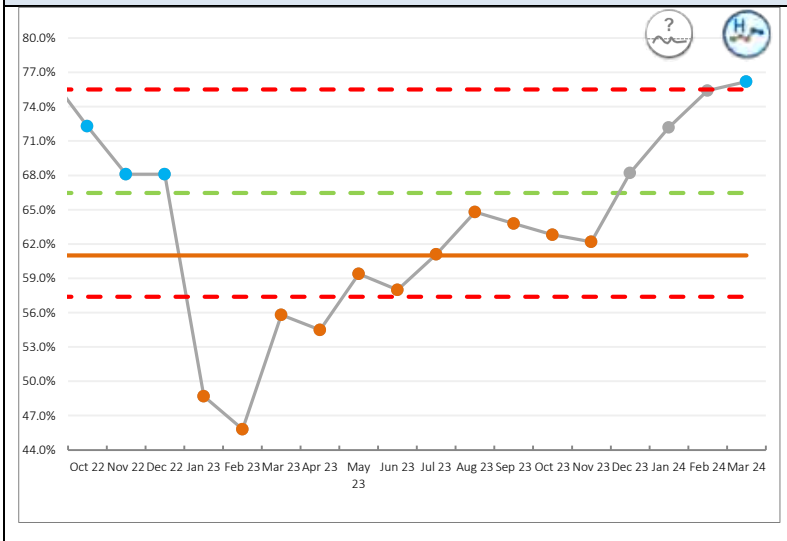
Trust	Community	Specialist Services	Acute and Urgent Care
✗	✗	✓	
89.1%	87.6%	95.1%	#N/A

25

Met - Service Users on CPA in settled accommodation ↗

A Higher Value Is Better

Actual	76.2%	M12	**Chief Nursing Officer** Safe
Target:	61.0%	Monthly	Trust Measure



-- Context --
National indicator - This overall indicator measures the proportion of adults in contact with secondary mental health services who have been recorded as being in settled accommodation the last 12 months - stable housing is critical for recovery and maintained health.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 76.2% during M12 and continues to exceed the required standard for over 8 months. It is recommended that the control limits be rebased as there has been a trend of continual improvement. This will take place in M1.

12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
54.5%	59.4%	58.0%	61.1%	64.8%	63.8%	62.8%	62.2%	68.2%	72.2%	75.4%	76.2%

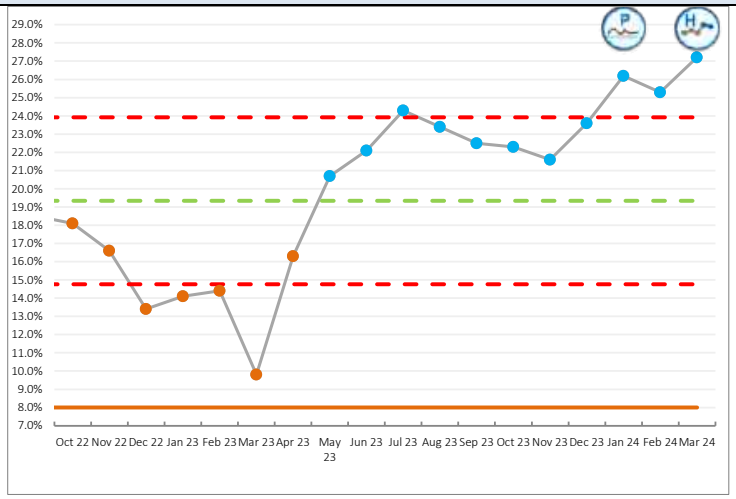
Trust	Community	Specialist Services	Acute and Urgent Care
✓	✓	✓	✓
76.2%	76.6%	72.3%	100.0%

26

Met - Service Users on CPA in Employment

A Higher Value Is Better

Actual	27.2%	M12	**Chief Nursing Officer**	Safe
Target:	8.0%	Monthly	Trust Measure	



-- Context --
National indicator - This overall indicator measures the proportion of adults in contact with secondary mental health services who are in paid employment (as of the last 12 months) - employment outcomes are a predictor of quality of life and are indicative of whether care and support is personalised.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 27.2% during M12 and continues to exceed the required standard. It is recommended that the control limits be rebased as there has been a trend of continual improvement. This will take place in M1.

12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16.3%	20.7%	22.1%	24.3%	23.4%	22.5%	22.3%	21.6%	23.6%	26.2%	25.3%	27.2%

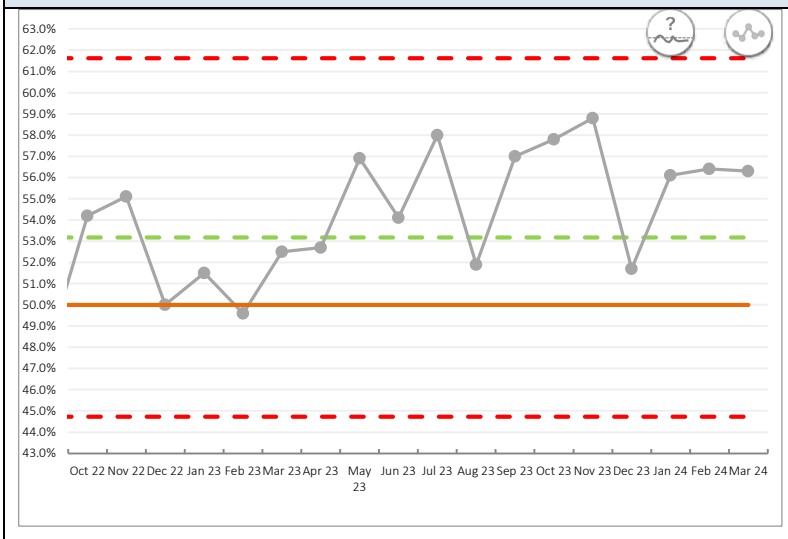
Trust	Community	Specialist Services	Acute and Urgent Care
✓	✓	✓	
27.2%	28.1%	8.0%	#N/A

27

Met - Talking Therapies for Anxiety and Depression Recovery

A Higher Value Is Better

Actual	56.3%	M12	**Chief Nursing Officer**	Safe
Target:	50.0%	Monthly	Trust Measure	



-- Context --
National indicator - This indicator shows how many people have shown a real movement in symptoms large enough to warrant the judgement that the person has recovered, moving from above the clinical threshold to below.

-- Monthly Narrative (Key Issues and Actions) --
Performance remains consistent at 56.3% during M12 above the 50% standard.

12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
52.7%	56.9%	54.1%	58.0%	51.9%	57.0%	57.8%	58.8%	51.7%	56.1%	56.4%	56.3%

Trust
✓
56.3%

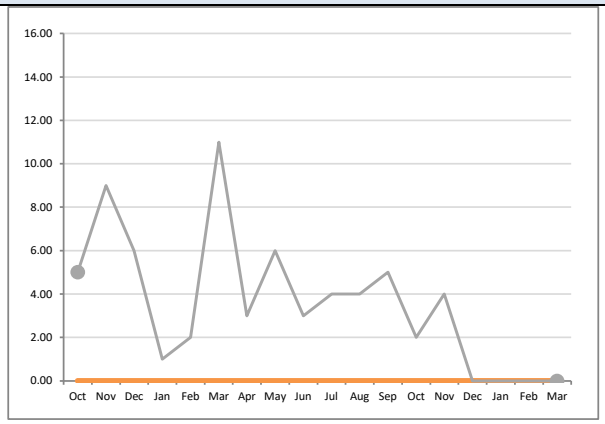
28

Organisational Health and Workforce

Met - Serious Incidents ↔

A Lower Value Is Better

Actual	0.00	M12	**Chief Medical Officer**		Safe
Target:		Monthly	Trust Measure		



-- Context --
Responding appropriately when things go wrong in healthcare is a key part of the way that the NHS can continually improve the safety of the services we provide to our patients.

-- Monthly Narrative (Key Issues and Actions) --
There are no serious incidents reported during M12

12 Month Trend

3	6	3	4	4	5	2	4	0	0	0	0
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

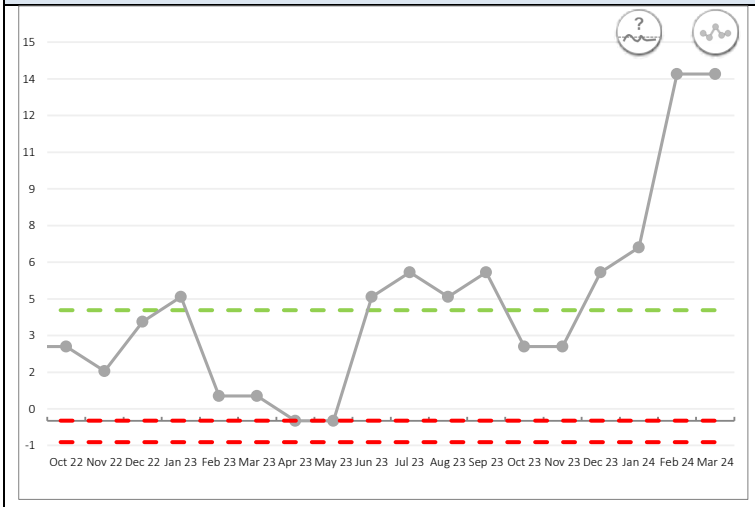
Trust	Community	Specialist Services	Acute and Urgent Care	Primary Care
0.00	0.00	0.00	0.00	0.00

29

Not Met - Complaints Open Beyond Agreed Timescale ↔

A Lower Value Is Better

Actual	14.00	M12	**Chief Nursing Officer**		Caring
Target:	0.00	Monthly	Trust Measure		



-- Context --
All formal complaints will receive a response detailing the outcome of investigation within 40 working days or, where an alternative timescale has been agreed with the complainant.

-- Monthly Narrative (Key Issues and Actions) --
There were 14 complaints outside of the 40 working day deadline. 10 were in the final stages of Executive review and sign off and 4 were still under investigation.

12 Month Trend

0	0	5	6	5	6	3	3	6	7	14	14
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

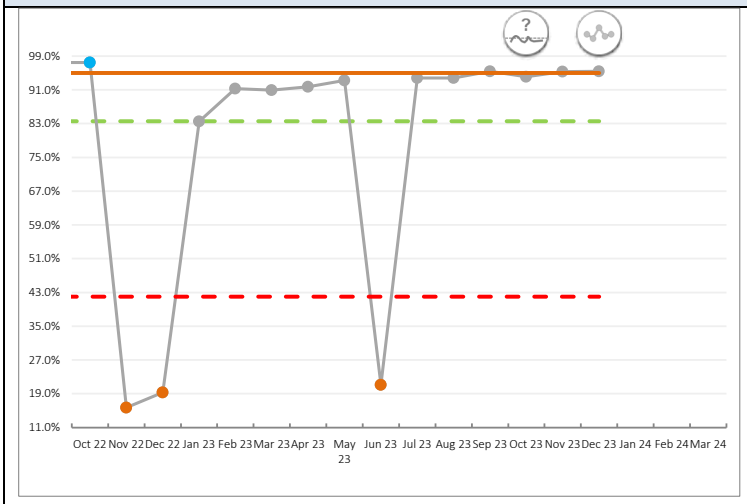
Trust
✖
14.00

30

- Data Quality Maturity Index (DQMI)

A Higher Value Is Better

Actual	#N/A	M12	**Chief Finance Officer**		Caring
Target:	95.0%	Monthly	Trust Measure		



-- Context --
National indicator - The DQMI supports commissioners by demonstrating the quality of providers' submissions and identifying areas for improvement. A provider's DQMI score is based upon several measures of data quality including coverage, completeness, validity, and default values.

-- Monthly Narrative (Key Issues and Actions) --
The latest available (Dec) DQMI score is meeting the standard and is at 95.4%. National Average MHSDS DQMI score is 75.1%.

12 Month Trend

91.7%	93.2%	21.1%	93.8%	93.8%	95.4%	94.1%	95.3%	95.4%			
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

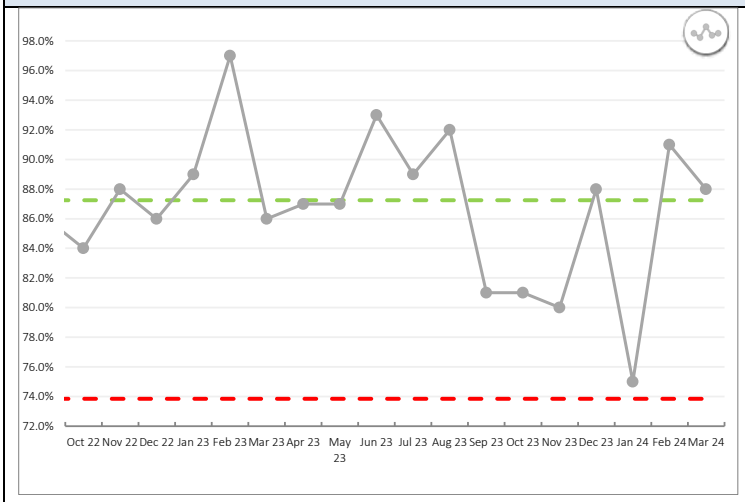
Trust
#N/A

31

Not Met - Friends and Family Test - Recommended ↘

A Higher Value Is Better

Actual	88.0%	M12	**Chief Nursing Officer**		Caring
Target:		Monthly	Trust Measure		



-- Context --
National indicator - This measure is a proxy for patient experience, and measures where the services user would recommend the Trust to others.

-- Monthly Narrative (Key Issues and Actions) --
There have been 186 FFT returns received in M12. 88% (164) of FFT returns rated the Trust as good, 5% (9) rated the Trust as poor and 7% (13) were undecided.

The Trust has deployed a digital solution to help to support an increase in patient engagement with the friends and family test. Actions are being taken, including a poster campaign and direct text links to the survey to improve engagement and the piloting of electronic FFT via tablets in the Crisis Care Centre and CMHT Bases. A QR code to link directly to FFT has now been included as part of the discharge letter template in Lorenzo.

12 Month Trend

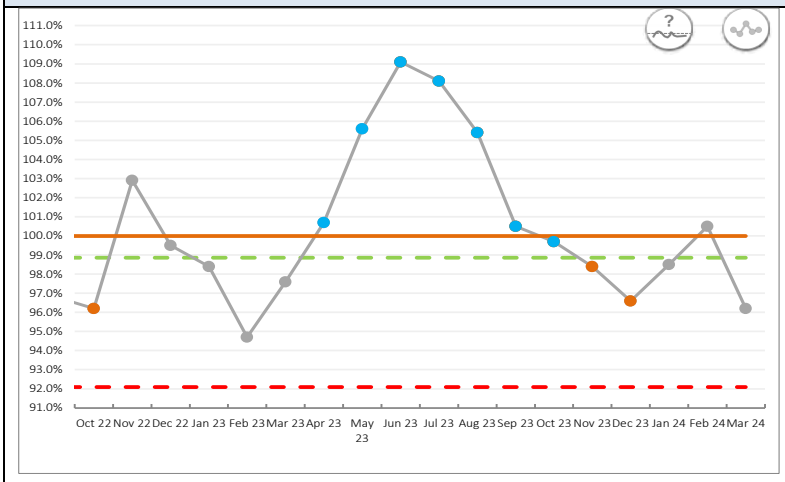
87.0%	87.0%	93.0%	89.0%	92.0%	81.0%	81.0%	80.0%	88.0%	75.0%	91.0%	88.0%
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

Trust	Community	Specialist Services	Acute and Urgent Care	Primary Care
88.0%	94.0%	89.0%	96.0%	83.0%

32

Not Met- Safe Staffing ↘

Actual	#N/A	M12	**Chief Nursing Officer**	Responsive
Target:	100.0%	Monthly	Trust Measure	



-- Context --
National measure (Trust target) - This measures the total planned hours divided by the actual hours.

-- Monthly Narrative (Key Issues and Actions) --

During March 2024, an overall fill rate of 96.2% was achieved; this is a decrease from 100.5% in February 2024.

Recruitment to vacancies is challenging, graduate nurses continue to fill a majority of RN vacancies, highlighting a need for robust supervisory support which is being addressed with additional improvements being made to the preceptorship programme.

12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
100.7%	105.6%	109.1%	108.1%	105.4%	100.5%	99.7%	98.4%	96.6%	98.5%	100.5%	96.2%

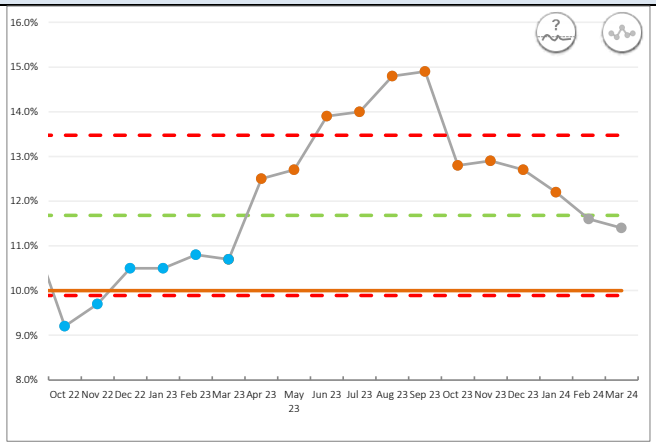
Trust
✘
96.2%

33

Not Met - Vacancy Rate ↗

A Lower Value Is Better

Actual	11.4%	M12	**Chief People Officer**	Organisational Health
Target:	10.0%	Monthly	Trust Measure	



-- Context --
Trust measure - High vacancy rates has an impact on care quality and the finances within the trust due to reliance on bank and locum staff.

-- Monthly Narrative (Key Issues and Actions) --
The vacancy rate remains consistently high at 11.4% during M12 and is exceeding the standard. This is within the normal control limit range for our Trust.

Vacancy rate has decreased by 0.3% compared with the prior month, which is due to decrease in vacancies across all clinical directorates. Corporate vacancies has increased by 3.3%.

Specialist / Community / Primary Care Directorates	Teams with highest vacancy rates	WTE Vacancies	WTE %
SPECIALIST SERVICES	THE DARWIN CENTRE	16.58	**27%**
COMMUNITY	SUTHERLAND - RESOURCE CENTRE	11.45	**28%**
COMMUNITY	NEWCASTLE CMHT ADULT	7.38	**18%**
COMMUNITY	GREENFIELDS - RESOURCE CENTRE	7.12	**15%**
PRIMARY CARE DIRECTORATE	IAPT	11.8	**31%**

12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
12.5%	12.7%	13.9%	14.0%	14.8%	14.9%	12.8%	12.9%	12.7%	12.2%	11.6%	11.4%

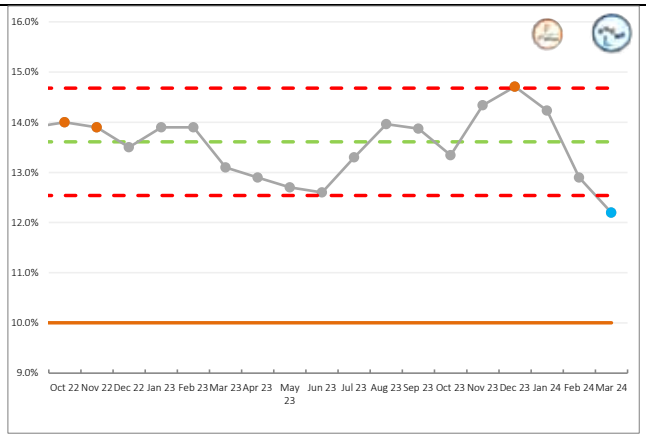
Trust	Community	Specialist Services	Acute and Urgen Care	Primary Care	Corporate
✘	✘	✘	✘	✘	✓
11.4%	12.5%	15.3%	10.9%	10.4%	6.0%

34

Not Met - Staff Turnover ↗

A Lower Value Is Better

Actual	12.2%	M12	**Chief People Officer**	Organisational Health
Target:	10.0%	Monthly	Trust Measure	



12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
12.9%	12.7%	12.6%	13.3%	14.0%	13.9%	13.3%	14.3%	14.7%	14.2%	12.9%	12.2%

Trust	Community	Specialist Services	Acute and Urgen Care	Primary Care	Corporate
✖	✖	✖	✖	✖	✖
12.2%	10.5%	13.5%	13.6%	12.3%	11.8%

-- Context --
Trust measure - High turnover represents an unstable workforce with high costs associated with turnover - retention represents a more stable organisation that is a positive place to work and provides continuity of care to service users.

-- Monthly Narrative (Key Issues and Actions) --
The Trust moved to reporting mitigated staff turnover from M6, to exclude rotational trainees and TUPE transfers. Performance is consistently above the 10% threshold at 12.2% in M12 but is improving. It continues to remain challenging for all directorates although is in line with the increase in nationally reported turnover.

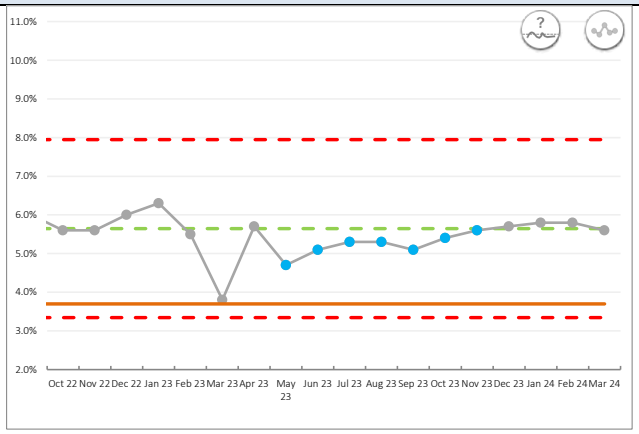
The top three reported reasons for leaving the Trust include: work life balance, promotion and retirement. Work remains ongoing to stabilise the turnover position as part of the Trust's People Plan and retention work streams which includes a focus on talent management, flexible retirement and flexible working.

35

Not Met - Agency Spend ↗

A Lower Value Is Better

Actual	5.6%	M12	**Chief Operating Officer**	Organisational Health
Target:	3.7%	Monthly	Trust Measure	



12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
5.7%	4.7%	5.1%	5.3%	5.3%	5.1%	5.4%	5.6%	5.7%	5.8%	5.8%	5.6%

Trust
✖
5.6%

-- Context --
National measure - The agency ceiling is set as part of the Trust Financial Plan and reported to NHSI.

-- Monthly Narrative (Key Issues and Actions) --
Agency spend remains at 5.6% in M12 and the less than 3.5% target remains consistently challenging.

Agency spend in Mar-24 totalled £507k, of which £277k is medical, £221k nursing and £9k non clinical. Of the £277k medical agency costs, £186k relates to Community, £67k Specialist & £24k Primary Care. Of the £221k nursing agency spend, £168k relates to Specialist, £45k ASUC & £7k Primary care.

PIPs have been issued to all Directorates in M12 for reporting in M1 2024/25.

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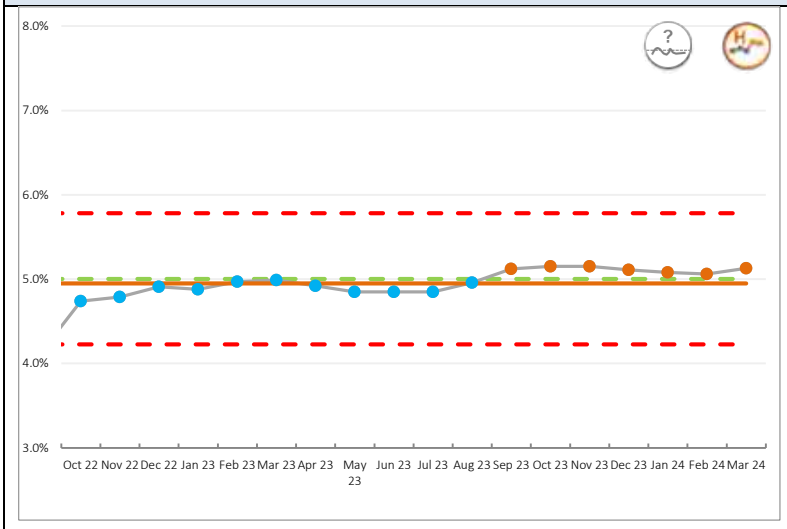
Not Met - Sickness Absence ↘

A Lower Value Is Better

Actual 5.13%	M12	**Chief People Officer** Organisational Health
Target: 4.95%	Monthly	Trust Measure



-- Context --
12 Month Rolling - Trust measure - Sickness absence represents a strain on the organisation that should be minimised to allow for efficient use of resources and less strain on other members of staff.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 5.13% at M12 and is not meeting the required standard with the exception of Community and Corporate directorates.

12 Month Trend

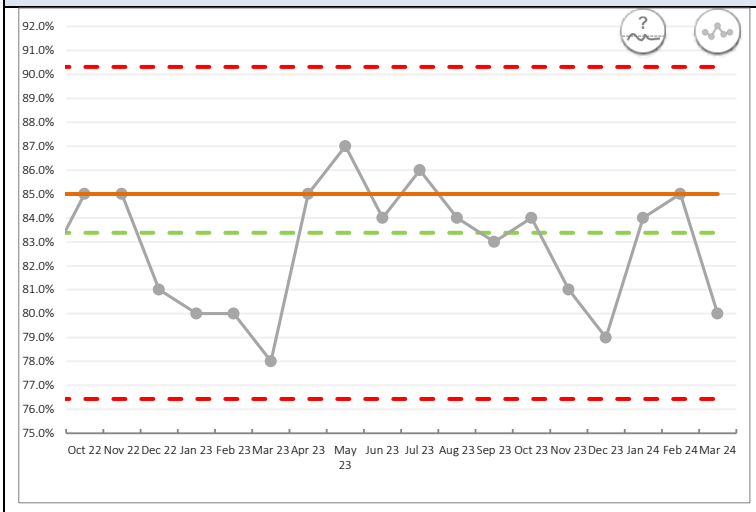
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
4.92%	4.85%	4.85%	4.85%	4.96%	5.12%	5.15%	5.15%	5.11%	5.08%	5.06%	5.13%

Trust	Community	Specialist Services	Acute and Urgen Care	Primary Care	Corporate
✖	✓	✖	✖	✖	✓
5.13%	4.16%	5.99%	7.10%	5.45%	2.80%

Not Met - Clinical Supervision ↘

A Higher Value Is Better

Actual 80.0%	M12	**Chief People Officer** Organisational Health
Target: 85.0%	Monthly	Trust Measure



-- Context --
Clinical Supervision is key to the delivery of quality patient care.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 80% during M12 and is not meeting the required standard.

All Associate Directors receive details regarding their Directorate position, identifying those who are non-compliant for them to take appropriate action to remedy.

All Directorate teams receive the fortnightly clinical supervision report identifying percentage compliance rates and individuals who are non-compliant to support action going forward.

Individual managers in Corporate directorate have been contacted directly for resolution.

Corporate figures have been updated due to an error on initial report submission.

12 Month Trend

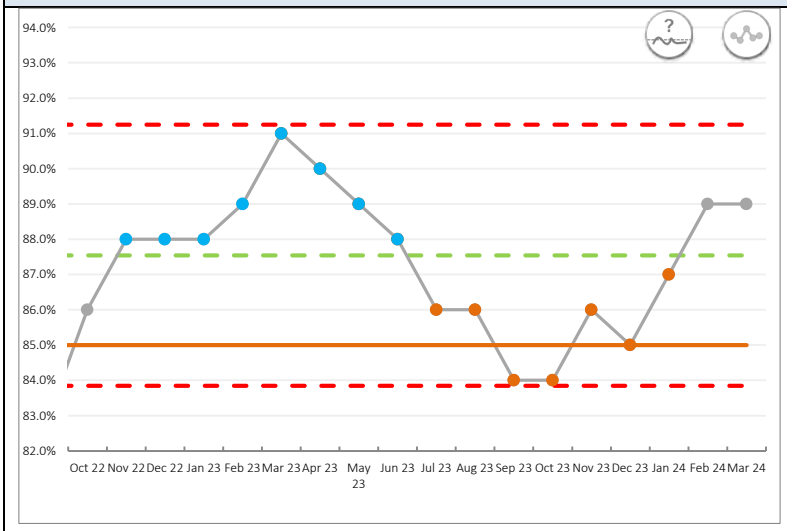
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
85.0%	87.0%	84.0%	86.0%	84.0%	83.0%	84.0%	81.0%	79.0%	84.0%	85.0%	80.0%

Trust	Community	Specialist Services	Acute and Urgent Care	Primary Care	Corporate
✖	✖	✓	✖	✓	✓
80.0%	76.0%	86.0%	77.0%	86.0%	100.0%

Met - Appraisal ↔

A Higher Value Is Better

Actual	89.0%	M12	**Chief People Officer**	Organisational Health
Target:	85.0%	Monthly	Trust Measure	



-- Context --
Trust measure - Appraisals and PDR's have been linked to staff performance and patient outcomes, as well as linking to staff turnover by reflecting a supportive environment that helps staff to develop.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 89% during M12.

Regular reminders are sent to managers/staff 30 days prior to compliance due to expire, with the window to complete the appraisal open for a further 60 days, giving managers 90 days to complete with the appraise. All Directorate senior teams receive the fortnightly appraisal report identifying percentage compliance rates and individuals who are non-compliant to support action going forward.

12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
90.0%	89.0%	88.0%	86.0%	86.0%	84.0%	84.0%	86.0%	85.0%	87.0%	89.0%	89.0%

Trust	Community	Specialist Services	Acute and Urgen Care	Primary Care	Corporate
✓	✓	✓	✘	✓	✘
89.0%	93.0%	90.0%	84.0%	94.0%	83.0%

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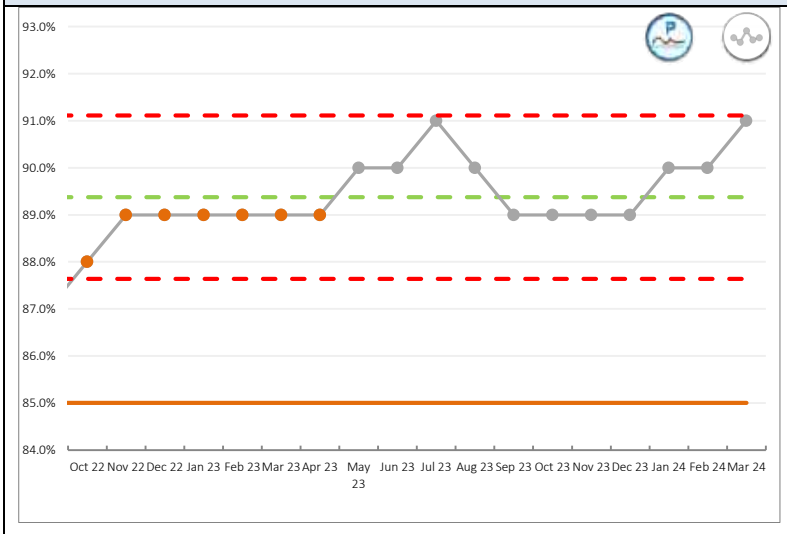
Met - Statutory & Mandatory Training ↗

A Higher Value Is Better

Actual	91.0%	M12	**Chief People Officer**	Organisational Health
Target:	85.0%	Monthly	Trust Measure	



-- Context --
Trust measure - Statutory and mandatory training is determined essential to the safe and efficient delivery of services, therefore completion links directly to care quality and efficiency.

-- Monthly Narrative (Key Issues and Actions) --
Performance remains at 91% during M12 with all directorates achieving the required standard.

Statutory training compliances continue to improve. Face to face sessions have increased for all required subjects due to the opening of a second training venue in January. Face to face training is now delivered in Ashtenne 22 & 23. The second venue is specifically to deliver: Safety Intervention, Conflict Resolution and In Hospital Resuscitation, enabling increased capacity for all face to face subjects.

12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
89.0%	90.0%	90.0%	91.0%	90.0%	89.0%	89.0%	89.0%	89.0%	90.0%	90.0%	91.0%

Trust	Community	Specialist Services	Acute and Urgen Care	Primary Care	Corporate
✓	✓	✓	✓	✓	✓
91.0%	92.0%	91.0%	92.0%	92.0%	87.0%

40

Appendix 1

Long Term Plan and National Mental Health Priorities: Performance against Operational Planning Forecasts 2023/2024

		Out of Area Bed days		Average	Qtr 1	Qtr 2	Qtr 3	Qtr 4
3	Count	Number of inappropriate OAP bed days for adults by quarter that are either 'internal' or 'external' to the sending provider	*Forecast*	0	0	0	0	0
	Count		*Actual*	0	0	0	0	0

		Dementia Diagnosis		Average	Qtr 1	Qtr 2	Qtr 3	Qtr 4
5	Numerator	Number of people aged 65 or over diagnosed with dementia	*Forecast*	14,903	14,740	14,909	15,060	14,903
	Denominator	Estimated prevalence of dementia based on GP registered populations		19,676	19,656	19,703	19,669	19,676
	Rate	%		76%	75%	76%	77%	76%
	Numerator	Number of people aged 65 or over diagnosed with dementia	*Actual*	15,870	15,498	15,951	16,162	
	Denominator	Estimated prevalence of dementia based on GP registered populations		19,850	19,713	19,871	19,966	
	Rate	%		80%	79%	80%	81%	

*Data not yet published

		Perinatal access		Average	Qtr 1	Qtr 2	Qtr 3	Qtr 4
9	Count	Number for women accessing specialist community PMH and MMHS services in the reporting period	*Forecast*	308	123	246	369	492
	Count		*Actual*	303	120	245	355	492

		Overall access to Core Community Mental Health Services for Adults with SMI		Average	Qtr 1	Qtr 2	Qtr 3	Qtr 4
11	Count	Number of people who receive two or more contacts from the NHS or NHS commissioned community mental health services (in transformed and non-transformed PCNs) for adults and older adults with severe mental illnesses	*Forecast*	4,861	5,063	4,897	4,622	4,861
	Count		*Actual*	6,790	6,942	6,758	6,642	6,818

		Numbers of CYP in contact		Average	Qtr 1	Qtr 2	Qtr 3	Qtr 4
13	Count	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact	*Forecast*	5,759	5,838	5,826	5,612	5,759
	Count		*Actual*	7,163	7,351	7,189	7,117	6,993

With the CYP 1 contact metric being a 12 month rolling measure, quarter on quarter variances are driven by the previous reported quarter's first 3 months being removed and the new reported quarters latest 3 months being introduced.

Between January-23 to March-23, 3,132 distinct patients received a contact in accordance with the metrics methodology, this has reduced to 2,853 between January-24 to March-24.

Essentially between January-23 to March-23 more distinct patients received a contact than between January-24 to March-24 which negatively impacted the CYP 1 Contact Metric. This is being reviewed with the Community Directorate.

Statistical Process Control

What is It?

SPC enables analysis of a process as a whole, rather than as merely the relationship between 2 data points as is used in RAG ratings and in-month trends. The aim is to categorise data into common and unusual in relation to the established trend, allowing for decision contextualised within the process and its expected variation, rather than as being reactive to a single change.

"All too often, we overreact to variation which is normal – we waste lots of time investigating a 'deterioration' which SPC tells us is normal; wild goose chases. Another word for this is tampering. Tampering is not a good thing as it distracts you from situations that merit focus." -Plot The Dots.

When to use it

SPC should be used throughout the life cycle of the project to help you identify a project, get a baseline and evaluate how you are currently operating. SPC will also help you to assess whether your project has made a sustainable difference.

How to use it

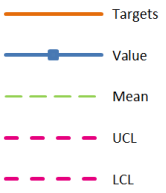
An SPC chart has a mean line and two control lines, both of which allow more statistical interpretation. These control lines are 3σ (3 Sigma) away from the Mean - with recalculation of these lines occurring when significant changes in the process occur.

Additional points of interest are the zones, calculated in the same manner as the control lines, with Zone C within 1σ of the Mean, Zone B within 2σ of the Mean, and Zone C within 3σ of the Mean (within the control lines).

These limits, which are a function of the data, give an indication by means of chart interpretation rules as to whether the process exhibits common cause (predictable) variation or whether there are special causes. After plotting your chart, the next stage is therefore analysing the chart by looking at how the values fall around the average and between the control limits.

Interpreting the Report

Variation			Assurance		
					
Common cause - no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target



Variation icons: Orange indicates concerning special cause variation requiring action; **Blue** indicates where improvement appears to lie, and Grey indicates no significant change (common cause variation).

Assurance icons: **Blue** indicates that you would consistently expect to achieve a target. Orange indicates that you would consistently expect to miss the target. A Grey icon tells you that sometimes the target will be met and sometimes missed due to random variation - in a RAG report this indicator would flip between Red and Green.

Directional Arrows:

↗ If performance this month is **positive** when compared to last month's performance (a higher value is better or a lower value is better)

↘ If performance this month is **negative** when compared to last month's performance (a higher value is better or a lower value is better)

↔ There have been **no change** in performance levels when compared to last month

REPORT TO PUBLIC TRUST BOARD

Date of Meeting:	9th May 2024		
Title of Report:	Children and Young People's Complex Project		
Presented by:	Liz Mellor, Chief Strategy Officer and Primary Care Project Team		
Author:	Niketa Sanderson-Gillard, The Care Leaders and Liz Mellor, Chief Strategy Officer		
Executive Lead Name:	Liz Mellor, Chief Strategy Officer	**Approved by Exec**	☐

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Purpose of the report:							
Approval	☐	**Information**	☒	**Consider for Action**	☐	**Assurance**	☒

Executive Summary:

Over the past few years there have been a small number of children and young people who present to services with behaviours which have increased in complexity. These presentations and behaviours can be described as emotionally dysregulated and can impact their ability to reach their potential, form and sustain positive relationships and function well within their communities. The majority of these children and young people are known to the care system and existing services are at risk of failing to meet their needs. Early research suggests existing legislative frameworks, such as, the Children Act 2004 and the Mental Health Act 1983 are also not appropriate. This is not an issue isolated to the Staffordshire and Stoke-on-Trent ICS yet is recognised as a national challenge, there is currently no ICS or single statutory partner at a stage of fully preventing these children and young people being at risk of poor life outcomes.

The Chief Strategy Officer is leading a piece of work on behalf of the West Midlands MHLD&A Provider Collaborative and the SSoT ICS to seek sustainable solutions which will ensure children and young people who experience trauma are better supported and have greater life opportunities despite their backgrounds.

The attached paper provides a summary of the progress and activity which has formed part of year 1 of this project. It is also provided to give assurance of the leadership role the Trust are taking in order to seek better solutions for these children, young people and families at a national, regional and local ICS level.

Seen at:	SLT ☒ Execs ☐ February 2024	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Resource Committee ☐ • Audit Committee ☐ • People, Culture & Development Committee ☐ • Charitable Funds Committee ☐		
Strategic Priorities (please indicate)	1. **Growth** - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care ☒ 2. **Access** - We will ensure that everybody who needs our services will be able to choose the way, the time, and the place in which they access them ☒		

	3. **Prevention** - To will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce. ☒
BAF / Risk / legal implications: Risk Register Reference	1. We will provide the highest quality, safe and effective services ☒ 2. We will attract, develop and retain the best people ☒ 3. We will actively promote partnership and integrated models of working ☒ 4. We will increase our efficiency and effectiveness through sustainable development ☒ Any Risk/legal implications: (please reference if any)
Sustainability:	1. Reduce the environmental impact of health and social care in Staffordshire and Stoke on Trent ☐ 2. Build a network of climate and sustainability champions across Staffordshire and Stoke on Trent ☐ 3. Share learning and best practice ☐
Resource Implications: Funding Source:	N/A
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	There is no direct impact on the protected characteristics as part of the completion of this report.
ICS Alignment / Implications:	N/A
Recommendations:	The Board is asked to: • Consider the future strategic direction for Primary Care within the Trust.

Version	Name/group	Date issued

Staffordshire and Stoke-on-Trent Integrated Care System

Children and Young People's Complex Project
ICB SLT Discussion Paper
Thursday 14th March 2024

Project aims
'There are a number of children and young people (CYP) in every system with complexities, where standard procedures and usual practice might not meet their needs. These CYP are low in numbers and high in cost, yet their outcomes are poor and they are most likely to need adult services in the future'. This project has been testing that assumption and exploring what an improved and integrated, multi-disciplinary response may look like to change outcomes for this vulnerable group of children and young people.

Summary
The Chief Strategy Officer (CSO), North Staffordshire Combined Healthcare NHS Trust has been leading a multi-agency, multi-disciplinary Project Steering Group for the past year. Many members have commented on the complexity of the work and the importance of being in a 'room' together to try and find solutions, not just when individual CYP have escalated. Many practitioners engaged have reported the Steering Group has drawn much needed attention to a vulnerable group of CYP who risk not having their needs met by multiple systems despite best efforts. This paper provides a brief overview of the work, themes that have arisen and some options being developed to meet the needs of this vulnerable group of CYP.

The children and young people
In Staffordshire and Stoke-on-Trent, 1,858 children have been identified with complex needs (as defined by the NHS definition), predominantly White British and including overrepresented groups such as looked-after children, school-excluded youth, and LGBTQU+ individuals, face a variety of challenges. This includes mental health issues (59%), persistent school absence (37%), substance misuse (34%), and special educational needs (30%). Approximately 20 of these young people risk not having their needs met by current services, highlighting systemic strains, particularly in mental health services like CAMHS, due to high demand for diagnostic assessments and unclear support pathways.

Engagement
Many issues which have emerged throughout the project mirrored those found in other research in this area, notably the 2 Cordis Bright reports[2]. To build on this work and not further repeat findings, investment needs to be made in building relationships between professional groups, developing a new culture between statutory organisations and improving services to progress with outcomes. Significant commitment will continue to be needed from senior leaders across services to progress this work in a second year of delivery, this includes financial investment.

Consensus Issues
Commissioning Approaches: Current services are not adequately addressing children with complex needs; effectiveness could be improved by focusing on community-based operations and a review of pathways.
Importance of Relationships: Successful outcomes are seen as heavily reliant on the quality of relationships between practitioners across different services. This was particularly important as no existing model consistently offers positive outcomes, indicating a systemic flaw.
Acute and Preventative Focus: Emphasising both immediate and preventative care is vital for addressing urgent needs and reducing long-term service demand.
Hierarchy and Decision-Making: A culture of distrust and scepticism towards decision-making in assessments/access to services undermines team cohesion and delays child-centred solutions, highlighting the need for trust-based authority in any planned MDT environment.
Historical Context: There remains views amongst some partners that previous NHS restructuring is contributing to the current challenges, with perceptions about reducing services or changes in how services are delivered. There is a perception this is impacting on access to CAMHS and tier 4 bed availability.

Areas that lack clarity
CYP Clarification: There is ongoing confusion/disagreement about defining the group of CYP, with a need for clearer identification guidelines to ensure consistent understanding and support across services.
Progress and Collaboration: The establishment of a senior-level group has facilitated open dialogue on challenging issues, marking an important step in enhancing collaboration and service design for this and future CYPs.

Achievements to date

- Leadership role, governance and reporting established across the ICS.
- CSO has attended Upon (DfE) National Leadership Programme for Aspiring Directors of Children's Services to gather insight and knowledge at a national level.
- 30 1:1 stakeholder interviews conducted.
- 3 system workshops delivered, engaging over 100 staff from Health and Social Care.
- CYP analysis conducted on 20 CYP known to Children's Social Care.
- Desk top research on national models of best practice.
- Discussions with Somerset, Suffolk and Birmingham Local Authorities to gain evidence of best practice.
- Project Initiation Document (PID) produced in July 2023.
- North Staffordshire Combined Healthcare NHS Trust have commissioned The Care Leaders until March 2024 to provide skills, expertise and capacity not available in the ICS.
- The CSO has secured an additional £250,000 for 2024-25 to support project delivery from the West Midlands CAMHS Provider Collaborative.

Options

Some high level options are outlined in brief below, these will be expanded upon in the final report, which will also include the broader range of options that have been explored by the steering group.

1. **Develop and Implement Clear Identification Criteria:** Whilst acknowledging the complexities involved in definition it is important to agree a definition both for this CYP and for those at risk. This will allow more targeted support as well as better monitoring of the CYP group, interventions, outcomes and costs.

2. **Establish Regular Cross-Sector Training Programs:** Design and initiate regular, ongoing training programs that bring together professionals from health, social care, education, and other relevant sectors. These programs should focus on building a shared understanding of the CYP's needs, enhancing multi-disciplinary team (MDT) collaboration skills, and fostering a culture of trust and mutual respect among practitioners. Implementing more ambitious collaborative programs are unlikely to work without significant investment in workforce and culture.

3. **Pilot a Coordinated Service Model:** Launch a pilot program to test a new, coordinated service model based on the agreed-upon identification criteria and the principles of effective MDT collaboration. This model should aim to provide a holistic, person-centred approach to supporting the CYP, with mechanisms for continuous monitoring, feedback, and adjustment. The pilot's outcomes would inform broader implementation strategies and provide valuable insights into best practices and potential challenges.

4. **Steering Group:** Continue to build on the collaboration at a senior level, to actively seek and utilise opportunities to ensure continuous improvement and innovation in service delivery. Ensure accountability by developing clear workstreams that have wider involvement across NHS, LA and other relevant partners such as education.

Project success measures

- The number of CYP 'stuck inappropriately' in A&E, paediatric wards and Places of Safety (PoS) reduces.
- Less placement breakdowns for looked after children due to a 'crisis'.
- Co-production with CYP is embedded in solutions.
- Improved relationships, knowledge and understanding across social care and health.
- Production of a CYP Crisis Escalation Card and embedded practice.
- Access to services is reported as improved by practitioners.
- New services are developed and commissioned.

Produced by Niketa Sanderson-Gillard, The Care Leaders and Liz Mellor – North Staffordshire Combined Healthcare NHS Trust

REPORT TO PUBLIC TRUST BOARD

Date of Meeting:	9th May 2024		
Title of Report:	Finance Position M12		
Presented by:	Eric Gardiner - Chief Finance Officer		
Author:	Michelle Wild – Financial Controller/Lisa Dodds – Assistant Director of Finance/ Rachel Heath – Project Accountant		
Executive Lead Name:	Eric Gardiner – Chief Finance Officer	**Approved by Exec**	☒

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Purpose of the report:							
Approval	☐	**Information**	☒	**Consider for Action**	☐	**Assurance**	☒

Executive Summary:

As at month 12, the Trust is reporting an in-month deficit of £41k against a planned surplus of £7k giving an adverse variance of £48k.

The Adjusted Financial Performance year-to-date position is a surplus of £320k against a breakeven plan. (Please note that the year-to-date surplus is reported after adjusting for impairments transacted at month 5 & month 12 and the PFI IFRS16 implementation transactions as these do not form part of the Trust's reported financial performance to the System.)

The Trust achieved £6.6m of efficiencies at month 12 against a target of £6.5m. Within these figures, the Trust achieved £3,565k of internal Trust CIP against a target of £3,724k, therefore under delivered on CIP by £158k.

Trade receivables have decreased to £7.6m at month 12 and payables have decreased to £20.7m (£24.5m in month 11). The movement in payables relates to reductions in P86 and TCP accruals.

Cash was £2.9m above plan at month 12 due to lower payroll costs than planned, slippage on capital, higher VAT recovery, and higher interest received.

In month 12, 98% of invoices received by the Trust (both value and number) were paid within 30 days against the Better Payment Practice Code target of 95%

The Trust's capital expenditure at month 12 was £3,462k against a plan of £6,510k.

Seen at:	SLT ☒ Execs ☐	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Resource Committee ☒ • Audit Committee ☐ • People, Culture & Development Committee ☐ • Charitable Funds Committee ☐		
Strategic Priorities (please indicate)	1. **Growth** - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care ☒ 2. **Access** - We will ensure that everybody who needs our services will be able to choose the way, the time, and the place in which they access them ☐		

	3. **Prevention** - To will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce. ☐	
BAF / Risk / legal implications: Risk Register Reference	1. We will provide the highest quality, safe and effective services ☐ 2. We will attract, develop and retain the best people ☐ 3. We will actively promote partnership and integrated models of working ☐ 4. We will increase our efficiency and effectiveness through sustainable development ☒ Any Risk/legal implications: (please reference if any)	
Sustainability:	1. Reduce the environmental impact of health and social care in Staffordshire and Stoke on Trent ☐ 2. Build a network of climate and sustainability champions across Staffordshire and Stoke on Trent ☐ 3. Share learning and best practice ☐	
Resource Implications: Funding Source:	If the trust does not deliver recurrent CIP, it impacts on future sustainability, Not applicable	
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	There is no direct impact on the protected characteristics as part of the completion of this report.	
ICS Alignment / Implications:	Part of the aggregate ICS reported financial position	
Recommendations:	Receive the Month 12 position noting: ➢ The year-to-date surplus of £320k for system reporting purposes. ➢ Note the month 12 capital position. ➢ The cash position of the Trust at 31st March 2024 with a balance of £26.9m. ➢ Agency expenditure year to date of £5,428k. ➢ Note CIP delivery position.	
Version	Name/group	Date issued
		16/04/2024

Public Trust Board – 9th May 2024
Finance Position Month 12

Introduction:

This report summarises the Trust's financial position as at 31st March 2024. Key financial performance metrics are included for the following:

- Income and expenditure position
- CIP delivery
- Agency expenditure
- Capital expenditure
- Better Payment Practice Code performance
- Summary balance sheet position

Purpose of the Report (Executive Summary):

As at month 12, the Trust is reporting an in-month deficit of £41k against a planned surplus of £7k giving an adverse variance of £48k.

The Adjusted Financial Performance year-to-date position is a surplus of £320k against a breakeven plan. *(Please note that the year-to-date surplus is reported after adjusting for impairments transacted at month 5 & month 12 and the PFI IFRS16 implementation transactions as these do not form part of the Trust's reported financial performance to the System.)*

High Level Analysis	Annual Plan	Month 12 Budget	Month 12 Actuals	Variance	Year to Date Budget	Year to Date Actuals	Variance
	£000	£000	£000	£000	£000	£000	£000
Income from Patient Care Activities	147,876	13,012	16,585	3,573	155,220	150,011	(5,209)
Income from Other Operating Activities	14,904	1,413	2,723	1,311	16,767	17,466	699
Income	**162,780**	**14,424**	**19,308**	**4,883**	**171,987**	**167,476**	**(4,511)**
Pay Costs	(90,973)	(8,210)	(11,613)	(3,404)	(97,975)	(96,920)	1,055
Non Pay Costs	(68,278)	(5,818)	(12,499)	(6,682)	(69,486)	(72,848)	(3,362)
Finance & Other Non Operating Costs	(3,529)	(390)	(220)	170	(4,526)	(4,581)	(55)
Expenditure	**(162,780)**	**(14,417)**	**(24,333)**	**(9,916)**	**(171,987)**	**(174,349)**	**(2,361)**
Retained Surplus / (Deficit)	**0**	**7**	**(5,025)**	**(5,032)**	**0**	**(6,872)**	**(6,872)**
Add Back Impairment reversals	0	0	4,976	4,976	0	6,617	6,617
Add Back impact of DHSC consumables	0	0	9	9	0	9	9
Add Back DHSC Donated Assets Depreciation	0	0	0	0	0	8	8
Surplus/(deficit) before impairments	**0**	**7**	**(41)**	**(48)**	**0**	**(238)**	**(238)**
Add Back PFI IFRS16 Impact	0	0	(136)	(136)	0	558	558
Adjusted Financial Performance	**0**	**7**	**(177)**	**(184)**	**0**	**320**	**320**

The Trust achieved £6.6m of efficiencies at month 12 against a target of £6.5m. Within these figures, the Trust achieved £3,565k of internal Trust CIP against a target of £3,724k, therefore under delivered on CIP by £158k.

Trade receivables have decreased to £7.6m at month 12 and payables have decreased to £20.7m (£24.5m in month 11). The movement in payables relates to reductions in P86 and TCP accruals.

Cash was £2.9m above plan at month 12 due to lower payroll costs than planned, slippage on capital, higher VAT recovery, and higher interest received.

In month 12, 98% of invoices received by the Trust (both value and number) were paid within 30 days against the Better Payment Practice Code target of 95%

The Trust's capital expenditure at month 12 was £3,462k against a plan of £6,510k.

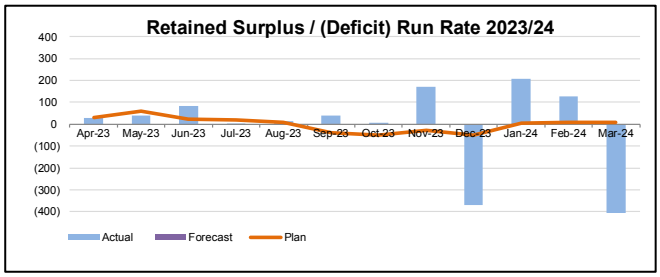
Financial Overview as at 31st March 2024

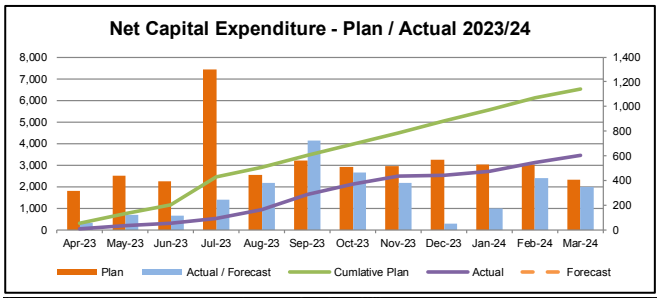
Key Metrics

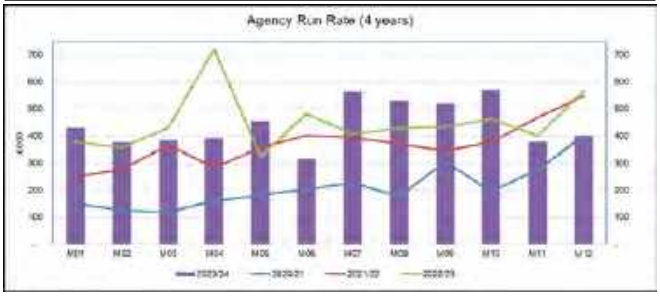
		Plan £000	Actual £000	Var £000	%	RAG
Financial Position	YTD	0	320	320	0	G
Charge to CRL	YTD	6,510	3,462	3,048	47	G
Cash Balances	YTD	22,949	26,892	3,943	17	G
CIP Programme (Transactable)	YTD	3,273	3,287	14	0	G
CIP Programme (Other efficiencies)	YTD	2,555	2,811	256	10	G
Total Identified Schemes	Full Year	6,526	6,631	105	2	G

Better Payment Practice Code

	In month		YTD	
	Number	£000	Number	£000
Total trade invoices paid in period	1,481	10,930	16,541	111,493
Total trade invoices paid within target	1,456	10,751	15,646	106,761
% paid within target	98%	98%	95%	96%







Key Recommendations to Consider:

Receive the Month 12 position noting:

- The year-to-date surplus of £320k for system reporting purposes.
- Note the month 12 capital position.
- The cash position of the Trust at 31st March 2024 with a balance of £26.9m.
- Agency expenditure year to date of £5,428k.
- Note CIP delivery position.

Background:

1. Income

The table below shows the Trust's 2023/24 income position at 31st March 2024.

- Most of the ICB and NHSE block income is fixed for 2023/24 under the block payments arrangements. In month 12 block contract income totalled £12,262k against a plan of £8,453k giving a favourable variance in month of £3,809k. This was mainly due to the NHSE funding received for the 6.3% employers pension adjustment.
- Patient Placements income relates to TCP and Community Rehab Placements income from the ICB and Local Authorities per appendix E, this is separate from the ICB block. The under-recovery of income in month 12 is offset by an equal decrease in costs.
- Under recovery of income on non-patient care services to other bodies relates to L & D expansion service development slippage.
- Other income includes an in-month adjustment for bad debt which is now included in other non-pay.

Income	Annual Plan	Month 12 Budget	Month 12 Actuals	Variance	Year to Date Budget	Year to Date Actuals	Variance
	£000	£000	£000	£000	£000	£000	£000
Income From ICBs and NHSE / Block Contract Income	96,704	8,453	12,262	3,809	101,251	101,380	129
Local authorities	4,228	510	761	252	6,053	5,869	(184)
Patient Placements Income	42,261	3,574	3,110	(464)	42,650	36,965	(5,685)
Non-NHS: Private Patients	0	0	0	0	0	17	17
Non-NHS: other	4,683	476	452	(24)	5,266	5,780	514
Total Income From Patient Care Activities	**147,876**	**13,012**	**16,585**	**3,573**	**155,220**	**150,011**	**(5,209)**
Research and development	90	35	32	(3)	156	155	(1)
Education and training	3,390	363	524	161	4,804	5,729	925
Non-patient care services to other bodies	11,004	936	819	(117)	10,864	9,772	(1,092)
Other Income	420	79	1,348	1,270	942	1,810	867
Total Income from Other Operating Activities	**14,904**	**1,413**	**2,723**	**1,311**	**16,767**	**17,466**	**699**
Total Income	**162,780**	**14,424**	**19,308**	**4,883**	**171,987**	**167,476**	**(4,511)**

2. Expenditure

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

- Pay costs in month are £11,613k, against a budget of £8,210k giving an overspend of £3,404k. This is mainly due to the 6.3% employers pension adjustment which is offset by funding received from NHSE. In month 12 there were 222.56wte vacancies (budgeted wte less contracted wte, the figures in the table below show budgeted wte and worked wte to show the inclusion of overtime, bank, and agency). 111.95 wte of these vacancies are in nursing and 64.73 wte are in other clinical. Agency expenditure in month 12 was £507k.
- Non-pay is over-spent by £6,682k in month 12. £4,976k relates to impairments (these are below the line adjustments for System adjusted financial performance) and £927k increase in credit loss provisions. There were also increases in premises costs and IT licences.
- Investment revenue is over-achieving year to date due to increases in interest rates during the year.

Expenditure	Annual Plan	Month 12 Budget	Month 12 Worked	Month 12 Budget	Month 12 Actuals	Variance	Year to Date Budget	Year to Date Actuals	Variance
	£000	WTE	WTE	£000	£000	£000	£000	£000	£000
Medical	(10,761)	(96.95)	(74.53)	(971)	(1,485)	(514)	(11,289)	(9,928)	1,361
Nursing	(31,930)	(614.67)	(517.82)	(2,744)	(3,326)	(582)	(33,439)	(28,255)	5,184
Other Clinical	(31,532)	(831.42)	(841.86)	(2,934)	(4,259)	(1,325)	(35,388)	(35,257)	131
Non-Clinical	(16,854)	(417.56)	(391.18)	(1,558)	(2,043)	(485)	(17,830)	(18,059)	(229)
Agency	(166)	0.00	(57.07)	(3)	(507)	(504)	(29)	(5,428)	(5,399)
COVID-19 Pay Costs	0	0.00	0.00	0	7	7	0	7	7
Total Pay	**(91,243)**	**(1,960.60)**	**(1,882.46)**	**(8,210)**	**(11,613)**	**(3,404)**	**(97,975)**	**(96,920)**	**1,055**
Drugs & Clinical Supplies	(216)			(244)	(238)	6	(2,911)	(2,647)	264
Establishment Costs	(696)			(113)	(115)	(1)	(1,253)	(1,137)	116
Premises Costs	(5,040)			(473)	(1,378)	(904)	(5,201)	(7,617)	(2,416)
Private Finance Initiative	(3,492)			(340)	(339)	1	(4,082)	(4,088)	(7)
Services Received	(6,710)			(726)	(941)	(215)	(8,790)	(8,806)	(16)
Patient Placements	(42,650)			(3,574)	(3,082)	492	(42,650)	(36,797)	5,852
Consultancy & Prof Fees	(120)			(5)	39	44	(140)	(170)	(31)
External Audit Fees	(108)			(10)	(12)	(2)	(114)	(107)	8
Other	(6,210)			(451)	(6,435)	(5,984)	(3,839)	(11,479)	(7,640)
Unmet Cost Improvement	0			117	0	(117)	(508)	0	508
Total Non-Pay	**(65,242)**			**(5,818)**	**(12,499)**	**(6,682)**	**(69,486)**	**(72,848)**	**(3,362)**
Finance Costs	(3,529)			(268)	(172)	96	(3,221)	(4,224)	(1,003)
Dividends Payable on PDC	(500)			(18)	(0)	18	(216)	0	216
Investment Revenue	500			150	159	9	1,800	2,137	336
Depreciation & Amortisation	(3,036)			(254)	(207)	47	(2,890)	(2,494)	396
Total Non-operating Costs	**(6,565)**			**(390)**	**(220)**	**170**	**(4,526)**	**(4,581)**	**(55)**
Total Expenditure	**(163,050)**	**(1,960.60)**	**(1,882.46)**	**(14,417)**	**(24,333)**	**(9,916)**	**(171,987)**	**(174,349)**	**(2,361)**

3. Agency Utilisation

Headlines - Trust Agency Use

For 2023/24 the agency will be monitored against a target of 3.7% of the total NHS pay bill. The agency costs to month 12 are shown below.

Month 12 YTD expenditure on agency is £5,428k; **which is over the YTD agency target by £1,842k**.

47% of agency costs to date were incurred in the Specialist directorate, with 37% in Community and 9% in Acute and Urgent Care directorates, the remainder related to Primary Care and Corporate areas. The table below shows total agency expenditure by staffing group.

Agency Expenditure	Actual												
	Apr-23 £000	May-23 £000	Jun-22 £000	Jul-23 £000	Aug-23 £000	Sep-23 £000	Oct-23 £000	Nov-23 £000	Dec-23 £000	Jan-24 £000	Feb-24 £000	Mar-24 £000	YTD £000
Medical	(251)	(127)	(160)	(170)	(200)	(32)	(180)	(168)	(221)	(165)	(220)	(253)	(2,147)
Nursing	(109)	(93)	(68)	(36)	(244)	(169)	(291)	(266)	(237)	(350)	(87)	(140)	(2,092)
Other Clinical	19	(69)	(87)	(145)	44	(54)	(29)	(26)	(1)	(16)	(15)	(74)	(451)
Non Clinical	1	(20)	(10)	(11)	(25)	(11)	(17)	(13)	(11)	(9)	(12)	(9)	(148)
Sub Total	**(340)**	**(310)**	**(326)**	**(361)**	**(425)**	**(266)**	**(517)**	**(473)**	**(470)**	**(540)**	**(334)**	**(476)**	**(4,839)**
Primary Care	(89)	(67)	(59)	(30)	(31)	(52)	(48)	(57)	(51)	(31)	(44)	(31)	(589)
Total Agency	**(430)**	**(377)**	**(384)**	**(391)**	**(457)**	**(318)**	**(565)**	**(530)**	**(521)**	**(571)**	**(378)**	**(507)**	**(5,428)**
Agency as a % of Pay	5.75%	4.69%	5.12%	5.28%	5.85%	4.25%	6.85%	6.71%	6.61%	7.45%	4.77%	4.37%	5.75%

Year to date agency nursing and other clinical agency costs includes £1,194k of Thornbury spend.

Performance against the agency ceiling excluding the Thornbury spend would be £692k over the ceiling year to date compared to £1,842k year to date over the ceiling including Thornbury.

The table below shows the percentage of agency usage that has been provided by off framework agency providers. This information is currently reported from the purchase ledger system based on when invoices are paid. Off framework nursing agency in month 12 mainly relates to Thornbury nursing at the Darwin. Off framework medical usage is for locums at the GP practices.

% Agency off framework	M01 %	M02 %	M03 %	M04 %	M05 %	M06 %	M07 %	M08 %	M09 %	M10 %	M11 %	M12 %
Medical	11%	15%	13%	29%	43%	0%	7%	29%	4%	56%	1%	56%
Nursing	24%	46%	15%	2%	12%	84%	73%	76%	73%	78%	67%	30%
Other Clinical	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Non Clinical	9%	5%	24%	23%	35%	25%	28%	7%	0%	0%	0%	15%
Total	**12%**	**27%**	**11%**	**13%**	**36%**	**65%**	**55%**	**59%**	**55%**	**68%**	**48%**	**36%**

The table below shows the Trust's off framework agency usage excluding the impact of Thornbury Nursing services at the Darwin.

% Agency off framework exc Thornbury	M01 %	M02 %	M03 %	M04 %	M05 %	M06 %	M07 %	M08 %	M09 %	M10 %	M11 %	M12 %
Medical	11%	15%	13%	29%	43%	0%	7%	29%	4%	56%	1%	56%
Nursing	12%	13%	14%	1%	13%	0%	0%	0%	0%	1%	0%	2%
Other Clinical	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Non Clinical	9%	5%	24%	23%	35%	25%	28%	7%	0%	0%	0%	15%
Total	**10%**	**10%**	**11%**	**13%**	**36%**	**2%**	**4%**	**4%**	**1%**	**19%**	**1%**	**23%**

4. CIP

The below table shows the identified schemes and outturn against the overall efficiency target of £6.5m for 2023/24 following the submission of the plan. Of the £6.5m, £3.7m is the internal Trust CIP target and £2.8m are the below the line efficiencies.

At month 12 the Trust has achieved internal CIP of £3,565k against the plan of £3,724k, an underachievement of £158k. The Trust has achieved below the line efficiencies of £2,811k against the plan of £2,555k, an overachievement of £264k.

The Trust is showing total trust CIP / efficiency achievement of £6,631k against the £6,526k plan, this is an overachievement of £106k. Recurrently the Trust has achieved £2,813k against the recurrent plan of £2,214k, an overachievement of £599k. All schemes have been fully identified / transacted to achieve the 23/24 target, therefore any schemes that are currently in development will be transferred to 24/25 to help deliver next financial years target.

2023/24 Planned CIP / Efficiency Summary	Target £000	YTD 2023/24 Plan £000	YTD 2023/24 Actual £000	YTD 2023/24 Variance £000	Outturn 2023/24 Plan £000	Outturn 2023/24 Actual £000	Outturn 2023/24 Variance £000	*Of which is Recurrent* Plan £000	*Of which is Recurrent* Actual £000	*Of which is Recurrent* Variance £000
Clinical	2,419	2,419	848	(1,572)	2,419	848	(1,572)	*1,177*	*503*	(675)
Corporate	705	705	306	(399)	705	306	(399)	*343*	*234*	(109)
Trustwide	599	599	2,411	1,812	599	2,411	1,812	*292*	*1,410*	1,119
Internal Trust CIP	**3,724**	**3,724**	**3,565**	**(158)**	**3,724**	**3,565**	**(158)**	***1,812***	***2,147***	***335***
TCP Cost Reduction-System Stretch Target	1,400	1,400	1,400	0	1,400	1,400	0	*0*	*0*	0
New Service Development Slippage*	1,000	1,000	1,000	0	1,000	1,000	0	*0*	*0*	0
Reduction in unfunded budget pressures	402	402	666	264	402	666	264	*402*	*666*	264
Below the line efficiencies	**2,802**	**2,802**	**3,066**	**264**	**2,802**	**3,066**	**264**	***402***	***666***	***264***
Total Trust CIP / Efficiency	**6,526**	**6,526**	**6,631**	**106**	**6,526**	**6,631**	**106**	***2,214***	***2,813***	***599***

5. Statement of Financial Position

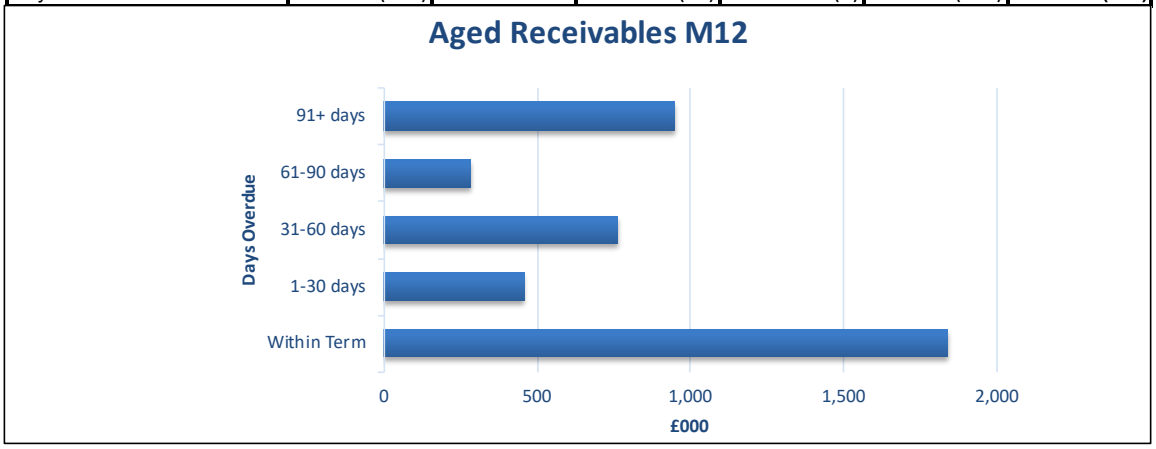
The table below shows the Statement Financial Position of the Trust.

SOFP	Jan-24 £000	Feb-24 £000	Mar-24 £000
Non-Current Assets			
Property, Plant and Equipment - PFI	20,999	20,950	18,133
Property, Plant and Equipment	17,362	17,696	17,467
Right of Use Assets	4,994	4,941	3,205
Intangible Assets	1,224	1,197	1,166
NCA Trade and Other Receivables	786	780	678
Other Financial Assets	0	0	0
Total Non-Current Assets	**45,365**	**45,564**	**40,649**
Current Assets			
Inventories	130	138	93
Trade and Other Receivables	9,254	8,715	7,683
Cash and Cash Equivalents	37,981	30,245	26,893
Non-Current Assets Held For Sale	0	0	0
Total Current Assets	**47,364**	**39,098**	**34,669**
Current Liabilities			
Trade and Other Payables	(32,703)	(24,509)	(20,726)
Provisions	(1,297)	(1,525)	(1,215)
Borrowings	(3,004)	(3,004)	(3,004)
Total Current Liabilities	**(37,003)**	**(29,038)**	**(24,945)**
Net Current Assets / (Liabilities)	**10,361**	**10,061**	**9,724**
Total Assets less Current Liabilities	**55,726**	**55,625**	**50,373**
Non Current Liabilities			
Provisions	(1,416)	(1,416)	(1,416)
Borrowings	(19,477)	(19,249)	(18,969)
Total Non-Current Liabilities	**(20,893)**	**(20,665)**	**(20,385)**
Total Assets Employed	**34,833**	**34,959**	**29,988**
Financed by Taxpayers' Equity			
Public Dividend Capital	20,496	20,496	20,496
Retained Earnings reserve	7,423	7,549	2,580
Revaluation Reserve	6,913	6,913	6,912
Total Taxpayers' Equity	**34,833**	**34,959**	**29,988**

Current receivables are £7,587k of which:

- £3,395k is based on accruals (not yet invoiced) relating to income for services invoiced retrospectively at the end of every quarter.
- £4,289k is trade receivables; based on invoices raised and awaiting payment of invoice (£1,839k within terms).
- Invoices overdue by more than 31 days are subject to routine credit control processes.
- Local Authority and Non-NHS invoices overdue by 91+ days are included in the bad debt provision.
- Trade and Other payables remain high because of patient placement invoices and accruals.

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 Local Authority	374	0	197	251	225	**1,047**
Receivables Non NHS	333	314	458	30	740	**1,875**
Receivables NHS	1,132	144	110	0	(18)	**1,367**
Payables Local Authority	(52)	0	(24)	0	0	**(76)**
Payables Non NHS	(1,835)	(131)	(30)	0	263	**(1,732)**
Payables NHS	(147)	0	(53)	(3)	(742)	**(946)**

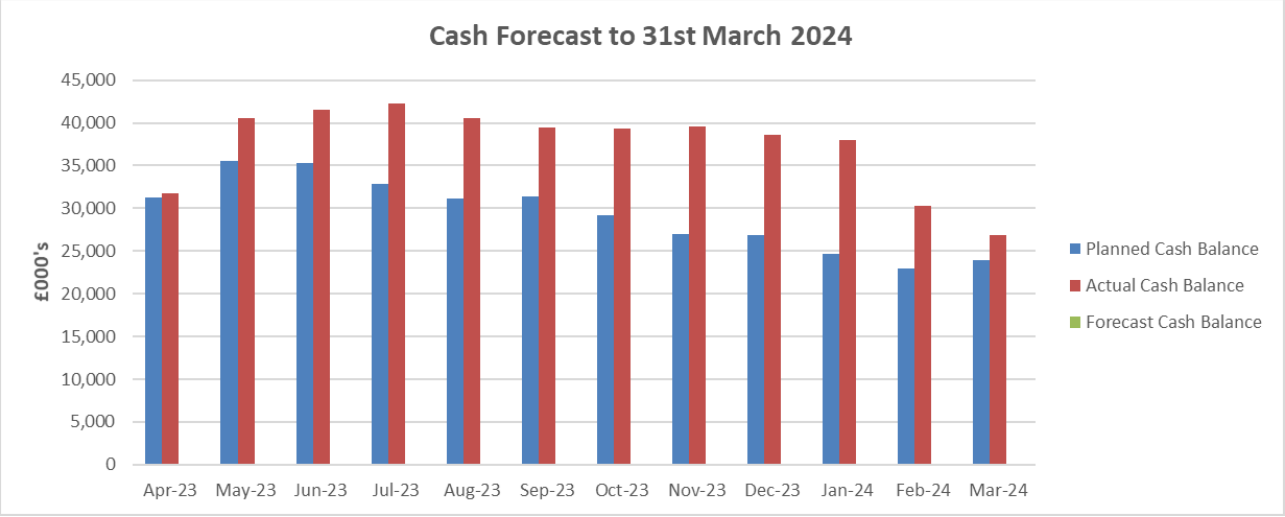


6. Cash Flow Statement

The Trust's cash balance at 31st March 2024 is £26.9m. This is above plan by £2.9m due to lower payrolls, capital slippage, high levels of interest received, higher and higher than planned VAT recovery.

	Cashflow summary - Apr 23 - Mar 24											
	Actuals											
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Balance b/fwd	**29,969**	**31,758**	**40,540**	**41,587**	**43,993**	**40,717**	**39,414**	**39,378**	**39,578**	**38,643**	**38,109**	**30,238**
Patient Income ICB & NHSE	11,680	18,341	14,597	11,529	9,997	11,473	11,497	10,809	11,099	10,997	6,419	9,379
Local Authority Income	0	1,640	27	889	375	0	256	1,147	14	866	0	1,524
Other income	2,589	2,351	2,223	3,135	1,453	1,795	4,114	2,817	1,044	2,144	2,723	2,087
PDC Funding	0	0	0	0	208	0	1,277	0	697	0	0	0
Total Receipts	**14,269**	**22,332**	**16,848**	**15,553**	**12,033**	**13,268**	**17,144**	**14,773**	**12,854**	**14,008**	**9,141**	**12,990**
Monthly Pay	(7,001)	(7,172)	(9,408)	(8,968)	(7,210)	(7,371)	(7,496)	(7,493)	(7,444)	(7,588)	(7,451)	(7,652)
Non Pay	(5,590)	(6,474)	(6,480)	(3,857)	(8,254)	(6,432)	(9,515)	(7,058)	(6,259)	(7,035)	(9,558)	(8,468)
Capital	110	97	86	(321)	154	(490)	(169)	(22)	(87)	82	(4)	(470)
PDC	0	0	0	0	0	(278)	0	0	0	0	0	250
Total Payments	**(12,480)**	**(13,549)**	**(15,801)**	**(13,146)**	**(15,310)**	**(14,571)**	**(17,180)**	**(14,573)**	**(13,789)**	**(14,541)**	**(17,013)**	**(16,340)**
Closing Cash Balance - Main Accounts	**31,758**	**40,540**	**41,587**	**43,993**	**40,717**	**39,414**	**39,378**	**39,578**	**38,643**	**38,109**	**30,238**	**26,888**
Unpresented cheques/uncleared deposits	**(6)**	**(4)**	**(17)**	**(1,677)**	**(145)**	**32**	**(2)**	**(5)**	**(4)**	**(138)**	**(3)**	**(6)**
Cash in Hand (Petty Cash)	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**
Total Reported Cash Book Balance	**31,761**	**40,545**	**41,579**	**42,325**	**40,580**	**39,456**	**39,385**	**39,582**	**38,648**	**37,980**	**30,244**	**26,892**
Plan	**31,222**	**35,547**	**35,349**	**32,888**	**31,113**	**31,348**	**29,167**	**26,981**	**26,850**	**24,649**	**22,949**	**23,949**
Variance to Plan	**539**	**4,998**	**6,230**	**9,437**	**9,467**	**8,108**	**10,218**	**12,601**	**11,798**	**13,331**	**7,295**	**2,943**

The graph below shows the cash position, plan and forecast for 2023/24.



7. Capital Expenditure

The Trust's final gross capital expenditure plan for 2023/24 is £6,510k including £3,182k PDC funding. Capital expenditure at month 12 is £3,462k, £3,048k below plan. This is mainly due to delays on Project Chrysalis due to the water temperature issue, frontline digitisation now expected to commence next year and the reduction in asset value of the Keele GP Lease.

The table below shows the annual plan and spend for 2023/24.

		Outturn Against Plan	
Capital Expenditure	**Annual Plan £000**	**Actual £000**	**Variance £000**
Operational Schemes			
Backlog Maintenance	150	253	103
Anti Ligature - planned	170	0	(170)
Anti Ligature - Perimeter fencing	50	65	15
IFRS16 Leases	1,100	254	(846)
IFRS16 Lease Remeasurements	0	(85)	(85)
Digital			
Capitalised Salaries IT Rolling Replacement	40	40	(0)
IT - Device Replacement	0	401	401
Digital Infrastructure	266	181	(85)
Contingency / Reactive			
A & T Bathrooms (22-23 scheme)	0	65	65
A & T Emergency Works - Anti-climb	0	0	0
A & T Emergency Works - Bathroom refurb	0	12	12
Contingency	0	(41)	(41)
Strategic Schemes			
Dormitory Conversion Trust funded	1,552	136	(1,416)
Total Trust Funded Capital Expenditure	**3,328**	**1,280**	**(2,048)**
Dormitory Conversion PDC Funded	2,000	2,000	(0)
Frontline Digitisation Programme PDC Funded	1,000	0	(1,000)
Mental Health Urgent Care Pathways Project Chrysalis PDC Funded	182	182	0
Total Gross Capital Expenditure	**6,510**	**3,462**	**(3,048)**
Total Project Chrsyalis Capital Expenditure (for information on	**3,734**	**2,318**	**(1,417)**

The table below shows the financial position for Project Chrysalis as at 31 March 2024. The scheme expenditure for the year was £2.3m funded entirely from PDC and Trust BAU capital funding. The delay on Ward 1 completion and resulting late start on the Ward 2 phase of the programmes has meant that expenditure has slipped into subsequent years and, therefore, the scheme did not require funding support from the Staffordshire system capital allocation in 23/24.

The scheme QS and Contractor have been asked to update their timeline and cashflow projections to reflect the Ward 1 delay. The table below will be updated in line their projections when received.

Project Chrysalis	**Cashflow - Revised plan**					
Project Chrysalis	**Actual 21/22**	**Actual 22/23**	**Actual 23/24**	**Forecast 24/25**	**Forecast 25/26**	**Total**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Interclass	1,921	**5,126**	**2,138**	3,574	1,444	14,203
SPV Charges		**165**	**64**	80	40	349
Sub Total Construction Costs	**1,921**	**5,291**	**2,202**	**3,654**	**1,484**	**14,552**
Fees, project Management & Other	479	**218**	**116**	140	30	983
Data Cabling (slippage from 21/22)	0	**0**	**0**	25	0	25
Total	**2,400**	**5,509**	**2,318**	**3,819**	**1,514**	**15,560**

Project Funding	**21/22**	**22/23**	**23/24**	**24/25**	**22/26**	**Total**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
PDC (DHSC Funding)	**2,750**	**3,808**	**2,000**	**2,000**	**0**	**10,558**
PDC (Urgent & Emergency Care)	**0**	**895**	**182**	**487**	**0**	**1,564**
Additional PDC Support	**0**	**900**	**0**	**0**	**0**	**900**
Trust Funding	**0**	**0**	**136**	**785**	**820**	**1,741**
System Support	**0**	**0**	**0**	**547**	**694**	**1,241**
TOTAL FUNDING	**2,750**	**5,603**	**2,318**	**3,819**	**1,514**	**16,004**

Spend to funding variance	***350***	***94***	***0***	***0***	***0***	***444***

8. Better Payment Practice Code

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

During month 12, the Trust achieved the 95% target overall for both the value of invoices paid and number of invoiced paid within 30 days at 98% on the number paid and 98% on the value paid within 30 days.

Year to date, the Trust achieved 95% on the number of invoices and 96% on the value of invoices paid within 30 days.

	2022/23 Total			2023/24 Month 12			2023/24 Total		
Better Payment Practice Code	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**
Number of Invoices									
Total Paid	385	15,302	15,687	41	1,440	1,481	400	16,141	16,541
Total Paid within Target	346	14,106	14,452	38	1,418	1,456	382	15,264	15,646
% Number of Invoices Paid	90%	92%	92%	93%	98%	98%	96%	95%	95%
% Target	95%	95%	95%	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**-5%**	**-3%**	**-3%**	**-2%**	**3%**	**3%**	**1%**	**0%**	**0%**
Value of Invoices									
Total Value Paid (£000s)	7,945	100,222	108,167	2,246	8,684	10,930	8,277	103,216	111,493
Total Value Paid within Target (£000s)	7,105	93,418	100,523	2,178	8,573	10,751	7,992	98,769	106,761
% Value of Invoices Paid	89%	93%	93%	97%	99%	98%	97%	96%	96%
% Target	95%	95%	95%	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**-6%**	**-2%**	**-2%**	**2%**	**4%**	**3%**	**2%**	**1%**	**1%**

Recommendations:

Trust Board are asked to receive the Month 12 position noting:

- The month 12 surplus of £320k for system reporting.
- Note the month 12 capital position.
- The cash position of the Trust at 31st March with a balance of £26.9m.
- Agency expenditure at month 12 of £5,428k.
- Note CIP delivery position.

REPORT TO PUBLIC TRUST BOARD

Date of Meeting:	9th May 2024		
Title of Report:	Finance and Resource Committee Assurance Report		
Presented by:	Russell Andrews- Chair/Non-Executive Director		
Author:	Lisa Dodds - Deputy Chief Finance Officer		
Executive Lead Name:	Eric Gardiner - Chief Finance Officer	**Approved by Exec**	☒

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Purpose of the report:								
Approval	☐	**Information**	☒	**Consider for Action**	☐	**Assurance**	☒	

Executive Summary:

This paper details the items discussed at the Finance and Resource Committee meeting held on the 2nd May 2024. Updates were received relating to:

- M12 Trust performance
- Business Opportunities
- Finance M12 Position
- ICS Updated Plan
- CIP Update
- Estates and Capital
- Digital project updates
- Business Development Opportunities
- F&R Risk Register
- BAF Q4
- F&R Committee Effectiveness Review

Seen at:	SLT ☒ Execs ☒	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Resource Committee ☒ • Audit Committee ☐ • People, Culture & Development Committee ☐ • Charitable Funds Committee ☐		
Strategic Priorities (please indicate)	1. **Growth** - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care ☒ 2. **Access** - We will ensure that everybody who needs our services will be able to choose the way, the time, and the place in which they access them ☐ 3. **Prevention** - To will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce. ☒		
BAF / Risk / legal implications: Risk Register Reference	1. We will provide the highest quality, safe and effective services ☐ 2. We will attract, develop and retain the best people ☐ 3. We will actively promote partnership and integrated models of working ☐		

	4. We will increase our efficiency and effectiveness through sustainable development ☒ Any Risk/legal implications: (please reference if any) Links to Trust risks around delivery of recurrent cost improvement target and delivery of trust financial position	
Sustainability:	1. Reduce the environmental impact of health and social care in Staffordshire and Stoke on Trent ☐ 2. Build a network of climate and sustainability champions across Staffordshire and Stoke on Trent ☐ 3. Share learning and best practice ☒	
Resource Implications: Funding Source:	If the Trust does not deliver recurrent CIP, it impacts on future sustainability Not applicable	
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	There is no direct impact on the protected characteristics as part of the completion of this report.	
ICS Alignment / Implications:	Part of the aggregate ICS reported financial position	
Recommendations:	The Board is asked to receive the contents of this report and take assurance from the review and challenge evidenced in the Committee.	
Version	Name/group	Date issued
	Trust Board	3rd May 2024

Finance and Resource Committee
Assurance Report to the Trust Board
02nd May 2024

Finance and Resource Committee Report to the Trust Board – 9th May 2024.

This paper details the items discussed at the Finance and Resource Committee meeting held on the 2nd May 2024. The meeting was quorate. The meeting was held as a MS Teams conference meeting and minutes were reviewed and approved from the previous meeting on the 4th April 2024. Progress was reviewed and actions confirmed from previous meetings. Declarations of interest were noted.

Performance

- **IQPR**

The Committee received the IQPR report for month 12 which was taken as read.

In month 12 there are 16 RAG rated measures that have achieved required standard (16 in M11) and 17 that have not met the required standard and highlighted as exceptions (13 in M11).

There are 4 special cause variations (orange variation flags) - signifying concern, compared to 2 in M11:

1. CAMHS 18 week waits
2. MH Liaison 24 hours
3. Talking Therapies 6 weeks (target continues to be met).
4. Risk Assessment Compliance

All PIPs in place will be reviewed in month 1 except CPA 12-month review which was reviewed in month 12 and has a new trajectory. 4 new PIPs have been issued to the Directorates for agency usage. Modelling is taking place with the Directorates to ensure the PIPs are challenging but achievable. Other exceptions to note were staff turnover and vacancy rates. National waiting times targets have been met for Early Interventions and CAMHS Eating Disorders.

The Committee noted the contents of the report.

Business Opportunities

Q4 TMO Assurance Report

Recognition that overall project/programme health is good with a total of 27 programmes. Currently 4 projects/programmes have risk score of 12+ are to be noted. TMO are supporting on delivering the next phase of the Engagement Values Outcomes (EVO) Framework as well as a focus on the 5 key priorities identified as part of TMO's operational plan and supporting key elements of the 2024/25 Cost Improvement Programme.

Reviewing the feasibility of expression of interest from NHSE for 24/7 Community MH hubs by the end of May 24.

The Committee noted the contents of the report.

Q4 Sustainability Assurance Report
Highlights include the launch of the Trust's "Sustainability Team Reward Scheme" with uptake covering almost 25% of our workforce; the Trust's Carbon Footprint to February 2024 shows a 38% reduction for 2023/24 from the previous year. Identified increase in mileage as a concern which is being reviewed by the Trust Travel and Transport Group.

Developed a Proud to be Green Plan for 24/25. Reviewing dashboards and metrics around sustainability and new national reporting requirements for the Annual Report.

The Committee noted the contents of the report.

Finance

Month 12 Position
The Committee took the paper as read. Key messages highlighted included small a yearend surplus was achieved. Agency costs in month continue to exceed the required target of 3.7% of total pay. The Trust achieved the CIP target for 23/24. Capital came in lower than plan due to lower than plan lease values and delays to Project Chrysalis. The BPPC target was achieved for the year.

Committee noted that agency and particularly medical agency usage and costs need to be a key focus for 24/25.

The Committee noted the report.

ICS Updated Plan
The System reported a year end deficit lower than their agreed control total with the overspend driven by the ICB. System capital was over committed; the Trust's underspend helped to mitigate some of this position.

CIP Update
Department leads are developing further potential opportunities to understand the delivery potential, associated risks and potential financial benefit. To improve the System financial plan for 2024/25, the System agreed a stretch target for £40m, which equates to an additional CIP target for the Trust of £1.4m.

Estates and Capital

M12 Capital and Estates Report
The Associate Director of Estates provided an update on capital and revenue projects currently in progress. Projects complete on time. Hope Street CDAS lease is in process of being terminated. Water temperature valve work commencing in May at Harplands. Public Sector Decarbonisation application for A&T for air source heat pumps funding.

The Committee noted the update.

Digital

The Committee took the paper as read, which included an update across key activities. The main points highlighted to the Committee by the Chief Digital Information Officer were:

- Annual Digital Maturity Assessment - Digital What Good Looks Like (WGLL) assessment widow is open. Trust has been partnered by NHSE with MPUFT for peer review. Submission on 13th May.
- ORBIS – Ministerial sign off is still pending, NHSE expect this shortly with no issues highlighted. Legal and procurement advice now received and passed to NHSE.
- Text Messaging – All outpatient clinic appointments for community teams are now live. Benefits will now be tracked, and a summary will be provided May.

Governance Items

- **Risk Register**

The Committee received the report there was one new risk, one risk closure and one score change.

A new risk relating to the delivery of the 24/25 CIP programme. Committee discussed increasing the risk score. To bring a score change back to next Committee.
Risk closure relating to Project Chrysalis overrunning. Delays to project cannot be mitigated. This will now be complete in Autumn 2025.
A score change relating to the costs of Project Chrysalis.

Committee approved changes to the risk register.

- **BAF Q4**

The Committee reviewed and discussed the contents of the BAF and approved the closure of risk relating to delivery of the financial plan in 23/24. Three BAF risks had mitigations updated which resulted in no score changes.

- **F&R Committee Effectiveness Review**

Committee discussed the positive report, both areas of good practice and areas for attention were highlighted. It was noted that the quality of debate has improved over time. An area for future focus would be defining objectives at the start of the year and having these linked to the strategic priorities followed up with a periodic review.

Other Reports Received:

- North Midlands and Black Country Procurement Group Partnership Agreements – approved.
- Policy Report – Information Security Policy was approved.

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 Russell Andrews
Chair of Finance and Resource Committee

REPORT TO PUBLIC TRUST BOARD

Date of Meeting:	9th May 2024		
Title of Report:	Board Assurance Framework 2023/24 Quarter 4		
Presented by:	Nicola Griffiths, Deputy Director of Governance/Board Secretary		
Author:	Jayne Mottram, Risk Assurance Manager		
Executive Lead Name:	Dr Buki Adeyemo, Chief Executive Officer	**Approved by Exec**	☒

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Purpose of the report:								
Approval	☐	**Information**	☒	**Consider for Action**	☐	**Assurance**	☒	

Executive Summary:

The Board Assurance Framework (BAF) Quarter 4 update is provided for assurance to the Board having been seen and approved at Senior Leadership Team meeting.

Risk 1 - The Trust fails to deliver safe and effective care resulting in patient harm, reputational harm and regulatory restrictions.
Residual Score – 12 proposing a score decrease to a revised residual score of 8, reducing the likelihood from 3 (possible) to 2 (unlikely).
Rationale **–** Majority of the mitigating actions have been achieved, whilst a limited number of actions remain work in progress which can be seen within the body of the BAF document.
Score change agreed at Quality Committee 2nd May 2024

Risk 2 - Failure to deliver the Financial Plan in 2023/24.
Residual score – 4.
Update **-** No longer a risk in 23/24, CIP achieved.
Risk closure agreed at Finance and Resource Committee 2nd May 2024

Risk 3 – Failure to attract, develop and retain talented people resulting in reduced quality and increased cost of services.
Residual score -16
Update **-** Mitigations updated in quarter 4 resulting in no residual score change. Further consideration to be given around the effectiveness of mitigations if not resulting in a score reduction. There was no movement in the residual score for all of 23/24.
BAF circulated virtually to PCDC members as Committee falls after Board.

Risk 4 - The Trust fails to collaborate with service users, carers and communities resulting in an inability to deliver responsive services.
Residual score -12.
Update **-** Mitigations updated in quarter 4 resulting in no residual score change. Further consideration to be given around the effectiveness of mitigations if not resulting in a score reduction. There was no movement in the residual score for all of 23/24.
Noted at Quality Committee 2nd May 2024

Risk 5 - Failure to respond to the demands of services caused by internal and external factors, which might impact on the access, quality and overall experience of services and the wellbeing of service users and staff.
Residual Score **–** 12, proposing decrease to a revised residual score of 8, reducing the likelihood from 3 (possible) to 2 (unlikely).

Rationale – NHS Operating Framework, Combined Healthcare are in segment 1 which is the highest level of assurance as all of our relevant national mental health metrics are in the upper quartile or interquartile range.
Score change agreed at Quality Committee 2nd May 2024

Risk 6 - Failure to optimise resources resulting in an inability to be sustainable and work towards carbon net zero.
Residual score - 9.
Update **-** Mitigations updated in quarter 4 resulting in no score change. Please note there was a residual score change approved within the year, quarter 1 the residual score was 12 reducing in quarter 2 to a residual score of 9.
Noted at Finance and Resource Committee 2nd May 2024

Risk 7 - Failure to develop the estates strategy as a key enabler of quality and transformation may impact on delivery of care, improvement, service user, staff experience and efficiency.
Residual score - 12.
Update **-** Mitigations updated in quarter 4 resulting in no residual score change. Further consideration to be given around the effectiveness of mitigations if not resulting in a score reduction. There was no movement in the residual score for all of 23/24.
Noted at Finance and Resource Committee 2nd May 2024

Risk 8 - Failure to lead and evolve relationships with partners resulting in an absence of system and Trust integration opportunities.
Residual score - 12.
Update **-** Mitigations updated in quarter 4 resulting in no residual score change. Further consideration to be given around the effectiveness of mitigations if not resulting in a score reduction. There was no movement in the residual score for all of 23/24.
Noted at Finance and Resource Committee 2nd May 2024

Other Activities during Quarter 4

- CMO requested a piece of work so Executive leads could easily identify and link 12+ Trust and Operational risks to their individual BAF risks. This has been actioned.
- Running parallel with the Quarter 4 review we have started a piece of work to develop the BAF for 24/25, giving consideration to risks which will close, carry over or new risks which need to be established. This work is ongoing with Executive leads and will be reported in Quarter 1 of 24/25.
- Our internal auditors - MIAA have provided the annual Risk Audit Review final report which notes the improvements made to the BAF so far and includes recommendations for the Trust BAF going forward including developing risk appetite statements against our key risks.
- Board Development will review the proposed BAF 24/25 which includes a number of changes from the 23/24 BAF

Seen at:	SLT ☒ Execs ☒	Document Version No.	1
Committee Approval / Review	• Quality Committee ☒ • Finance & Resource Committee ☒ • Audit Committee ☒ • People, Culture & Development Committee ☒ • Charitable Funds Committee ☒		

Strategic Priorities (please indicate)	1. **Growth** - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care ☒ 2. **Access** - We will ensure that everybody who needs our services will be able to choose the way, the time, and the place in which they access them ☒ 3. **Prevention** - To will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce. ☒	
BAF / Risk / legal implications: Risk Register Reference	1. We will provide the highest quality, safe and effective services ☒ 2. We will attract, develop and retain the best people ☒ 3. We will actively promote partnership and integrated models of working ☒ 4. We will increase our efficiency and effectiveness through sustainable development ☒ Any Risk/legal implications: (please reference if any)	
Sustainability:	1. Reduce the environmental impact of health and social care in Staffordshire and Stoke on Trent ☒ 2. Build a network of climate and sustainability champions across Staffordshire and Stoke on Trent ☒ 3. Share learning and best practice ☒	
Resource Implications: Funding Source:	N/A N/A	
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	There is no direct impact on the protected characteristics as part of the completion of this report.	
ICS Alignment / Implications:	N/A	
Recommendations:	Board to receive the Quarter 4 BAF update for information / assurance.	
Version	Name/group	Date issued

Board Assurance Framework 2023/24

Welcome to the Board Assurance Framework for North Staffordshire Combined Healthcare NHS Trust.

The Trust Board is responsible for ensuring that North Staffordshire Combined Healthcare NHS Trust consistently follows the principles of good governance applicable to NHS organisations. The Board does this through the development of systems and processes for financial and organisational control, clinical and information governance and risk management.

Our Board Assurance Framework identifies the procedures for risk management against our new key strategic objectives, encompassing the management of all types of risk to which the Trust may be exposed, our controls and the assurances we have in place. This includes the effective integration and management of clinical and non-clinical risk.

Those key risks, mapped against our current new three strategic priorities are set out in the following pages.

Strategic Priorities	1. PREVENTION - We will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce. 2. ACCESS - We will ensure that everybody who needs our services will be able to choose the way, the time, and the place in which they access them. 3. GROWTH - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care.

BOARD ASSURANCE FRAMEWORK 2023-2024

BAF Dashboard 2023-2024

Strategic Priority	Risk No.	Risk Description	Executive Lead	Gross Score	Residual Risk Score Qtr. 1	Residual Risk Score Qtr. 2	Residual Risk Score Qtr. 3	Residual Risk Score Qtr. 4	Risk Movement from Previous Qtr.	Target Score	Target Achievement Date	Lead Committee
Prevention	1	The Trust fails to deliver safe and effective care resulting in patient harm, reputational harm and regulatory restrictions.	Chief Medical Officer	16	12	12	12	8	⇩	4	Mar-25	Quality
	2	Failure to deliver the Financial Plan in 2023/24.	Chief Finance Officer	16	12	8	4	4	⇔	4	Mar-24	Finance & Resource
Access	3	Failure to attract, develop and retain talented people resulting in reduced quality and increased cost of services.	Chief People Officer	16	16	16	16	16	⇔	4	Mar-28	People Culture & Development
	4	The Trust fails to collaborate with service users, carers and communities resulting in an inability to deliver responsive services.	Chief Nursing Officer	16	12	12	12	12	⇔	8	Mar-25	Quality
	5	Failure to respond to the demands of services caused by internal and external factors, which might impact on the access, quality and overall experience of services and the wellbeing of service users and staff.	Chief Operating Officer	16	12	12	12	8	⇩	4	Mar-24	Quality
Growth	6	Failure to optimise resources resulting in an inability to be sustainable and work towards carbon net zero.	Chief Strategy Officer	15	12	9	9	9	⇔	6	Mar-28	Finance & Resource
	7	Failure to develop the estates strategy as a key enabler of quality and transformation may impact on delivery of care, improvement, service user, staff experience and efficiency.	Chief Finance Officer	16	12	12	12	12	⇔	8	Mar-24	Finance & Resource
	8	Failure to lead and evolve relationships with partners resulting in an absence of system and Trust integration opportunities.	Chief Strategy Officer	16	12	12	12	12	⇔	8	Mar-25	Finance & Resource

BAF RISK 1	The Trust fails to deliver safe and effective care resulting in patient harm, reputational harm and regulatory restrictions.

SPAR	Safe	Risk Appetite	RAG Rating (Key Showing on Appendix Page)					Gross Score	Residual Risk Score 2023/2024				Target Score / Achievement Date
Risk Start Date	1.4.23	Strategic Priority											
Executive Lead	Chief Medical Officer	Prevention	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Year End	Gross Score (raw score before applying any mitigations)	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Target Score / Achievement Date
Lead Committee	Quality	Level 4 - Seek	On Target for Delivery	On Target for Delivery	On Target for Delivery	On Target for Delivery	On Target for Delivery	Impact 4 x Likelihood 4 = 16	Impact 4 x Likelihood 3 = 12	Impact 4 x Likelihood 3 = 12	Impact 4 x Likelihood 3 = 12	Impact 4 x Likelihood 2 = 8	Impact 4 x Likelihood 1 = 4
									⟺	⟺	⟺	⇩	Mar-25

Context
The Trust currently has a CQC rating of outstanding but this does not mean that we can be complacent, we must continue to strive to be outstanding in everything that we do and ensure that we are continually responding to the dynamic and changing macro-environment within which we work. We continue to face a number of challenges including workforce shortages, increasing demand on services and a reduction in real terms funding for our services. We need to ensure that we mitigate all risks where possible to provide assurance that all services are aligned to the Trust's values and meet expected standards of care. We must continue to harness a learning culture that enables individuals, teams and the organisation to apply learning in order to enhance and improve service delivery. This will be supported through embedding of the principles of quality improvement. COVID shone a light on health inequalities, we have both a legal and ethical duty to ensure we promote and provide services that are accessible and supportive to all within our communities. We will work to break down barriers to care through understanding our equity data and through co-production, reduce and mitigate these differences. We will equip our staff with local data to improve their understanding of health inequalities in our services and empower them apply mitigations to limit the effects of any differences.

	Progress	
Control to Mitigate Strategic Risk	What's Going Well	What are the Current Challenges/ Gaps in Assurance
1. Tackle Health Inequalities: all patients will receive outstanding care irrespective of differences.	Our performance team has developed a model for monitoring of Health Inequalities which enables us to review the impact of differences/diversity on our services and patients. CMO is presenting the findings at the next SLTD (April) to show what has been identified so far and to get ideas and suggestions from the Directorates to formulate next steps.	Data gaps are the issue in terms of not having rich enough data to reach conclusions. Work in progress by engaging with directorate's and teams.
2. Maintenance of CQC Rating of 'Outstanding' by ensuring quality assurance is embedded in the trust as part of usual business.	Preparation in place to prepare for CQC inspection, Trust Quality Assurance meetings are in place, chaired by CNO & overseeing workstreams - quality assurance, towards outstanding, estates & facilities, communication and governance. Well-led external review took place and we are currently awaiting the outcome. Quality assurance visits and inspection preparation for all staff - ongoing.	Clinical directorates are at different stages of preparedness, being supported by corporate teams.
3. Every patient can expect Mental Health Law compliance including response to new reforms. Zero tolerance for failure to comply with the MHA.	Monthly audits are being conducted by all inpatient wards . March compliance equals 78.8% with the range of MHA questions. The Audit allows further scrutiny and identification of areas of focus for the QLIN's to work with ward managers on addressing, 132 section rights. There have been 3 MHA reviewer visits in Q4 :- •Ward 6 – response submitted and action plan progressed. •Summers View formal written report received and response being drafted. •Darwin Centre - not yet received formal written report.	Resolution of IT bottleneck around internal mental health audits.

4. Implementation and embedding system wide agreed ESCA's.	The clinical pathways in Adult services has been agreed and currently being implemented. Identified key collaborators in General Practice, work is still in progress in relation to anti psychotic's. The lithium ESCA has been approved on the 8.4.24 and will be going to clinical senate for ratification.	Supply chain issues with ADHD medication, this has stabilised and we are gently initiating ESCA's into General Practice's but have to be cautious due to an unstable supply chain. Anti psychotic ESCA's, the Trust need to formulate a way forward to address legacy patients.
5. Continue and enhance suicide prevention strategy.	Work plans in place to :- • Increase focus on learning via the implementation of PSIRF - action complete, this will fall part of the internal audit to review the implementation process. • NCISH report reviewed and identified learning opportunities and action plan developed - completed and presented to Quality Committee.	Embedding the PSIRF Trust wide process and there is concern around staff not being up to date, once audit review received we will then be able to understand any gaps which need to be addressed.
6. Implement nursing excellence programme, working with system partners, to ensure that clinical, academic and research excellence is nurtured and recognised.	Engagement to develop programme is underway.	
7. Improve research output by 15%.	Publications have increased in 23/24 from 6 publications in 22/23 to 26 publications in 23/24. Research enabling plan in place and agreed by Trust Board, to provide updates on improved research output. Number of PIs have improved, more people are now trained and 2 to 3 people are doing randomised controlled trials, this is slow positive progress. Received £25k NIHR bid, utilising funding for training and development, our workforce capabilities. Recruited to two posts - Clinical Education and Research Fellows.	

Internal/External Assurance	Category of Assurance
Equality Framework will be rolled out (included PCREF), updates to be reported to QC. Patient reported outcome measures will be planned to be reported via performance monitoring. **Assurance relates to mitigation 1.**	**Category 1**
A rating of 'good' for all core services in the Safe domain (Adult Inpatient Wards). CQC Inspections and finalised ratings. **Assurance relates to mitigation 2.**	**Category 3**
An increase in the number of core services rated as 'outstanding' currently 3/11. **Assurance relates to mitigation 2.**	**Category 3**
Improve ratings of internal MH audits from current baseline and reduce the number of actions generated from CQC unannounced Mental Health Act monitoring visits. Reported through Mental Health Law Group. **Assurance relates to mitigation 3.**	**Category 3**
Harmonise pathways that are aligned to ESCA's, assurance delivered through capturing GP acceptance of ESCA's, reported qtr. 4 through QC. **Assurance relates to mitigation 4.**	**Category 1**
Reduce rates of suicides and ensure up to date risk assessment on all patients. Reporting process through performance. Benchmarked externally. **Assurance relates to mitigation 5.**	**Category 1 & 3**
Accredited preceptorship programme for newly qualified nurses. **Assurance relates to mitigation 6.**	**Category 2**
Work with partners to enhance the Trusts research output and reputation :- Increase number of staff participating in research. Increase number of staff trained as Principal investigator (PI). Increase publications output. **Assurance relates to mitigation 7.**	**Category 2 & 3**

Links to 12+ Trust Risks	Links to 12+ Directorate Risks
Risk 1112 - Patients may use anchored and none anchored ligature points within the environment to cause harm to themselves.	**Risk 601 ASUC** - Patient safety in inpatient areas due to non-anchored ligature self harm.
Risk 1139 - Risk in providing accessible, safe prescribing to patients via effective shared care arrangements (ESCA's).	**Risk 1298 ASUC** - Directorate fails to comply with the MHA/MCA regarding S17 leave, section 132 consent standards.
Risk 1277 - Risk that the Trist fails to comply with MHA/MCA, resulting in risk to quality of care.	**Risk 1837 Community** - Risk of increased waiting times for psychological therapies in the Newcastle, Sutherland and Greenfields CMHT Teams due to a lack of psychological therapist.
Risk 1696 - Risk to the quality and capacity of the pharmacy services due to recruitment challenges. This could result in inadequate governance in relation to medicines, with potential impact to the safety of patients.	**Risk 1897 Specialist, Assessment & Treatment** - Lack of clinical psychologists resources as a result of vacancies and resignations, one single clinician attempting to cover a number of clinical areas potentially leading to workforce stress, client waits, delays in clinical responsiveness, limited resources for supervision of associated psychology workforce.
Risk 1953 - Risk of continued depletion and /or absence of psychological provision in several areas across the organisation.	

BAF RISK 2	Failure to deliver the Financial Plan in 2023/24.													
SPAR	Safe	Risk Appetite	RAG Rating (Key Showing on Appendix Page)					Gross Score	Residual Risk Score 2023/2024				Target Score / Achievement Date
Risk Start Date	1.4.23	Strategic Priority											
Executive Lead	Chief Finance Officer	Prevention	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Year End	Gross Score (raw score before applying any mitigations)	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Target Score / Achievement Date
Lead Committee	Finance & Resource	Level 4 - Seek	On Target For Delivery	On Target For Delivery	On Target For Delivery	On Target For Delivery	On Target For Delivery	Impact 4 x Likelihood 4 = 16	Impact 4 x Likelihood 3 = 12	Impact 4 x Likelihood 2 = 8	Impact 4 x Likelihood 1 = 4	Impact 4 x Likelihood 1 = 4	Impact 4 x Likelihood 1 = 4
									⟺	⇩	⇩	⟺	Mar-24

Context
Achieving financial balance is a statutory financial duty, for which the Trust has a very strong track record. 2023/24 is known to be a challenging financial year with less resource being available than requested by the NHS against a backdrop of industrial action and increasing waiting lists. NSCHT is as well placed as other Trusts to deal with these challenges having planned for a challenging year and has set a recurrent CIP of 3% to reduce the underlying cost base. The overall ICS system remains in a challenging financial position with CHC and prescribing costs being above national benchmarks for the ICB.

	Progress	
Control to Mitigate Strategic Risk	What's Going Well	What are the Current Challenges/ Gaps in Assurance
1. Ensure a business planning cycle is developed for the Trust to demonstrate impact against the new Strategy and Operation Plan.	Planning meeting relating to 24/25 is ongoing, timeline for completion 2nd May.	Deliver developments within the resources available for 24/25.
2. Budget agreed and signed off by the Trust Board prior to 31st March.	Budgets have been agreed and signed off by the Board.	
3. Budget holders sign off their individual budgets and CIP targets.	Budgets have been signed off by individual budget holders.	CIP has been achieved Corporately. Directorates have not achieved their CIP targets and need to focus on the recurrent delivery of their CIP in 24/25.
4. Monthly monitoring of CIP targets and monitoring of progress via F&R Committee.	As at the end of qtr. 4 the Trust has delivered its CIP but the Directorates have not met their individual targets.	
5. Five year financial model aligned to organisational and ICB strategy (year 1 of 5).	Five year financial plan has been presented to the Trust Board.	
6. Maintain MHIS and LDA SDF Investment Standards.	Plan agreed with the ICS to deliver investment standards.	Recruitment into new posts/ substantive posts.
7. Work with ICS partners to jointly own and deliver the ICS financial plan.	Combined Healthcare Trust and MPFT are delivering ahead of plan, the ICB is behind plan.	The System is forecasting a deficit of £91 million.
	General Comments	
		Agency expenditure is above the 3.7% agency cap.

Internal/External Assurance	Category of Assurance
Monthly reports to SLT and F&R. **Assurance relates to all mitigations.**	**Category 1**
Monthly budget statements issued to all budget holders followed up with regular budget holder meetings. **Assurance relates to mitigations 2, 3 and 4.**	**Category 1**
Monthly review of the financial position with oversight by the senior finance team, including the CFO. **Assurance relates to mitigations 2,3,4 and 6.**	**Category 2**
Monthly CIP meeting chaired by the Chief Operating Officer. **Assurance relates to mitigation 4.**	**Category 3**
Monthly review of the ICS financial position with challenge from ICS partners. **Assurance relates to mitigation 7.**	**Category 3**
Annual review of financial management by Internal Audit. **Assurance relates to all mitigations.**	**Category 3**
Scrutiny of finical controls through the Audit Committee. **Assurance relates to all mitigations.**	**Category 1**
Annual external audit of accounts. **Assurance relates to all mitigations.**	**Category 3**

	Links to 12+ Directorate Risks
Risk 868 - Risk to the Trust using agency staff due to staffing difficulties, vacancies, staff sickness and recruitment issues. As a consequence this could impact on the quality of care and Trust reputation due to staff who are unfamiliar and the depth of the induction process, this also as a financial implication for the Trust both in terms of expenditure and exceeding the agency cap set by NHSE.	**Risk 1832 Community** - Expenditure on locum medics will cause financial pressure due to the inability to recruit to substantive medic vacancies.
Risk 1762 - Risk of increased and unexpected costs to be incurred during the phases of work for the Chrysalis project.	**Risk 1836 Specialist** - Expenditure on locum medics will cause financial pressure due to medical vacancies including medical sickness.
	Risk 1952 Specialist Darwin Centre - Financial risk to the directorate due to 3 beds being closed at the Darwin Centre and not being funded by the West Midlands Provider Collaborative due to the Court Ordered patient remaining on the unit.

BAF RISK 3	Failure to attract, develop and retain talented people resulting in reduced quality and increased cost of services.

SPAR	Safe	Risk Appetite	RAG Rating (Key Showing on Appendix Page)					Gross Score	Residual Risk Score 2023/2024				Target Score / Achievement Date
Risk Start Date	1.4.23	Strategic Priority											
Executive Lead	Chief People Officer	Access	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Year End	Gross Score (raw score before applying any mitigations)	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Target Score / Achievement Date
Lead Committee	People Culture & Development	Level 4 - Seek	Risk To Delivery, Plan In Place	Risk To Delivery, Plan In Place	Risk To Delivery, Plan In Place	Risk To Delivery, Plan In Place	Risk To Delivery, Plan In Place	Impact 4 x Likelihood 4 = 16	Impact 4 x Likelihood 4 = 16	Impact 4 x Likelihood 4 = 16	Impact 4 x Likelihood 4 = 16	Impact 4 x Likelihood 4 = 16	Impact 4 x Likelihood 1 = 4
									⟷	⟷	⟷	⟷	Mar-28

Context
Our services are our People. As an organisation the quality and safety of our services is 100% reliant on attracting, developing and retaining talented people. The current climate for the healthcare workforce is challenging. Across the NHS we are seeing record numbers of vacancy and turnover levels and Combined is not immune to these challenges. At Quarter 1 we have 13.9% vacancy level (an increase from 10.7% due to additional investment in services and therefore an increased establishment). Encouragingly we are seeing a reduction in turnover however, this is still not at target levels of 10%. In response to these challenges the Trust has developed a refreshed People Plan with an aspiration of achieving a vacancy level below 5%: turnover level of less than 8%: a workforce which is representative of our communities at every level: a sickness absence rate of less than 4% and NHS Staff Survey Results in the top 3 nationally and to be one of the best employers in the country. In addition, the new Long Term Workforce Plan supports the development of substantial, additional, professional registered practitioners across the country over the next 15 years. The Trust will be linking these two documents together to ensure we have the most robust plans in place.

	Progress	
Control to Mitigate Strategic Risk	What's Going Well	What are the Current Challenges/ Gaps in Assurance
1. Maximise collaborative working across the ICB, to build skills and capacity in the local health economy.	High Potential Scheme cohort 2 underway. System leadership role for EDI and leadership talent. Hosting the Psychological Wellbeing hub for the system. Working collaboratively on delivering the system people plan and priorities. Leading Education & Development project group: statutory/mandatory and digital education.	Financial challenges linked to additional bureaucracy around vacancies. A number of projects will either have reduced funding or confirmed no funding at all to deliver certain programmes.
2. People Plan.	People Plan agreed by Board - ongoing monitoring of work streams and KPIs via People Culture and Development Committee.	Ensuring we have sufficient capacity to deliver our Combined People Plan (ongoing funding arrangements). Appropriate digital systems and automation of some people practices - Rostering for all, Electronic Staff Records, Self Service for all. National challenge around Medical and Dental pay and terms and conditions remains ongoing leading to continued industrial action. Financial challenges and lack of identified budgets/agreements may impact on future delivery for year 2.
3. NHS Long Term Workforce Plan.	Scoping exercise to align with our People Plan. Paper was submitted to PCDC in December 23, currently awaiting national guidance.	National shortage of many professionally registered healthcare professionals. Delivery against national Long Term Workforce Plan aspirations with growing workforce.

4. Inclusion Delivery Plan (including Equality Delivery System, National Equality, Diversity & Inclusion Plan) - The care that services users and carers receive respects (reflects) the diverse requirements of our local population The workforce more accurately represents the community it serves through themes identified.	Continued work throughout 2023-24 to further embed our culture of inclusion throughout the organisation. Key approaches and achievements in 2023-24 to deliver:- WF representation (comp. to 31.3.23) -10.5% ethnic diverse wf (up from 9.7%) - 5.0% LGB (up from 4.3%) - Disability 8.3% (up from 7.1%) Trust Anti-Racist Statement and See Me First badge launched. Programme of activities and education delivered for Black History Month, October 2023, including Show Racism the Red Card Trust Conference. Trust 7th nationally for 2023 WDES performance and in top 10% on WRES performance for a number of measures, including best score nationally on belief in equal opportunities (in WRES). Three Trust services have been reviewed over a 2-year period as part of the EDS: Learning Disabilities services, Health Checks in SMI and Interpretation and Translation services. (Report for approval and publication shortly). Trust new Inclusion and Belonging Strategic Plan going through approvals (as at end March 2024).	Current Census figures demonstrate a clear overall underrepresentation compared to local ethnic diverse population (11.2% in the revised 2022 census data), even though our representation is increasing. Whilst the Trust continues to perform strongly in national benchmarking, there are concerns about lack of psychological safety to raise concerns raised via the ENRICH Network and concerns that our recruitment processes continued to be impacted on by racial bias and/or discrimination. This is a key area for action in 2024-25.
5. Enhance our staff and wellbeing activities and initiatives to ensure that our working environment is supportive and encourages self-care.	The Trust hosts the Staffs and Stoke Staff Psychological Wellbeing Hub on behalf of the ICS and has sufficient funding remaining to continue the provision of the service until at least until November 2024 to ensure we offer confidential, high quality, timely and personalised support to our colleagues. Exploration of longer term sustainable solution is being reviewed via the ICB. Health and Wellbeing Champions relaunched and developed further - currently have 28 Wellbeing Ambassadors with further recruitment drives planned. Wellbeing Toolkits and training for all Wellbeing champions delivered. Health and Wellbeing plan in development for 24/25. Health and Wellbeing initiatives across the Trust have been met with positivity, initiatives launched for: Health and wellbeing facilitated days, Menopause, Men's Health, Weight Management, Combined Choir, Combined Running Club, Health and Wellbeing Days, new chapter on LMS to support H&W, Staff MOT days etc.	Post Pandemic reported staff fatigue remains a challenge in general. Business case submitted to the ICS for continued funding for the Psychological Hub. If no further funding ICS shared risk of redundancy for 1 WTE Band 8 employed by Combined. Workforce capacity for staff to be released and being able to attend to participate in the Wellbeing programmes is a challenge due to the ongoing staffing pressures. Financial challenges may impact this work stream moving forwards in terms of the ability to continue to deliver Health & Wellbeing initiatives.
6. Embed Values and Behaviour Framework.	Aspect of values based recruitment is in place. WRES/WDES demonstrates improved equity in employment practices. Working group is formed and plan is in development. Values and behaviours framework to be reviewed and re-launched through JRLC & Civility project. Initial civility leadership academy held. Just Restorative Learning Culture and Civility steering group commenced, plan in place to develop roll out. Civility LMS e package developed and launched.	Continue to abide and deliver our Trust values based approach, within our behavioural framework in a time pressured environment with financial constraints.
7. Workforce Planning regarding Vacancies.	Recruitment programmes are in place with new cohorts of nurses to start autumn 2023 - 43 nurses started October/November. Business case for workforce planning developed and approved. Training to develop operational knowledge and skills for Workforce planning to all Associate Directors remains ongoing.	Workforce Planning, operational capacity and capability within the Trust. National challenges with regards to the operational planning cycle and financial pressures across the system.
8. Development of clinical leadership.	Work ongoing with partners to produce excellent clinicians to: Improve and maintain excellent Medical Education QA ratings - recently received excellent. Embed physician associate training and contribute to regional review and development for Educational framework for PA apprentice recruited and in place. Combined has commenced PA workstream with the WM Provider Collaborative to support PA. PLAG to be re-established and to host an MDT conference to take place 20th March 2024. Clinical Director leadership Programme being scoped ensuring alignment with existing internal offers and new Leadership Competency Framework.	Plans to develop Clinical Leadership Framework across the Trust.
9. Job Planning / resourcing/maximising.	New job planning process procured and implemented. Training for all CD's for job planning now actioned. Transition over to SARDS has been received well, it is anticipated to improve the process of job planning (medics specifically).	Ensuring CD's proactive schedule job plans.

10. Develop The Trust's workforce and ensuring Combined Healthcare continues to be a great place to work.	Delivery of people plan - refer to action reference 2. Coaching Culture Platform launched. 2023 Staff Survey results show that Combined continues to perform well, achieving better that average across all domains, and benchmarks higher that other MH Trusts in the majority of scored domains. To include as part of work plan: Medical Appraisal: Every doctor to have a high quality annual appraisal, this is on track and annual organisational appraisal statement has gone through PCDC. Enhance and embed digital opportunities to improve patient care (PLICS etc.). Just Restorative Learning Culture and Civility 3 year transformation plan developed. Year 1 - training for 20+ people, steering group, project plan, 8 Task and Finish Group commenced: Psychological Safety, Processes, Policies, Communications, Staff & Patient Safety, Training, OD and Data. Widening Participation - Fully maximised Apprenticeships, 2 cohorts Princes Trust, commenced T Levels, Work Experience delivered F2F and virtually. ICS Occupational Health contract launched April 2023.	Ensuring capacity to deliver people plan. Occupational Health contract delivery challenges and issues identified: Hep B & MMR, recruitment, PEP letters. Vaccination risks raised on Trust Risk Register. Work ongoing to resolve and monitor these issues (which are system wide - improving performance to date.
11. Senior Leadership Development.	Procured Deloitte provider to lead on a Trust Well Led Review, to be delivered in Q4.	Slight delay as a result of protractive procurement process. Well led review is now underway.

Internal/External Assurance	Category of Assurance
Continue to develop programmes in collaboration with delivery partners and other NHS Trusts and stakeholders. Cohorts of staff from local health economy learning together. **Assurance relates to mitigation 1.**	**Category 3**
Deliver 23/24 outcomes of the People Plan as assured through PCDC. **Assurance relates to mitigation 2.**	**Category 1**
Delivery of targets / outcomes - modify People Plan to incorporate elements. **Assurance relates to mitigation 3.**	**Category 1**
Staff Survey, WRES / WDES Annual D&I Report. **Assurance relates to mitigation 4 and 6.**	**Category 2 - Aiming**
Continue to deliver targets for wellbeing hub as per internal reporting. **Assurance relates to mitigation 5.**	**Category 1 & Category 3**
Evidenced in all development programmes e.g. In Place Systems Leadership Programme. **Assurance relates to mitigation 6.**	**Category 2**
Continues to be monitored via monthly performance meetings. **Assurance relates to mitigation 7.**	**Category 1**
Plans developed and delivered/realised for: Nursing. Medical. Psychology. AHP. Social Worker, Pharmacy. **Assurance relates to mitigation 8.**	**Category 1**
Review implementation and report through PCDC, ensuring best value of resources and staff wellbeing. **Assurance relates to mitigation 9.**	**Category 1**
Learning and Development Annual Report outlines both activity and impact of development within Combined and is presented to PCDC. **Assurance relates to mitigation 10.**	**Category 2**
11. Lead Well Review, Develop and implement Board Development, Programme based on Well Led Review and wider feedback, Deliver Year 1 of Governance Plan. **Assurance relates to mitigation 11.**	**Category 1**

Links to 12+ Trust Risks	Links to 12+ Directorate Risks
Risk 12 - Insufficient staff to deliver appropriate care because of staff vacancies and increased referrals.	**Risk 1238 ASUC** - Over reliance of temporary staffing due to number of vacancies across inpatient areas and Crisis Care centre.
Risk 868 - Trust using agency staff due to numerous staffing difficulties.	**Risk 1906 ASUC, Crisis Care Centre** - Risk of service responsiveness, quality, effectiveness and safety for individuals referred due to significant increase in referrals and current vacancies.
Risk 900 - Trust does not provide inclusive services that recognise the diverse nature of our service users.	**Risk 1609 Community, CAMHS Core Services** - Not achieving the 3 week wait target due to low level staffing levels.
Risk 1696 - Risk to the quality and capacity of the pharmacy services due to recruitment challenges. This could result in inadequate governance in relation to medicines, with potential impact to the safety of patients.	**Risk 1832 Community** - Expenditure on locum medics will case financial pressure due to the inability to recruit to substantive medic vacancies.
Risk 1699 - Increased pressure on staff to deliver appropriate clinical services due to cumulative result of an increase service demand and ongoing workforce supply challenges.	**Risk 1837 Community** - Risk of increased waiting times for psychological therapies in the Newcastle, Sutherland and Greenfields CMHT Teams due to a lack of psychological therapist as a consequence of this waiting times could increase.
Risk 1856 - Threat to not achieving a small number of statutory and mandatory training.	**Risk 1880 Community, ASD School Age** - Risk to waiting times in CAMHS ASD service due to the challenges in recruitment.
Risk 1948 - Employees may experience violence and aggression within the work place from people that use our services.	**Risk 1836 Specialist** - Risk that the expenditure on locum medics will cause financial pressure on the Specialist Directorate budget due to medical vacancies including medical sickness, a consequence of which is the directorate will overspend against budget.
Risk 1953 - Risk of continued depletion and /or absence of psychological provision in several areas across the organisation.	**Risk 1897 Specialist** - Risk to learning disability services due to the lack of clinical psychologists resources as a result of vacancies and resignations. A consequence of this is one single clinician attempting to cover a number of clinical areas potentially leading to workforce stress, client waits, delays in clinical responsiveness, limited resources for supervision of associated psychology workforce i.e. assistance/trainees.
	Risk 1937 Specialist, CDAS Stoke Community - Increased wait times due to reduced medic cover within Stoke CDAS as a consequence patients are not currently being reviewed in line with trust standards/national standards.

BAF RISK 4	The Trust fails to collaborate with service users, carers and communities resulting in an inability to deliver responsive services.												
SPAR	Personalised	Risk Appetite	RAG Rating (Key Showing on Appendix Page)					Gross Score	Residual Risk Score 2023/2024				Target Score / Achievement Date
Risk Start Date	1.4.23	Strategic Priority											
Executive Lead	Chief Nursing Officer	Access	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Year End	Gross Score (raw score before applying any mitigations)	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Target Score / Achievement Date
Lead Committee	Quality	Level 4 - Seek	On Target For Delivery	On Target For Delivery	On Target For Delivery	On Target For Delivery	On Target For Delivery	Impact 4 x Likelihood 4 = 16	Impact 4 x Likelihood 3 = 12	Impact 4 x Likelihood 3 = 12	Impact 4 x Likelihood 3 = 12	Impact 4 x Likelihood 3 = 12	Impact 4 x Likelihood 2 = 8
									⟺	⟺	⟺	⟺	Mar-25

Context
The Trust aims to provide outstanding, high quality care for the people of Stoke on Trent and North Staffordshire. In order to achieve the delivery of truly outstanding care, we must have strong collaboration with service users, carers and communities to ensure care is tailored to meet the needs of our people. Collaboration will take the form of a wide range of activities across the Trust including in clinical practice, operational management and corporate governance. A key enabler for this is our work on further embedding co-production across our clinical services and corporate departments. Co-production refers to a way of working where service providers and users work together to reach a collective outcome. The approach is value-driven and built on the principle that those who are affected by a service are best placed to help design it. Without strong collaboration with service users, carers and communities, we are unlikely to deliver our strategic aims in relation to access, prevention and growth.

	Progress	
Control to Mitigate Strategic Risk	What's Going Well	What are the Current Challenges/ Gaps in Assurance
1. Implementation of Community Mental Health Transformation Programme – including greater emphasis on working in partnership with non-statutory partners and communities.	Existing structures in place to enable service users & carers views to be heard, including Service Users and Carer Council and peer involvement in the programme and community engagement.	Capacity to undertake true coproduction and resource pressures across partners in Local Authority and VCSE organisations who we partner with.
2. Health inequalities work - Focus on identifying and targeting those with highest need and addressing equality issues for minority groups.	Patient and Carer Race Equality Framework (PCREF) analysis and launch being planned with ENRICH forum which will identify and develop model for monitoring of health inequalities and review impact of differences/diversity on our services and patients. Our performance team has developed a model for monitoring of Health Inequalities which enables us to review the impact of differences/diversity on our services and patients. CMO is presenting the findings at the next SLTD (April) to show what has been identified so far and to get ideas and suggestions from the directorates to formulate next steps.	PCREF work in early stage development, not socialised across the Trust or partners. Data not yet available in a coherent way to shape our approach. Embedding the PSIRF Trust wide process and there is concern around staff not being up to date, once audit review received we will then be able to understand any gaps which need to be addressed.
3. Design and implementation of new approach to assessment and planning of care for mental health as a replacement for the Care Programme Approach (CPA), including recovery focussed care planning and standardised outcome measures.	Currently testing new care planning standards and piloting roll out of the implementation of dialogue plans. Training in place and delivered for community staff, phase two commencing in 24/25 targeting in patient staff.	Although training is being rolled out, cultural change will take longer for the new ways of working and recovery principles to be fully adopted.
4. Develop a Trust wide systematic approach to co-produce quality improvements and determine the frequency of QI reporting through performance.	Training accessible at all levels. Live QI project and completed projects reported to SLT.	Linking operational challenges, quality assurance activity and being able to intelligently target quality improvement activity still an area which is under-developed.
5. Recovery and living well approach – expansion of the number and scope of peer recovery roles across the Trust, expansion of wellbeing college and inclusion of lived experience into governance and management decision making processes.	Network of peer support workers established. Review of SUCC reported during November 2023.	Approach has been approved by Trust board, which will now be implemented in 24/25.
6. Maintain Veterans Aware Status and improve Veterans Healthcare.	Plan developed for reaccreditation and regular 'touch points of what we have achieved so far. Veterans inclusion event.	
7. Capacity in community mental health teams to meet the needs of local communities.	Reporting of community safe staffing metrics reported through committee and Trust board in January 2024.	Development and refinement of metrics and actions relating to community safe staffing assurance needed during 2024.

Internal/External Assurance	Category of Assurance
Measure SU experience of the Academy and report to QC. **Assurance relates to mitigation 1.**	**Category 2**
The Trust will achieve a year on year improvement for the overall indicator of "better" in the Community Mental Health Survey. **Assurance relates to mitigation 1**.	**Category 3**
Equality Framework will be rolled out (included PCREF), updates to be reported to QC. Patient reported outcome measures will be embedded and reported via performance monitoring. **Assurance relates to mitigation 2.**	**Category 1**
Implementation of PRSB care planning standards and outcome measures. **Assurance relates to mitigation 3.**	**Category 3**
Percentage of QI activity which is co produced will be monitored through performance & QI reporting through performance will be routine. **Assurance relates to mitigation 4.**	**Category 1**
Improve ratings of internal MH audits from current baseline and reduce the number of actions generated from CQC unannounced Mental Health Act monitoring visits. Reported through Mental Health Law Group. **Assurance relates to mitigation 5.**	**Category 3**
Achieve Veterans Aware reaccreditation. **Assurance relates to mitigation 6.**	**Category 3**
Community safer staffing monitoring implemented. **Assurance relates to mitigation 7.**	**Category 1**

Links to 12+ Trust Risks	Links to 12+ Directorate Risks
Risk 900 - Risk that the Trust does not provide inclusive services that recognise the diverse nature of our service users.	**No linked risks.**

BAF RISK 5	Failure to respond to the demands of services caused by internal and external factors, which might impact on the access, quality and overall experience of services and the wellbeing of service users and staff.

SPAR	Accessible	Risk Appetite	RAG Rating (Key Showing on Appendix Page)					Gross Score	Residual Risk Score 2023/2024				Target Score / Achievement Date
Risk Start Date	1.4.23	Strategic Priority											
Executive Lead	Chief Operating Officer	Access	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Year End	Gross Score (raw score before applying any mitigations)	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Target Score / Achievement Date
Lead Committee	Quality	Level 4 - Seek	Risk To Delivery, Plan In Place	Risk To Delivery, Plan In Place	On Target For Delivery	Risk To Delivery, Plan In Place	Risk To Delivery, Plan In Place	Impact 4 x Likelihood 4 = 16	Impact 4 x Likelihood 3 = 12	Impact 4 x Likelihood 3 = 12	Impact 4 x Likelihood 3 = 12	Impact 4 x Likelihood 2 = 8	Impact 4 x Likelihood 1 = 4
									⟺	⟺	⟺	⇩	Mar-24

Context
There remains a constant increase in the number of people both requiring and accessing mental health, learning disability and autism services. In part this relates to the increased availability of historically underinvested services due to additional funding streams including the MHIS and SDF but services are also seeing increases in demand due to demographic changes and the after affects of the COVID pandemic. As a result Combined services are expanding from a financial perspective, but the phasing of the increased funding does not necessarily match with the ability to recruit staff or the ability to obtain other supporting resources to meet the increase in need. The Trust sits within segments1 (the highest, best performing) of NHS England's single oversight framework.

	Progress	
Control to Mitigate Strategic Risk	What's Going Well	What are the Current Challenges/ Gaps in Assurance
1. Additional funding allocations have been secured for Childrens ASD assessments, Adult ADHD, Perinatal Mental Health Services and the integration of mental health into NHS 111 services. Although the Trust was ready for a soft go live of the NHS 111 Mental Health option on the 1st December, NHS England were not and therefore this has been delayed , this does not impact on the full go live from the 1st April 2024.	Additional funding allocations have been secured for Childrens ASD assessments, Adult ADHD, Perinatal Mental Health services and the integration of mental health into NHS 111 services. Trust Board approved additional funding for 111 at January 24 meeting. As a Trust we we are ready for the soft launch for 111, this did not happen on the 1st December due to the national position. The hard launch which was provisionally planned for 2nd April is not happening on this date due to the national team are not ready. We are awaiting a revised date from NHS England.	Childrens ASD waiting times are still too long, and the capacity is still being outstripped by demand. Due to challenges with the procurement process we were unable to outsource any assessments during the time period despite the funding being allocated. Adult ADHD staff are in place and are now being trained, however this is taking longer than anticipated and therefore there remains some concerns around capacity around the service, this will be monitored once the system goes live. The Trust now has a plan in place for the implementation of NHS 111, however this is based on theoretical data supplied by the centre and therefore it is not known if our capacity will meet the demand, this will be continued to be monitored. There is further investment plans into Perinatal Mental Health Services for 24/25 as part of the MHIS, however the system financial plan has not yet been fully agreed, this cannot be confirmed at this stage.
2. Recruitment in all of these areas is underway and each service has introduced innovative new staffing models to aid in their ability to meet increasing demands when considering the available staffing challenges. In addition the previous decisions of the Trust board to invest in additional staffing resources (such as apprentices) is also aiding in mitigating the risk.	Recruitment in each of these areas is progressing. Community Mental Health services perform well against national measures. TCP (adults and NHSE) is on track to meet its challenging trajectory and Childrens has a mitigation plan in place. The majority of national performance standards are consistently met.	Childrens autism waiting times remain the most significant challenge, in addition we have identified a data quality issue which was impacting on the children's data flowing into MHSDS, this has now been corrected and the Performance Team are looking at re-submitting the data.

3. Performance across all indicators continues to be monitored at both Directorate and Trust level through the trust Performance meetings and IQPR. .	The Trust continues to perform consistently well against a range of national measures and is in the upper or interquartile range for all relevant measures.	The Trust is undertaking work to prepare for the new national waiting times standards which will be implemented in 24/25. As part of this we are undertaking work to clear long waiting patients which were not as clearly defined using the old metrics. A specific update paper was taken to F&R in February 24 outlining the potential impact of the new waiting time standards. Working in conjunction with MPFT and the ICB we are doing a co-ordinated piece of work across the system to better understand the waiting times for children's autism services.

Internal/External Assurance	Category of Assurance
Continually monitor as part of performance management processes, occurs daily basis. **Assurance relates to mitigation 1.**	**Category 1**
Monitoring and assurance via the Integrated Quality and Performance Report to Board and sub-committees on a monthly basis. **Assurance relates to mitigation 1.**	**Category 2**
Monitoring of any Complaints and Concerns. **Assurance relates to mitigation 1.**	**Category 1**
Performance Scrutiny both internally, by the ICB/ICS and NHS England. System Mental Health review meetings with NHS England, and quarterly Learning Disability/Autism meetings, CHC data falls part of the meeting. The majority of systems across the Midlands are on a monthly reporting review for Learning Disability/Autism and we are one of two systems who are dropped to quarterly based on our performance**. Assurance relates to mitigation 3.**	**Category 2/3**
NHS England single oversight framework rating for the Trust, occurs quarterly basis. **Assurance relates to mitigation 3.**	**Category 3**
System piece of work understanding around children's autism waits. **Assurance relates to mitigation 3.**	**Category 3**

Links to 12+ Trust Risks	Links to 12+ Directorate Risks
Risk 1139 - Risk providing accessible safer prescribing to patients via effective shared care arrangements due to GP's refusing to accept ESCA's prescribing in the community.	**Risk 1238 ASUC** - Risk of over reliance on temporary staffing because of the number of vacancies for Registered Practitioners across the Directorate and the Crisis Care Centre. Consequence of potential challenge to achieve performance targets, inability to deliver high quality care and meeting service user expectations with an increased pressure upon existing substantive staff.
Risk 1699 - Risk due to increased pressure to deliver appropriate clinical services due to ongoing service pressures result in increase in service demand and ongoing workforce supply challenges.	**Risk 1906 ASUC, Crisis Care Centre -** Risk of service responsiveness, quality, effectiveness and safety for individuals referred due, to significant increase in referrals and current vacancies.
	Risk 1957 ASUC - There is a risk that a lack of bed availability for patients that have been assessed as requiring admission to hospital due to a reduction in bed numbers and a consequence of this is that a patient will have to remain in the community whilst waiting for a bed to be located.
	Risk 1893 ASUC - There is a risk to patients and staff safety due to the level of violence and aggression from members of the public displayed at the CCC. In addition to this weapons are being brought on site and a consequence of this could be harm to others.
	Risk 1609 Community, CAMHS Core Services - Not achieving the 3 week wait target due to low level staffing levels.
	Risk 1837 Community - Risk of increased waiting times for psychological therapies in the Newcastle, Sutherland and Greenfields CMHT Teams due to a lack of psychological therapist as a consequence of this waiting times could increase.
	Risk 1880 Community, ASD School Age - Risk to waiting times in CAMHS ASD service due to the challenges in recruitment.
	Risk 1919 Community - Risk that the mobilisation of the Adult ADHD service will not be fully functioning as per agreed contract by 1 July 2023 due to the team not being fully recruited.
	Risk 1968 Community - There is a risk relating to Adult ADHD due to the volume of referrals compared to the original data which informed the business case. As a consequence, waiting lists are increasing and patients will not be receiving timely assessments in line with the national guidance of 18 weeks.

Risk 1982 Community - There is a risk of internal waits for allocation to a care co-ordinator due to capacity of staffs caseloads as a consequence of this CYP will have longer waits for allocation and ongoing work/therapy.
Risk 1667 Primary Care Moorcroft - Risk that service users may not be able to access services in a safe and timely manner due to increasing service user demand (including winter pressures) and recognised challenged general practice access
Risk 1974 Primary Care - There is a risk that not enough patients are being referred into Stoke NHS Talking Therapies for them to achieve their prevalence metric. This is due to pathway awareness and knowledge within GP surgeries and consequently the trust is falling below the contract performance metric and an increase of referrals per month is needed to ensure patients receive NICE approved evidence based Talking Therapies.
Risk 1937 Specialist - There is a risk of increased wait times due to reduced medic cover within Stoke CDAS as a consequence patients are not currently being reviewed in line with trust standards/national standards.
Risk 1897 Specialist - Risk to learning disability services due to the lack of clinical psychologists resources as a result of vacancies and resignations.

BAF RISK 6	Failure to optimise resources resulting in an inability to be sustainable and work towards carbon net zero.

SPAR	Recovery	Risk Appetite	RAG Rating (Key Showing on Appendix Page)					Gross Score	Residual Risk Score 2023/2024				Target Score / Achievement Date
Risk Start Date	1.4.23	Strategic Priority											
Executive Lead	Chief Strategy Officer	Growth	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Year End	Gross Score (raw score before applying any mitigations)	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Target Score / Achievement Date
Lead Committee	Finance & Resource	Level 4 - Seek	Risk To Delivery, Plan In Place	On Target for Delivery Plan	On Target for Delivery Plan	On Target for Delivery Plan	On Target for Delivery Plan	Impact 3 x Likelihood 5 = 15	Impact 3 x Likelihood 4 = 12	Impact 3 x Likelihood 3 = 9	Impact 3 x Likelihood 3 = 9	Impact 3 x Likelihood 3 = 9	Impact 3 x Likelihood 2 = 6
									⟺	⇩	⟺	⟺	Mar-28

Context
On 1st July 2022, the NHS became the first health system to embed net zero into legislation, through the Health and Care Act 2022. This places duties on NHS England, and all trusts, foundation trusts, and integrated care boards to contribute towards statutory emissions and environmental targets. The Act requires commissioners and providers of NHS services specifically to address the net zero emissions targets. It also covers measures to adapt to any current or predicted impacts of climate change identified within the 2008 Climate Change Act. Trusts and integrated care boards (ICBs) will meet this new duty through the delivery of their localised Green Plans, and every Trust and ICB in the country now having a board-level lead. To support them, statutory guidance, including The Delivering a Net Zero National Health Service report, and the Net Zero Supplier Roadmap, are available to assist with the delivery of these duties. In 2022, the Trust developed Green Plan and this was approved by Board.

	Progress	
Control to Mitigate Strategic Risk	What's Going Well	What are the Current Challenges/ Gaps in Assurance
1. The Trust is a key system partner in delivering ICS Greener Plan based on 9 priority areas including the development of the ICS Green Delivery Plan 2023/25.	Regular attendance for System meetings and events and strengthening relationships contributing to sharing of information, ideas and good practice. ICS Greener Plan reporting now demonstrating positive contribution of the Trust in relative terms with other System partners. TMO Operational Plan for 24/25 includes refresh of Trust's Green Plan which will help to ensure alignment. Scoping activity has commenced on most appropriate format for Sustainability Impact Assessment with the aim of having this agreed and a process embedded during Q1 of 24/25.	Not all of the ICS Area of Focus working groups are operational yet, so there is a risk that in the absence of these groups Trust activity may not align with the direction of these groups once established. This is being mitigated through regular communication the with ICS Sustainability lead.
2. Developed the Trust's Green Plan for 2022 onwards and agreed 43 Green Sustainable Initiatives as part of the Delivery Plan to contribute to/achieve national targets.	TMO are now able to assure against the delivery of the Trust's Green plan. Successful roll out and uptake of Carbon Literacy Training, which the Trust led on for the system. NHSE Environmentally Sustainable Healthcare (ESH) training now part of Trust's mandatory training on LMS with increasing completion rates for all staff. Endotherm business case approved in Q3 which will be implemented from Q4 onwards and contribute to a reduction in emissions and costs. 'Go Green Go Digital' week held in December, the first of its kind within the Trust helping to raise awareness and offering a platform to develop similar activities. Staff Travel to Work Survey successfully completed with a good response rate and a Travel and Transport group has been established to progress a sustainable transport plan. This has included developing links with leads for sustainable transport in both local authorities. Regular reporting on CO2 emission data for vehicle use is now embedded.	Ensuring the continued motivation and meaningful engagement and contribution of Sustainability Champions with Trust-wide representation. Feedback from existing Sustainability Champions has been used to inform a plan of how we move forward. The number of Sustainability Champions has continued to grow. The Trust's Green Plan for 2022 onwards was developed in 2021 and is therefore approaching the point where a refresh is required. This has been planned to commence in Q1 of 24/25.

3. Commenced reporting against the initiatives through Trust Governance.	Quarterly Green dashboard is provided through to SLT and Finance and Resource Committee via a stand alone Sustainability Assurance report. A refreshed Governance structure has been agreed for 2024 and will include increased accountability for reporting via Area of Focus leads embedding ownership of the Delivery Plan across the Trust. A comms and engagement plan has been developed for 24/25 which includes a focus on KPIs for each Area of Focus and demonstrating and celebrating progress against these via a range of initiatives across the Trust. During Q4 there has been a significant reduction in the number of initiatives within the Trust Delivery Plan rated as Amber from 25% to 10%.	Recognising the high number of KPIs across the Sustainability Programme a proposal has been made to identify a small number of priority KPIs within each Area of Focus to drive progress. These KPIs are yet to be agreed but a plan is in place to ensure this is completed by the end of April 2024.

Internal/External Assurance	Category of Assurance
Attendance and participation at the ICS Greener Board which include the Trust quarterly NHSE Sustainability return - qtr. 3 actioned and now preparing for qtr. 4. **Assurance relates to mitigation 1.**	**Category 3**
Act as a workstream lead on behalf of the system against a priority area. **Assurance relates to mitigation 1.**	**Category 3**
The Trust Green Plan informed the development of the Trust Strategy 2023/2028 and gives commitment to the system contribution. **Assurance relates to mitigation 2.**	**Category 2**
Returns and reports on delivery and progress including TMO assurance report and annual report plus inputs to ICS Strategy and Operating Plans and QSRM packs, Estates and Facilities complete and submit their ERIC returns. **Assurance relates to mitigation 3.**	**Category 2**

Links to 12+ Trust Risks	Links to 12+ Directorate Risks
No linked risks.	**No linked risks.**

BAF RISK 7	Failure to develop the estates strategy as a key enabler of quality and transformation may impact on delivery of care, improvement, service user, staff experience and efficiency.

SPAR	Safe	Risk Appetite	RAG Rating (Key Showing on Appendix Page)					Gross Score	Residual Risk Score 2023/2024				Target Score / Achievement Date
Risk Start Date	1.4.23	Strategic Priority											
Executive Lead	Chief Finance Officer	Growth	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Year End	Gross Score (raw score before applying any mitigations)	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Target Score / Achievement Date
Lead Committee	Finance & Resource	Level 4 - Seek	On Target For Delivery	On Target For Delivery	Risk to delivery Plan	Risk to delivery Plan	Risk to delivery Plan	Impact 4 x Likelihood 4 = 16	Impact 4 x Likelihood 3 = 12	Impact 4 x Likelihood 3 = 12	Impact 4 x Likelihood 3 = 12	Impact 4 x Likelihood 3 = 12	Impact 4 x Likelihood 2 = 8
									⟺	⟺	⟺	⟺	Mar-24

Context
The estates strategy is seen as a key enabler to help deliver transformation and improve the patient experience. The Trust operates out of in excess of 30 sites which are a mix of leased and owned premises, and the demand for additional clinical space continues to increase. The overall strategy is about consolidating the estate we use and making more use of agile working and agile appointments. This aligns with the ICS estates strategy.

	Progress	
Control to Mitigate Strategic Risk	What's Going Well	What are the Current Challenges/ Gaps in Assurance
1. Deliver the Estates Strategy and start to implement it.	Draft Estates strategy has been reviewed leading to further work required to deliver the final strategy.	Delay in the final Estates strategy. Capacity within the Estates team due to being a small team, combined with some sickness and vacancies. Continual demand for additional space form clinical teams.
2. Delivery the Capital Programme, in particular Project Chrysalis.	Project Chrysalis is progressing well despite identifying water temperature issues on several wards. Project Chrysalis - 2 wards have now moved.	Project Chrysalis is currently 20 weeks behind schedule and will be further delayed, timescale still to worked through, this is due to water issues and will not be recovered.
3. Ensure the Trust's capital allocation is spent effectively and in a timely manner.	Going to plan.	
4. Support the transformational programmes of work to enhance service user experience and quality of care.	A number of projects which are ongoing.	Not enough capital resource to reconfigure our estates.
	General Comments	
	Good engagement of estates issues throughout the organisation.	Through closely monitoring of the PFI contract more issues have arisen, in particular in respect of water temperature issues and fire door safety compliance.
	Good progress is being made with P2G regarding PFI monitoring.	
	Achieving internal targets for planned preventative maintenance and reactive maintenance - performance has significantly improved in the last six months.	

Internal/External Assurance	Category of Assurance
Monitor Estates KPIs through the F&R Committee. **Assurance relates to mitigations 2,3 and 4.**	**Category 1**
Regular oversight of estates projects by the senior estates team and CFO. **Assurance relates to all mitigations.**	**Category 1**
Project Chrysalis Board chaired by SRO. **Assurance relates to mitigation 2.**	**Category 1**
Regular oversight by internal audit. **Assurance relates to all mitigations.**	**Category 3**
Benchmarking ERIC return, actioned and submitted to NHSE. **Additional assurance provided not tagged to any of the above mitigations, general comment.**	**Category 2**

Links to 12+ Trust Risks	Links to 12+ Directorate Risks
Risk 1760 - Project Chrysalis may run over timeline included within the business case and MOU agreed with NHSE.	**Risk 1677 Community** - Unable to deliver physical health checks and psychological assessments at the Hope Centre due to lack of availability of clinic rooms
Risk 1762 - Risk of increased and unexpected costs to be incurred during the phases of work for the Chrysalis project.	**Risk 1211 Specialist, Assessment & Treatment** - Risk to meeting the needs of the client group within A&T due to the required environmental improvements .
Risk 1828 - Risk at the Harplands site linked to Girpi pipework.	**Risk 1453 Specialist, Ward 5 Neuro** - Risk to patient and staff safety due to the inadequate environment
Risk 1869 - Risk that teams at the Hope Centre may need to be relocated due to the deterioration of the estate.	
Risk 1896 - Hot water temperatures at the Harplands site may be below HSE guidance, increased risk of legionella.	
Risk 1945 - Risk to the Harplands site as a high proportion of fire doors (circa 440 doors, 96%) are not compliant and have failed to be maintained due to the building owner and service company not undertaking there statutory duty. As a consequence there is a risk of injury/death of patients and staff if a serious fire broke out within the Harplands site.	
Risk 1955 - Risk service provider failing to deliver hard and soft FM.	

BAF RISK 8	Failure to lead and evolve relationships with partners resulting in an absence of system and Trust integration opportunities.

SPAR	Accessible	Risk Appetite	RAG Rating (Key Showing on Appendix Page)					Gross Score	Residual Risk Score 2023/2024				Target Score / Achievement Date
Risk Start Date	1.4.23	Strategic Priority											
Executive Lead	Chief Strategy Officer	Growth	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Year End	Gross Score (raw score before applying any mitigations)	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Target Score / Achievement Date
Lead Committee	Finance & Resource	Level 4 - Seek	Risk To Delivery, Plan In Place	Risk To Delivery, Plan In Place	Risk To Delivery, Plan In Place	Risk To Delivery, Plan In Place	On Target for Delivery Plan	Impact 4 x Likelihood 4 = 16	Impact 4 x Likelihood 3 = 12	Impact 4 x Likelihood 3 = 12	Impact 4 x Likelihood 3 = 12	Impact 4 x Likelihood 3 = 12	Impact 4 x Likelihood 2 = 8
									⟺	⟺	⟺	⟺	Mar-25

Context
Developing successful and effective relationships with partners is an integral part of our vision and strategic ambition. Collaboration promotes patient-centred care and choice. By working together to maximize public sector resource and share information appropriately we can ensure services are designed more preventatively at PLACE to better meet local need. There are a number of examples of where/how the Trust is working successfully with partners including: 4 x Community Mental Health VCSE contracts currently commissioned to March 2025; a range of partnership bids to deliver new and innovative service provision e.g. Pathfinders service (successful) and CYP Mental Health Hub (awaited), along with award submissions e.g. HSJ Partnership Awards 2024 (shortlisted in 2 categories). Attendance at a variety of local networks and collaborative forums also ensures that Trust has representation at cross-organisational junctures where development of community assets are taking place. It is imperative we continue to build on these approaches to maximise System and Trust integration opportunities.

	Progress	
Control to Mitigate Strategic Risk	What's Going Well	What are the Current Challenges/ Gaps in Assurance
1. Develop a 3 year Communication and Engagement Plan 2023-2027 to outline delivery against the Strategy.	Comms and engagement strategic review document has been completed and shared for consultation including a 3 year delivery plan.	Capacity and capability across the teams to deliver the formalised arrangement. Ensuring the right balance between formal and informal partnership relationships which will improve outcomes for patients. A delay between the sign-off of the Partnership Charter and implementing a full roll-out plan linked to its launch. This will be addressed during Q1 of 2024/25.
2. Identify a produce full stakeholder matrix.	Lots of activity with stakeholders - relationship development, commissioning, co-production and co-delivery. Formal stakeholder analysis is yet to start.	
3. Develop a 'Partnership Charter' as a formalised agreement outlining how we will work with our partners and to put people and the heart of everything we do.	Partnership charter agreed and launched Jan 24. Plans to recruit to a Deputy Chief Strategy Officer will provide additional resource and senior leadership to drive this agenda.	

Internal/External Assurance	Category of Assurance
Draft plan completed and shared for consultation during Q4. **Assurance relates to mitigation 1.**	Category 2
Work ongoing to identify full stakeholder matrix including assessment of existing relationships and opportunities for new. **Assurance relates to mitigation 2.**	Category 1
Partnership charter now actioned and launched Jan 24. **Assurance relates to mitigation 3.**	Category 3

Links to 12+ Trust Risks	Links to 12+ Directorate Risks
No linked risks.	No linked risks.

Appendix Page

RAG Rating Key

RAG Rating Criteria Key	Rating
Complete With Assurance	BLUE
On Target For Delivery	GREEN
Risk To Delivery, Plan In Place	AMBER
Not Deliverable By Target	RED

Scoring Matrix

		Likelihood				
		Rare	Unlikely	Possible	Likely	Almost Certain
Impact	Rating	1	2	3	4	5
Negligible/ Insignificant	1	1	2	3	4	5
Minor	2	2	4	6	8	10
Moderate	3	3	6	9	12	15
Major	4	4	8	12	16	20
Catastrophic	5	5	10	15	20	25

Assurance Level

Internal Audit Assurances		External Audit Assurances
Category 1	Category 2	Category 3
• Corporate Performance Report/Dashboard • Internal Performance • Reportable Issues Alert • Quality Account • Practice Improvement & Lessons Learnt Report • Complaints and Concerns Report • Incident Reports • SI Reports	• Strategy Implemented • Plan Realised • Clinical Audit • Unannounced Assurance Visits • Performance Scrutiny	• Internal Audit (linked to annual plan) • National Patient Satisfaction Surveys (F & F Test) • Healthwatch Reports • Independent Reviews (e.g. Ombudsman Reports) • External Visits/Inspection Reports • CQC • EY External Audit (e.g. Annual Governance Statement / Statement of Financial Control) • NHS Benchmarking Club • Quality Account • Annual Governance Statement • INSIGHT • NHSI Oversight • AQUA • NHS Operating Framework (NOF) - Provides externally generated report on the performance of the Trust against 18 Mental Health Metrix.

Risk Appetite Key

Strategic Objectives	Level 1 None	Level 2 Minimal	Level 3 Cautious	Level 4 Seek	Level 5 Significant	Supporting Narrative
Prevention				✓		We seek to be more innovative in order to pursue prevention and are prepared to take on financial risk in order to achieve this.
Access				✓		We seek to improve access to our services by co-producing new services with our communities but need to be cautious on the impact this will have on our staff.
Growth				✓		We seek to grow in a managed way to ensure we remain sustainable and are open to opportunities as they arise.

REPORT TO PUBLIC TRUST BOARD

Date of Meeting:	9th May 2024		
Title of Report:	Remuneration Committee Terms of Reference		
Presented by:	Nicky Griffiths Deputy Director of Governance		
Author:	Nicky Griffiths Deputy Director of Governance		
Executive Lead Name:	Janet Dawson, Chair	**Approved by Exec**	☐

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Purpose of the report:							
Approval	☐	**Information**	☒	**Consider for Action**	☐	**Assurance**	☐

Executive Summary:

The terms of reference for the Remuneration Committee (REMCO) due for review by May 2024 were approved by the Committee.

Seen at:	SLT ☐ Execs ☐	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Resource Committee ☐ • Audit Committee ☐ • People, Culture & Development Committee ☐ • Charitable Funds Committee ☐		
Strategic Priorities (please indicate)	1. **Growth** - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care ☐ 2. **Access** - We will ensure that everybody who needs our services will be able to choose the way, the time, and the place in which they access them ☐ 3. **Prevention** - To will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce. ☐		
BAF / Risk / legal implications: Risk Register Reference	1. We will provide the highest quality, safe and effective services ☐ 2. We will attract, develop and retain the best people ☒ 3. We will actively promote partnership and integrated models of working ☐ 4. We will increase our efficiency and effectiveness through sustainable development ☐ Any Risk/legal implications: (please reference if any)		
Sustainability:	1. Reduce the environmental impact of health and social care in Staffordshire and Stoke on Trent ☐ 2. Build a network of climate and sustainability champions across Staffordshire and Stoke on Trent ☐ 3. Share learning and best practice ☐		

Resource Implications: Funding Source:		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	There is no direct impact on the protected characteristics as part of the completion of this report.	
ICS Alignment / Implications:		
Recommendations:	The Board is asked to note approval of the Remuneration Committee terms of reference.	
Version	Name/group	Date issued

REMUNERATION COMMITTEE

TERMS OF REFERENCE

Membership	▪ Chair of the Trust Board ▪ All Non-Executive Directors ▪ All Associate Non- Executive Directors
Quorum	▪ Three members
In Attendance	▪ Chief Executive ▪ Chief People Officer People, ▪ Deputy Director of Governance/ Trust Board Secretary
Frequency of Meetings	▪ Planned Quarterly but no less than twice per year
Accountability and Reporting	▪ Accountable to the Trust Board ▪ Report to the Trust Board after each meeting ▪ Minutes of meetings available to the Chief Executive Officer and all Non-Executive Directors Directors on request
Date of Approval by Trust Board	
Review Date	No later than 1st May 2025

REMUNERATION AND TERMS OF SERVICE COMMITTEE

TERMS OF REFERENCE

1. Constitution

The Trust Board hereby resolves to establish a Committee of the Trust Board to be known as the Remuneration Committee (hereafter referred to as the Committee).

2. Membership

The membership of the Committee shall be the Chair of the Trust Board and all Non-Executive Directors appointed by the Trust Board.

The Trust Chair will Chair the Committee. In the absence of the Chair one of the other Non-Executive Directors will be elected by those present to Chair the meeting.

3. Quorum, Frequency of Meetings and Required Frequency of Attendance

No business shall be transacted unless three members are present.

The Committee shall plan to meet quarterly. Meetings will be called more frequently when vacancies arise or meetings can be called at the discretion of the Chair. This can be undertaken virtually.

Members of the Committee should attend regularly and should not be absent for more than two consecutive meetings.

4. In Attendance

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

- The Chief Executive, Deputy Director of Governance and Chief People Officer shall normally attend meetings.

- The Chief People Officer will attend to advise on:

  - trends in pay and benefit
  - alignment of reward policies and trust objectives
  - the relevance of surveys and changes in reward practice; and the application and impact of external regulation on appointment, compensation, benefit and termination practice (e.g. NHS England). The Deputy Director of Governance or their nominee shall act as secretary of the Committee. Those in attendance will be excluded from meetings when their own remuneration is considered.

5. Authority

The Committee has been delegated responsibility to agree the remuneration arrangements for Executive Directors and other senior managers employed on Trust terms and conditions. The quantum of such remuneration for to be agreed by the Committee in advance of appointments.

The remuneration for Non-executive Directors is currently set by NHS England and will not be considered by the Committee.

The Committee is authorised to seek any information it requires from an employee of the Trust in order to perform its duties.

The Committee is authorised by the Trust Board to obtain reasonable outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

The Committee also has authority to commission reports and surveys that it considers necessary to fulfil its obligations.

6. Duties

The purpose of the Committee is to determine appropriate remuneration and terms of service for the Chief Executive, Executive Directors and other staff employed on Trust terms and conditions, including:

- all aspects of salary (including cost of living or other increments and any performance related elements / bonuses)
- additional non-pay benefits, including pensions and cars
- contracts of employment
- arrangements for termination of employment and other contractual terms; and
- severance packages (severance packages must be calculated using standard guidelines any proposal to make payments must be subject to the approval of NHS Improvement and the Treasury)

The Committee shall receive reports from the Chief Executive with regard to performance of the Executive Directors against objectives for the previous year.

The Committee will receive reports relating to national and local market factors including benchmarking of senior managers pay. The Committee may request reports relating to the senior management workforce to ensure the consistent application of the Trust's equality obligations.

The Committee shall advise the Trust Board on its arrangements for succession planning for both executive and non-executive directors.

The Committee shall recommend to the Trust Board the form and content of the report on directors' remuneration for inclusion in the Trust's Annual Report.

7. Accountability and Reporting Arrangements

The minutes of Committee meetings shall be formally recorded by the Trust Board Secretary. Copies of the minutes of Committee meetings shall be available to the Chief Executive and all Non-Executive Directors on request.

The Trust Board Secretary shall prepare a report to the Trust Board after each meeting of the Committee. The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full Trust Board.

8. Sub-Committees and Reporting Arrangements

The Committee shall have the power to establish sub-committees for the purpose of addressing specific tasks or areas of responsibility. In accordance with paragraph 4.5 of the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee unless expressly authorised by the Trust Board.

The terms of reference, including the reporting procedures of any sub- committees must be approved by the Committee and regularly reviewed.

9. Committee Effectiveness

All Committees will have an annual Committee Effectiveness review.
The annual report will include information about compliance with the requirement that members should attend regularly and should not be absent for more than two consecutive meetings. The annual report will also include information about the reporting arrangements into the Committee from any sub-committees.

10. Administration

The Committee shall be supported administratively by the Trust Board Secretary, whose duties in this respect will include:

- Agreement of agenda with Chair and attendees and collation of papers
- Taking the minutes and keeping a record of matters arising and issues to be carried forward
- Preparing reports to the Trust Board after each meeting of the Committee

11. Requirement for Review

The Terms of Reference will be reviewed at least annually, and the next review must take place before May 2025 .

REPORT TO PUBLIC TRUST BOARD

Date of Meeting:	9th May 2024		
Title of Report:	Monthly Safer Staffing Report – March 2024.		
Presented by:	Kenny Laing – Chief Nursing Officer		
Author:	Zoe Grant – Deputy Chief Nursing Officer		
Executive Lead Name:	Kenny Laing – Chief Nursing Officer	**Approved by Exec**	☒

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Purpose of the report:								
Approval	☐	**Information**	☒	**Consider for Action**	☐	**Assurance**	☒	

Executive Summary:

Purpose:
This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during March 2024, in line with the National Quality Board requirements.

Key Findings:

- During March 2024, an overall fill rate of 96.2% was achieved; this is a decrease from 100.5% in February 2024.
- The fill rate for Registered Nurse (RN) shifts has decreased; from 76.1% in February 2024 to 72.9% in March.
- RN vacant posts in the inpatient wards remains similar to February which was 40.64wte vacant positions to 42.8wte in March.
- There were no HCSW vacancies during March 2024 and 3.37wte over establishment.
- The bed occupancy rate remained high at 96% in March, it was 98.1% in February.
- The Trust has seen a reduction in the latest CHPPD national benchmark reported for December 2023, where we dropped into the third quartile (from the fourth – top quartile).
- The community safer staffing report in Appendix 4 offers comparable data around workforce, bank and agency usage, alongside caseload acuity and will provide helpful insights into community staffing and how these impact on patient care going forward.
- Recruitment to vacancies is challenging, graduate nurses continue to fill most RN vacancies, highlighting a need for robust supervisory support which is being addressed with additional improvements being made to the preceptorship programme.

Recommendations:
The Quality Committee and Trust Board are asked to receive the report, to note the challenges in filling shifts and with recruitment to nurse vacancies, and to acknowledge and support the mitigations that are currently in place. The Board should be assured that the Trust are continuing to maintain safe staffing levels within our ward inpatient areas.

Seen at:	SLT ☒ Execs ☐	Document Version No.	
Committee Approval / Review	• Quality Committee ☒ • Finance & Resource Committee ☐ • Audit Committee ☐ • People, Culture & Development Committee ☐ • Charitable Funds Committee ☐		
Strategic Priorities (please indicate)	1. **Growth** - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care ☒ 2. **Access** - We will ensure that everybody who needs our services will be able to choose the way, the time, and the place in which they access them ☐ 3. **Prevention** - To will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce. ☒		
BAF / Risk / legal implications: Risk Register Reference	1. We will provide the highest quality, safe and effective services ☒ 2. We will attract, develop and retain the best people ☒ 3. We will actively promote partnership and integrated models of working ☐ 4. We will increase our efficiency and effectiveness through sustainable development ☒ Any Risk/legal implications: (please reference if any)		
Sustainability:	1. Reduce the environmental impact of health and social care in Staffordshire and Stoke on Trent ☐ 2. Build a network of climate and sustainability champions across Staffordshire and Stoke on Trent ☐ 3. Share learning and best practice ☒		
Resource Implications: Funding Source:	N/A N/A		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	There is no direct impact on the protected characteristics as part of the completion of this report.		
ICS Alignment / Implications:	N/A		
Recommendations:	Trust Board is asked to receive the report for assurance and information		
Version	Name/group	Date issued	

March 2024
Monthly Safer Staffing Report

1. Introduction:

This report details the ward daily staffing levels during the month of March 2024 following the reporting of the planned and actual hours of both Registered Nurses (RN) and Health Care Support Workers (HCSW) to NHS Digital and Care Hours per Patient Day (CHPPD) The CHPPD calculation is based on the cumulative total number of patients over the month divided by the total number of both RN and HCSW hours (appendix 1).

2. Purpose of the Report (Executive Summary):

Purpose:

This paper outlines the monthly performance of the Trust in relation to planned vs actual staffing levels during March 2024 in line with the National Quality Board requirements.

3. Key Findings:

- During March 2024, an overall fill rate of 96.2% was achieved; this is a decrease from 100.5% in February 2024.
- The fill rate for Registered Nurse (RN) shifts has decreased; from 76.1% in February 2024 to 72.9% in March.
- RN vacant posts in the inpatient wards remains similar to February which was 40.64wte vacant positions to 42.8wte in March.
- There were 0 HCSW vacancies during March 2024, with 3.37wte HCSW over establishment.
- The bed occupancy rate was high at 96% in March, it was 98.1% in February.
- The Trust has seen a reduction in the latest CHPPD national benchmark reported for December 2023, where we dropped into the third quartile (from the fourth – top quartile).
- The community safer staffing report in Appendix 4 offers comparable data around workforce, bank and agency usage, alongside caseload acuity and will provide helpful insights into community staffing and how these impacts on patient care.
- Recruitment to vacancies is challenging, graduate nurses continue to fill most RN vacancies, highlighting a need for robust supervisory support which is being addressed with additional improvements being made to the preceptorship programme.

3.1 Key Recommendations to Consider:

The Trust Board is asked to:

- Receive the report
- Note the challenges with recruitment and the mitigations that are currently in place

- Note the challenge in filling shifts in March
- Be assured that safe staffing levels can provide planned care and any deficits in care hours are escalated and managed

4. Background:

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

In addition to the monthly reporting requirements the Chief Nursing Officer is required to review ward staffing on a six-monthly basis and report an annual outcome of the reviews to the Trust Board of Directors.

A comprehensive annual report for 2022/23 was presented to the September 2023 Trust Board and the recommendations relating to safer staffing reviews are progressed and monitored through the Safer Staffing Group.

The first of the six monthly reviews for 2023 /24 took place throughout November 2023; the findings were reported to the Trust Board in March 2024.

5. Summary:

5.1. Trust Performance

During March 2024, the Trust achieved an overall staffing fill rate of 72.9% for Registered Nurses. This broken down to 72.95% during the day shifts and 72.86% during the night shift.

The overall staffing fill rate for HCSW staff was 113.9% which saw 108.63% fill rate during the day shifts and 121% fill rate during the night shifts.

Taking skill mix adjustments into account an overall fill-rate of 96.2% was achieved.

Details of the actions taken to maintain safe staffing levels are provided below. Staffing data, including 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.

The impact of unfilled shifts alongside the additional contributory factors are also provided below and are summarised in Appendix 3.

The Safer Staffing Group continues to oversee the safer staffing work plan and Safer Staffing Action Plan.

5.2. Care Hours per Patient Day (CHPPD)

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

Benchmarking for CHPPD is available through the Model Hospital for Mental Health Trusts. NSCHT performs in the upper quartile and, when compared to similar organisations, is well above the national median for the number of CHPPD. The latest reported benchmark position is for December 2023, this showed that the Trust was in the third quartile of care hours per patient per day nationally (see Appendix 1), this is unusual for the Trust as we have consistently been in the top (fourth) quartile for over 18months. In March 2024 the Trusts locally reported average was 10.67 CHPPD, this is a decrease from 11.38 CHPPD.

5.3. Impact

WMs report the impact of unfilled shifts on a shift-by-shift basis.

5.4. Incidents reported relating to staffing levels

There were ten reported incidents relating to safer staffing, within the in-patient wards during March 2024. Of these ten incidents eight incidents were 'no harm' incidents and two incidents reported had the potential to have caused harm due to delays in care due to care given to patients being delayed due to staffing constraints. These two incidents are subject to review by the nursing & quality and operational team involved.

This is a marked increase compared to previous months, some of this can be attributed recent focus being given to quality and safety issues attributed to staffing shortfalls during ward manager supervision sessions at the Reflect and Connect Group which is led by the Deputy Chief Nurse and Head of Nursing.

- Assessment & Treatment Unit – had 3 associated incidents, 2 related to shortfalls on the night shift where staff had been moved to cover another ward, leaving them with 2 staff members, nursing their one patient. This has the potential for the unit to be vulnerable from a safety intervention perspective, as to safety apply physical intervention due to disturbed or aggressive behaviours there needs to be a minimum of three staff present. It has been advised that an assessment of the likelihood of this need must take place prior to the team being reduced to two staff members. The 3rd incident was the impact on the Intensive Support Team due to a member of their staff being moved to cover a shortfall at the Assessment & Treatment Unit.

- Darwin Centre – reported 3 incidents, 2 were reports of insufficient staff, with one member of staff not being able to leave duty due to there not being a staff member to cover the shift due to sickness. The 3rd was due to the ward cover being depleted due to staff needing to escort a patient to A&E.

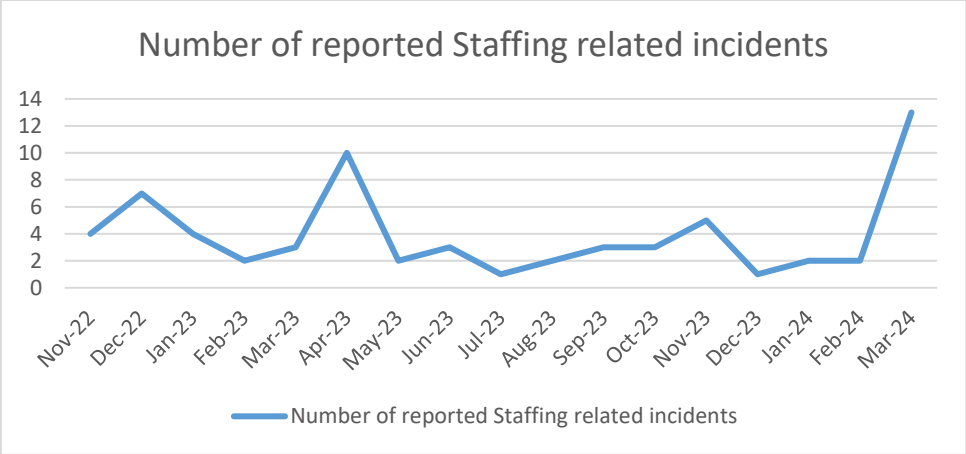
- PICU – reported one incident due to not feeling able to safely cover their zonal observations of the ward and leaving the safety of the ward vulnerable due to staff absence at short notice.

- EMU – reported one incident due to feeling that the safety of the ward was compromised due to a staff member being moved from them to cover a shortfall elsewhere.

  None of the above incidents reported any harm occurring.

- Ward 4 – reported 2 incidents; both of which are being reviewed further to consider the impact of potential harm. 1 was associated to a Nurse being the only registered nurse on

shift who was unable to tend to an open wound in a timely manner due to the demands on their time. The second related to a nurse escalating her staffing concerns to the site manager, the reports indicates that the site manager did not proactively support the ward to address her staffing concerns which were associated with the clinical safety of some of the patients on the ward, during the same shift, 2 x patients were taken to the Royal Stoke Hospital via emergency ambulance and another patient was reported to have been incontinent due to there not being enough to staff to escort them to the bathroom.



5.5. Impact on Patient Experience

Staff continue to prioritise patient experience and direct patient care. Ward managers have reported some cancellations of ward based activities, however attempts are made to ensure that these are rescheduled or support from the wider MDT is sort. The main issue for cancelling activities is related to the activity workers having to pick up a staffing shortfall.

The wards continue to hold patient community meetings which allow them to report issues of concern.

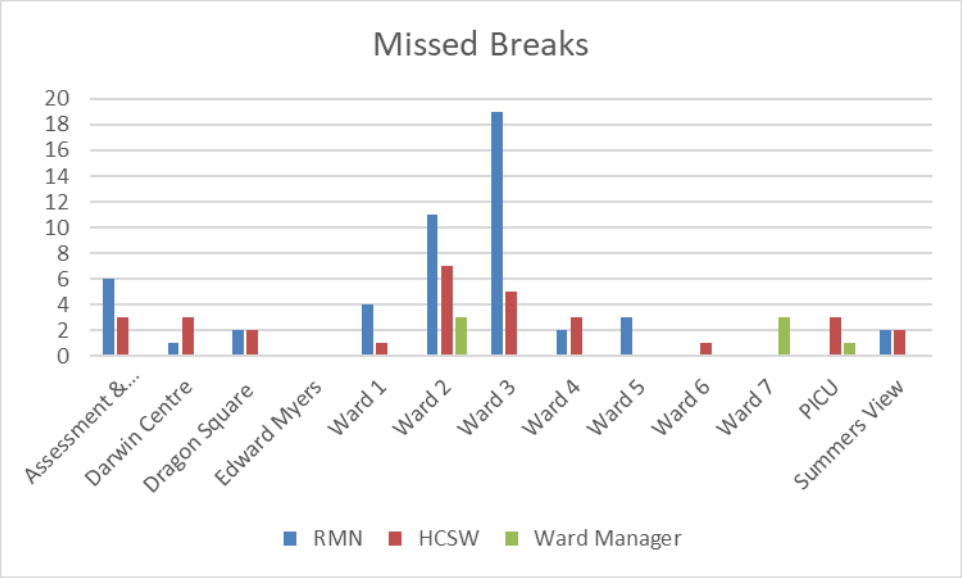
There were no reported PALs or complaints which could be related back to staffing issues or concerns.

There has been evidence to support that patient experience has been compromised as indicated above in the incident reported during March 2024.

5.6. Impact on Staff Experience

In order to maintain safe staffing levels the following actions were taken by Ward Managers during March 2024:

87 staff breaks were cancelled in March. Please see the breakdown of areas below:



5.7. Other incidents of note:

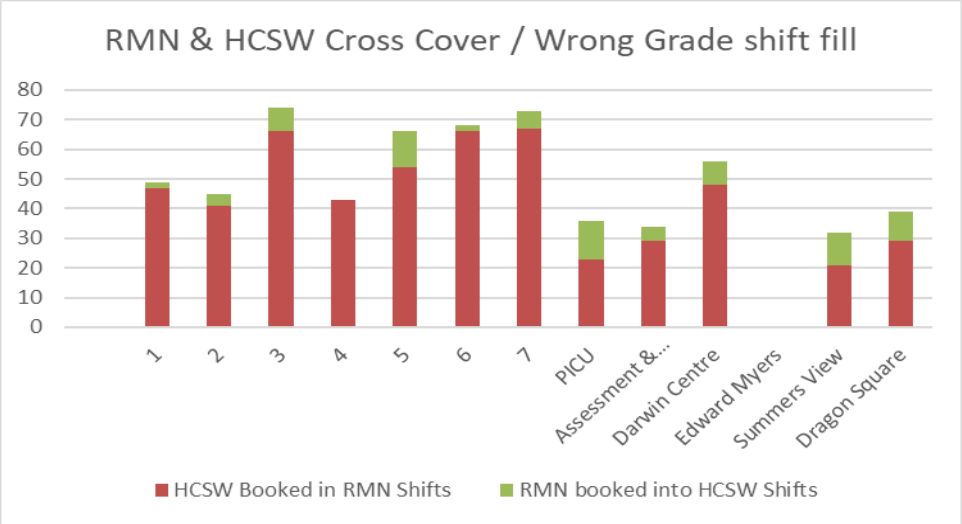
There were no outbreaks reported in March 24.

5.8. Mitigating Actions:

Ward Managers and members of the multi-disciplinary team have clinically supported day shifts to ensure safe patient care. 534 Registered Nurse shifts were covered by HCSW's where Registered Nurse temporary staffing was unavailable.

Registered Nurse staff covered 81 HCSW shifts where HCSW temporary staffing was unavailable. Additionally, as outlined above, staff breaks have been shortened or not taken (time is given in lieu) and wards have cross-covered to support safe staffing levels.

The graph below illustrates the number of times a HCSW has covered a Registered Nurse shift and how many times a Registered Nurse has filled a HCSW shift. Predominantly there is a need for Registered Nurse shifts to be filled by HCSW's which could impact on the effectiveness of care delivery, the highest occurrence of this in March was in ward 7 (67 Shifts) and ward 3 (66 shifts) and ward 6 (66shifts):



Ward manager report that the MDT continue to support and cover shortfalls and increase their visibility on the ward at times when the staffing levels or patient acuity requires.

The safer staffing fill rate has remained stable over the previous months, the Safer Staffing huddles remain stepped back to twice weekly throughout March 24. They continue to provide an efficient and effective response to identifying and mitigating potential staffing shortfalls. The commitment and dedication of all Trust staff in supporting and responding to staffing requests continues to be recognised.

The safe care tool enables the ward managers to make more informed decisions about staffing shortfalls by comparing ward acuity levels with staffing numbers. Compliance regarding completion of the safe care has improved, making this an easier process.

Following the 6 monthly safer staffing reviews in February 2023 with each of the Inpatient wards, 3 wards have had their establishments adjusted. This proceeded a period of review utilising the evidenced based Mental Health Optimal Staffing Tool (MHOST), alongside clinical discussions and reviews of additional staffing requirements over a prolonged period of time. Ward 4 uplifted the early, late and night shift with 1wte per shift and Ward 1 & Ward 5 received an uplift by 1wte on each of their night shifts. Additional reviews have taken place throughout November 2023, with recommendations reported via the Trusts Senior Leadership Team in March 2024.

5.9. Bank and Agency Usage

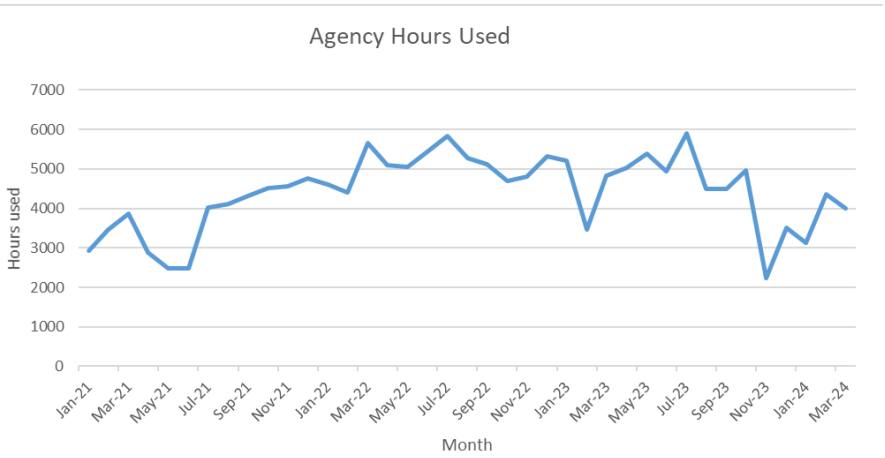
The Temporary Staffing Team have continued to engage bank and agency staff to cover staffing shortfalls.

There remains an increased use in bank cover, which continues to demonstrate a positive picture as bank staff are much more familiar with the Trust and tend to work regular shifts in one or two wards and does continue to be required to ensure safe staffing levels. The agency cover has increased slightly in March despite the influx of newly registered nurses in October 2023.

This is demonstrated in the two graphs below:

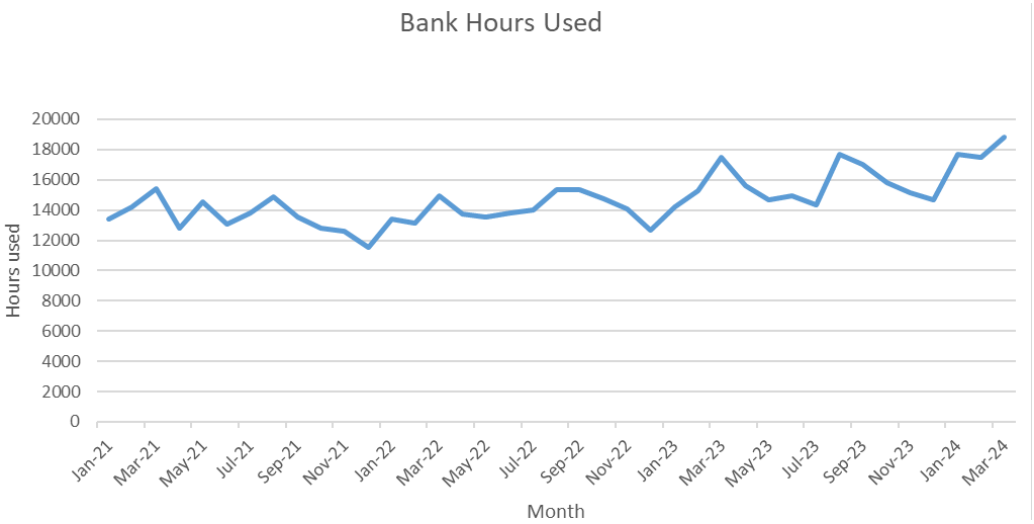
Graph 1 **- Agency usage within inpatient areas March 2021 – March 2024:**

The agency hours utilised in March were 3999.5hrs



Graph 2 **- Bank usage within inpatient areas Jan 2021 – March 2024:**

The Bank hours utilised in March were 18823.41hrs



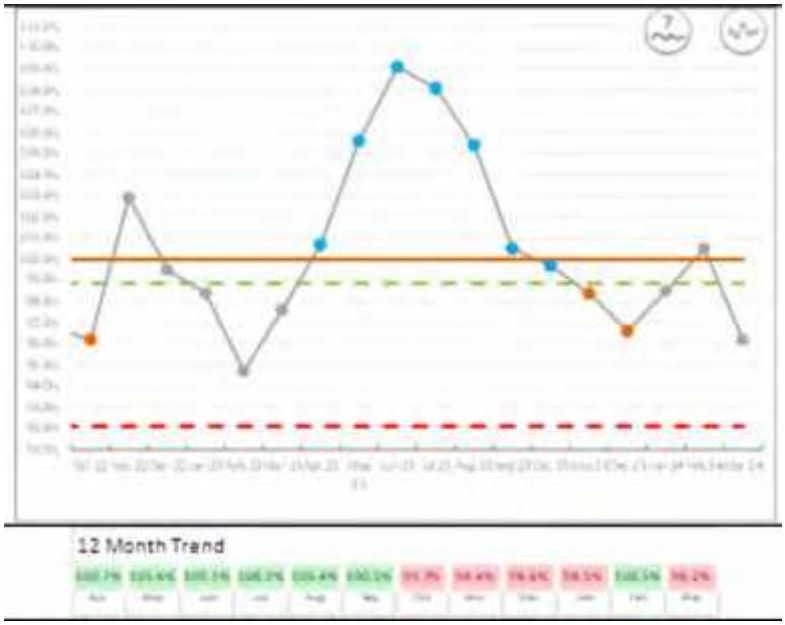
5.10. Overall Fill Rate

The overall staffing fill rate during March 2024 was 96.2%.

The SPC chart provides an overview of the total fill rate for the past 18 months. During this period staffing fill rates have remained within the area of common cause variation.

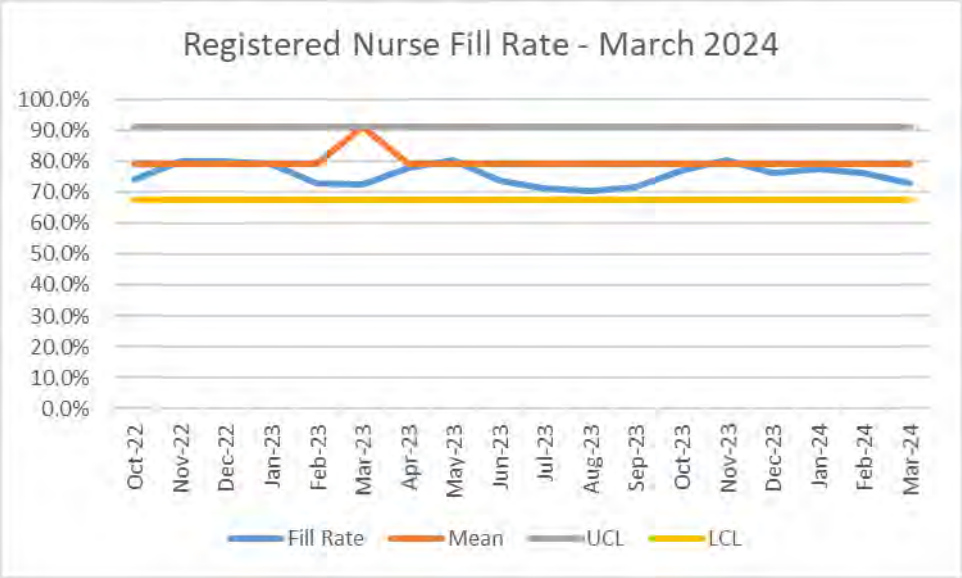
The Trust continues to take the required actions to mitigate any shortfalls in fill rate and this position is summarised above.

Overall Fill-Rate October 2022 – March 2024:



5.11. Total Registered Nurse Fill-Rate

The total Registered Nurse fill rate was 72.9%; the graph below shows the fill rate from October 2022 - March 2024:



6. Community Safer Staffing.

In early 2020 the Trust began to undertake safe staffing discussions with community teams. Currently there is no nationally mandated approach for safe staffing reviews in NHS community mental health and learning disability services. To gain more assurance in relation to the Trust's community services and resilience in relation to caseload and patient demand vs workforce available, the Trust Community Mental Health Teams (CMHT's) previously undertook a process of data collection using a model developed by Dr Keith Hurst. This approach consisted of the collection of weighed benchmarking data via the use of a diary exercise over a week time frame.

This work was placed on hold as a result of the ongoing challenges of the COVID-19 pandemic. Building upon the information that we already have we are working with the Performance Information Team to review a number of Community Team metrics including caseload size, vacancy level, absence rate, temporary staffing usage. These metrics (Appendix 4) will continue to be formally reported via the Trusts monthly safer staffing report and will eventually be aligned to evidence based pathway models of care to ensure our workforce is designed to achieve high quality and safe care throughout relevant Trust community services.

7. Recruitment

In line with the national picture, recruitment to all nursing posts continues to be a challenge, however due to increased placement capacity over several years, the Trust are beginning to see the benefits, with increased numbers of newly registered nurses graduating with local HEI's. There remains an ongoing need to attract and / or retain experienced Registered Nurses in the inpatient areas.

The following updates are relevant for this month:

Preceptorship programme remains underway for the newly registered nurses who took up post during March 23 and March 2024. Bespoke supervision and reflective sessions assist in ensuring their experiences are captured and any additional support requirements are being met.

14 Newly Registered Nurses commenced in March 23 and 43 newly registered nurses commenced during October 23. 11 Newly Registered Nurses also commenced in March 24, they work as a non-registered staff member whilst their NMC PIN, which is their formal registration, is pending.

5 Trainee Nurse Associate (TNA) commenced in posts in March 23, they were the remaining posts of the 20 which were centrally funded for 2022/ 23.

7.1. Registered Nurse and HCSW Retention

During March 2024, 8 Registered Nurse (6.2wte) left the Trust, 6 of these were staff members transferred to another organisation in relation to the handover of CDAS substance misuse services. There were no leavers from Inpatient areas.

3 HCSW's (2.8wte) left the Trust during March 2024 who was from an inpatient settings.

7.2. Staff support and well-being

The Nursing Directorate continue to offer support and advice on staffing issues and they receive staffing updates from Ward Managers, Quality Improvement Nurses (Matrons) and the E-Rostering and Temporary Staffing Team as appropriate.

Despite capacity issues within the team throughout February and March, the E-rostering team have continued to maintain the co-ordination and allocation of the bank staff and agency staff. The operational directorates have welcomed this support and intervention.

To further support the nursing teams eight Registered Nurses have completed the Professional Nurse Advocate (PNA) Training Programme. This is a Level 7 Accredited PNA Training Programme accessible to Bands 5 and above. It supports the facilitation of restorative clinical supervision in practise, with quality improvement initiatives being a key component of the model. There are an additional eight Registered Nurses undertaking a further cohort of training.

The Ward Managers reflect and Connect Forum takes place each month. Dedicated time is provided for reflection, group supervision, and wellbeing discussions. Additionally, the senior nursing team continue to maintain visibility within ward inpatient areas. A closed culture review took place within the acute inpatient ward areas during October 23, the findings were presented through to the Trusts Senior Leadership Team and progress against recommendations and actions is monitored via the Quality assurance Group.

Each ward team have access to the staff wellbeing support networks and also have regular reflective practice sessions within the wards.

Additionally, there are currently two Professional Nurse Educator's (PNE's) in post on a temporary basis; one within the Acute Inpatient wards and the other within the Older Persons wards. The role is a nationally recognised role designed to ensure there is dedicated day to day support to

Nurses and HCSW's, offering expert advice and clinical supervision, as well as being a role model who champions professional competencies, values and attitudes for new and existing staff.

8. To Conclude:

There has been a slight decrease in the Registered Nurse fill rate in March when compared to February and the overall fill rate has decreased to 96.2%.

Prior to the previous 5 months the occupancy levels within the wards averaged around 85%, there has been a sustained increase to this for the last 4 months, with occupancy being 96% in March 2024.

The community safer staffing report in Appendix 4 offers comparable data around workforce, bank and agency usage, alongside caseload acuity and will provide helpful insights into community staffing and how this impacts on patient care going forward.

The RN vacancy position during March 2024 was 42.80wte.

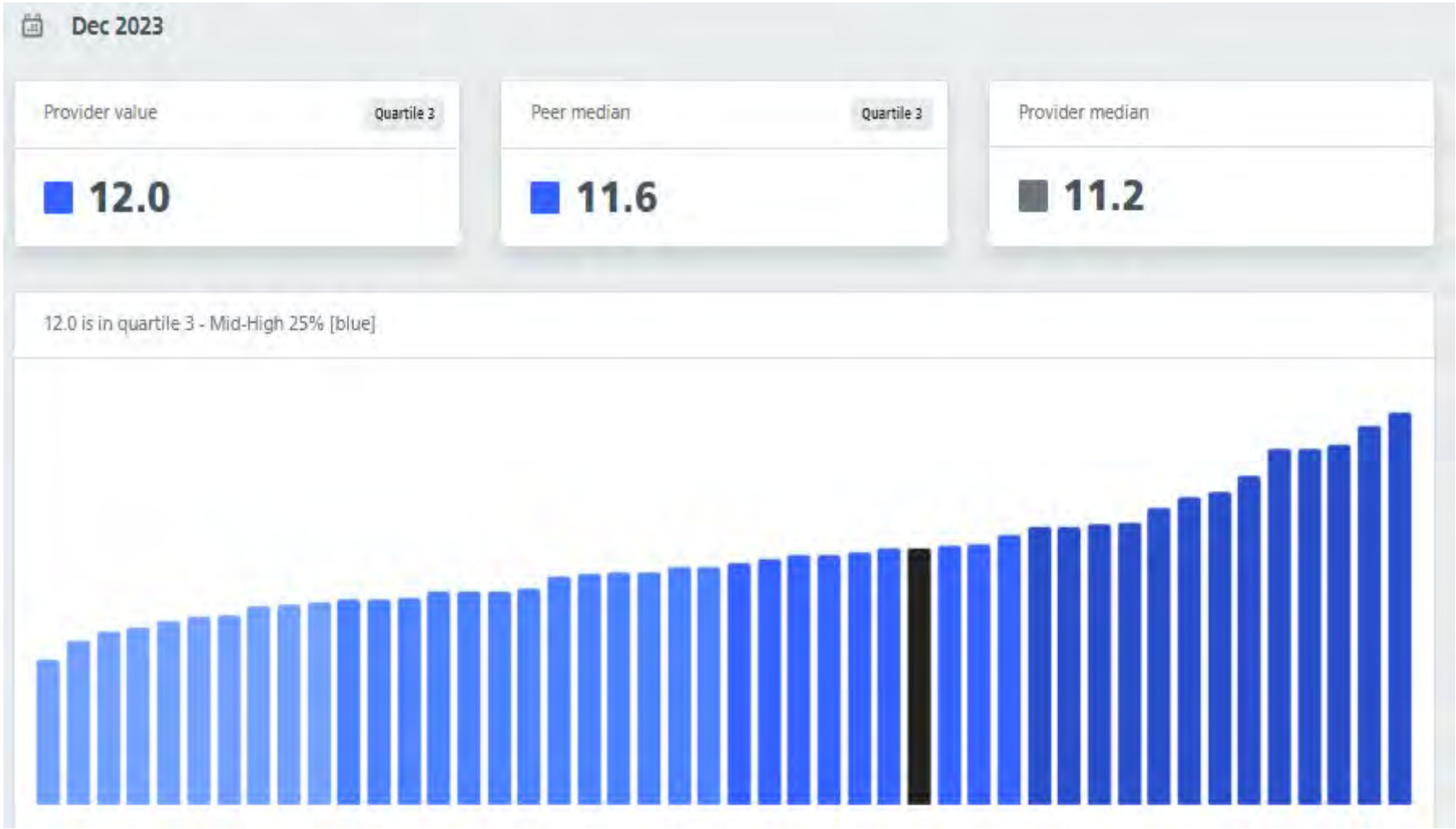
The HCSW vacancy position has improved and are now 3.37wte over established for the inpatient wards in March 2024.

Ward Managers, Service Manager and Quality Improvement Nurse (Matron) continue to review staffing levels on a daily basis to ensure that patient safety remains paramount. Any significant staffing concerns are escalated through the operational directorates and via the Senior Operational Team. The safe care tool has continued to be utilised in the safer staffing meetings to help inform safer staffing decisions, efforts need to be maintained to continue to embed this.

The national shortage of Registered Nurses and a reduction in university graduates continues to impact Registered Nurse vacancies. Although the local picture for uptake of people onto the Mental Health Nurse programmes via our local HEI's is looking positive. The Nursing, Operational and Workforce Directorates are continuing to employ a number of strategies to attract both Registered Nurses and HCSW's during this time.

APPENDIX 1

CHPPD – Model Hospital – benchmark – December 23



Appendix 2 March 2024 Safer Staffing:

	RMN				CARE STAFF				Registered Nurse		Care Staff		Total Nursing Staffing					
Ward	Day Clinically Required	Day Actual	Night Clinically Required	Night Actual	Day Clinically Required	Day Actual	Night Clinically Required	Night Actual	Day Fill Rate (%)	Night Fill Rate (%)	Day Fill Rate (%)	Night Fill Rate (%)	Overall RN %	Overall Care Staff %	Overall Staffing	Total Hours Per Day	Patients	CHPPD
Ward 1	1325.25	977.16667	681.6	440.7	1155.75	1514	688.2	1127.1	73.73%	64.66%	131.00%	163.78%	70.7%	143.2%	105.4%	4058.97	461	8.80
Ward 2	1467.25	998.98333	666	387.3	1536.5	1756.11667	688.2	1287.35	68.09%	58.15%	114.29%	187.06%	65.0%	136.8%	101.6%	4429.75	625	7.09
Ward 3	1318	876	710.4	549.3	954.25	1311.5	871.75	1275.75	66.46%	77.32%	137.44%	146.34%	70.3%	141.7%	104.1%	4012.55	446	9.00
Ward 4	1565.5	955.33333	342.6	361.3	1377	1600	1234.45	1256.7333	61.02%	105.46%	116.19%	101.81%	69.0%	109.4%	92.3%	4173.37	440	9.48
Ward 5	1189.25	967.75	688.2	388.5	1258.883333	1312.75	1032.3	1308.3	81.37%	56.45%	104.28%	126.74%	72.2%	114.4%	95.4%	3977.30	307	12.96
Ward 6	1134	777.75	688.2	366.3	1506	2012.25	1032.3	1600.2	68.58%	53.23%	133.62%	155.01%	62.8%	142.3%	109.1%	4756.50	428	11.11
Ward 7	1277.25	786.75	344.1	350.7	1164.25	1600.25	1021.2	1009.5	61.60%	101.92%	137.45%	98.85%	70.2%	119.4%	98.4%	3747.20	535	7.00
A&T	795.5	508.75	666	354.65	1630.366667	961.366667	688.2	914.2	63.95%	53.25%	58.97%	132.84%	59.1%	80.9%	72.5%	2738.97	35	78.26
Edward Myers	753.25	767.75	344.1	344.1	790.25	669	688.2	599.4	101.92%	100.00%	84.66%	87.10%	101.3%	85.8%	92.4%	2380.25	227	10.49
Darwin Centre	1152	818.66667	677.1	433.9	1933.733333	1909.73333	1720.5	1713.8	71.06%	64.08%	98.76%	99.61%	68.5%	99.2%	88.9%	4876.10	360	13.54
Summers View	857.5	735.5	321.5	358.683333	829.75	919.5	664.4333333	675.15	85.77%	111.57%	110.82%	101.61%	92.8%	106.7%	100.6%	2688.83	305	8.82
PICU	1143.366667	1027	687.45	631.95	1542.75	1466.75	1375.65	1396.15	89.82%	91.93%	95.07%	101.49%	90.6%	98.1%	95.2%	4521.85	176	25.69
Totals	13978.12	10197.40	6817.25	4967.38	15679.48	17033.22	11705.38	14163.63	72.95%	72.86%	108.63%	121.00%	72.9%	113.9%	96.2%	46361.63	4345.00	10.67

Appendix 3

Ward	Total Nursing Staffing			Total Hours Per Day	Patients	CHPPD	Bed Occupancy	Safe Staffing maintained by:	RN Vacancies	HCSW Vacancies
	Overall RN %	Overall Care Staff %	Overall Staffing							
Ward 1	70.7%	143.2%	105.4%	4058.97	461	8.80	111.9%	• Nurses working unplanned hours. • Wider MDT support. • Altered skill mix • Temporary & agency staff cover	4.91 ↓	(1.41) ↔
Ward 2	65.0%	136.8%	101.6%	4429.75	625	7.09	112.0%		2.94 ↓	(2.46) ↑
Ward 3	70.3%	141.7%	104.1%	4012.55	446	9.00	89.9%		3.02 ↓	(3.47) ↔
Ward 4	69.0%	109.4%	92.3%	4173.37	440	9.48	94.6%		3.51 ↓	1.61 ↓
Ward 5	72.2%	114.4%	95.4%	3977.30	307	12.96	99.0%		2.00 ↓	(0.12) ↑
Ward 6	62.8%	142.3%	109.1%	4756.50	428	11.11	92.0%		2.59 ↑	0.31 ↓
Ward 7	70.2%	119.4%	98.4%	3747.20	535	7.00	95.9%		1.53 ↑	(0.84) ↔
A&T	59.1%	80.9%	72.5%	2738.97	35	78.26	56.5%		2.76 ↑	2.16 ↔
Edward Myers	101.3%	85.8%	92.4%	2380.25	227	10.49	61%		2.16 ↔	1.80 ↓
Darwin Centre	68.5%	99.2%	88.9%	4876.10	360	13.54	105.6%		12.62 ↓	1.57 ↔
Summers View	92.8%	106.7%	100.6%	2688.83	305	8.82	98.4%		2.00 ↑	1.24 ↔
PICU	90.6%	98.1%	95.2%	4521.85	176	25.69	98.9%		2.76 ↓	(3.76) ↑
Totals	72.9%	113.9%	96.2%	46361.63	4345.00	10.67	96%		42.80 ↓	(3.37) ↑

KEY
↑ Improved since previous month
↓ Deteriorated since previous month
↔No change

APPENDIX 4

Community Safer Staffing Report
M12 2023/24

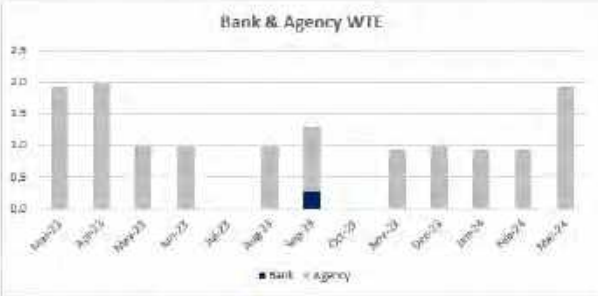
Community Safer Staffing Report M12 2023/24

This report sets out the impact of demand and capacity on core teams. It includes the Core CAMHS Teams, Adult CMHTs and Older Adult CMHTs and also an aggregated view of the 3 areas. It is comprised of staffing data split by Contracted and Vacancy WTEs, Actual WTE (which includes Bank & Agency staff), and a view of Referrals, Discharges, Caseloads, total contact duration and cancelled/ DNA contacts to demonstrate at a high level where teams may be facing particular challenges.

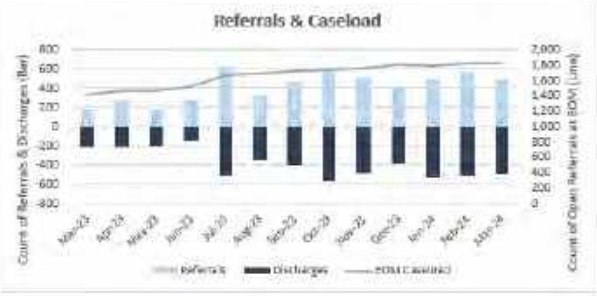
The limitations of the data mean that we are currently unable to split out staff absences or overtime from the Contracted WTE figures at the moment. Furthermore, the complexity of patients' individual needs within a team is not always reflected by a single referral. Despite this, the report provides insight into the challenges some teams are facing in managing demand and capacity.

Core CAMHS

Sum of patient facing roles where positions are filled (contracted) or vacant, and sum of actual people in post including bank & agency, by month.
*Patient Facing defined as anyone who has direct contact with the patient

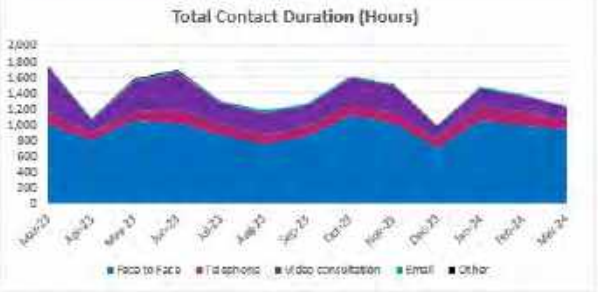


Count of Bank & Agency WTE in month.

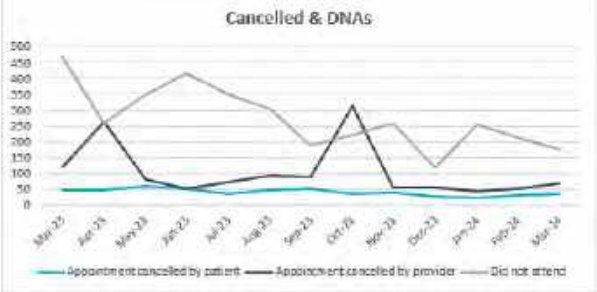


Count of referrals in, discharges & caseload as at end of month.

Count of contacts split by consultation mechanism.



Sum of total hours of contact time in month split by consultation mechanism.



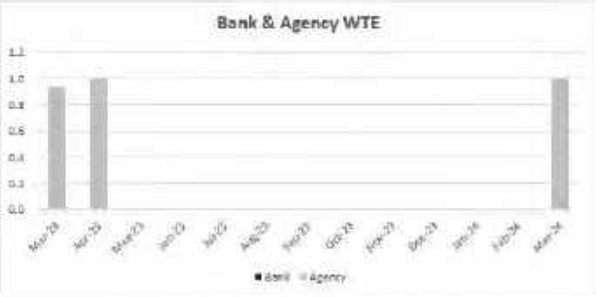
Count of Cancelled Contacts & DNAs.

The vacancies for Core CAMHS have reduced slightly from 6.1 WTE in January to 6.1 WTE in February. The number of patients on the Core CAMHS caseload has been gradually increasing all year and remains high at 1817 open referrals at the end of March.

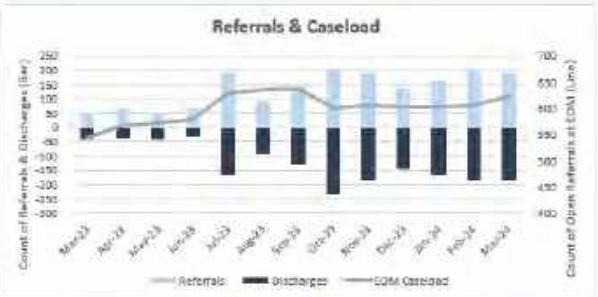
*Please note that a recent change in process has likely impacted the number of new referrals due to the Core CAMHS teams now process their own referrals where previously CAMHS Central Referral Hub would filter through these at first instance.

North Stoke CAMHS

Sum of patient facing roles where positions are filled (contracted) or vacant, and sum of actual people in post including bank & agency, by month.
*Patient Facing defined as anyone who has direct contact with the patient

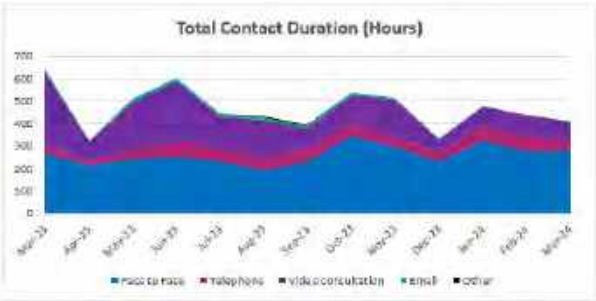


Count of Bank & Agency WTE in month.

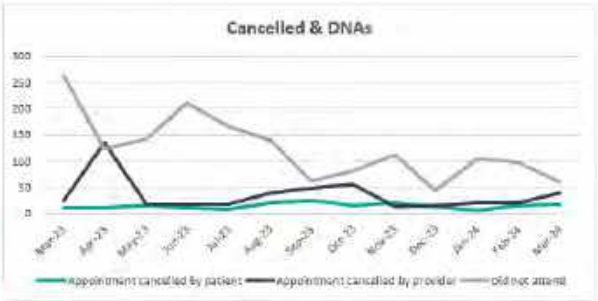


Count of referrals in, discharges & caseload as at end of month.

Count of contacts split by consultation mechanism.



Sum of total hours of contact time in month split by consultation mechanism.



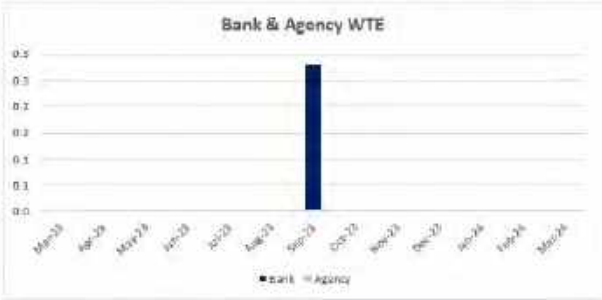
Count of Cancelled Contacts & DNAs.

North Stoke CAMHS vacancy rate has increased from 0.8 WTE in February to 2.5 WTE in March.

Their caseload numbers follows the trend of all Core CAMHS.

South Stoke CAMHS

Sum of patient facing roles where positions are filled (contracted) or vacant, and sum of actual people in post including bank & agency, by month.
*Patient Facing defined as anyone who has direct contact with the patient

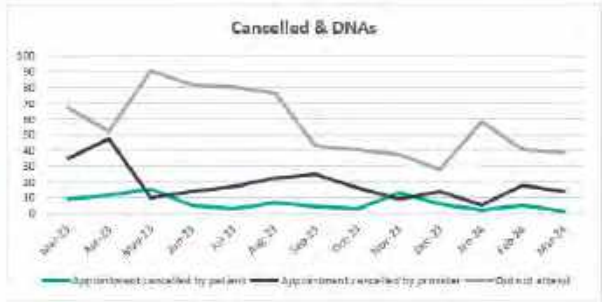


Count of Bank & Agency WTE in month.

Count of referrals in, discharges & caseload as at end of month.

Count of contacts split by consultation mechanism.

Sum of total hours of contact time in month split by consultation mechanism.



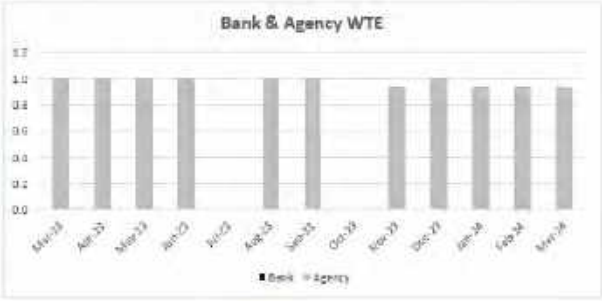
Count of Cancelled Contacts & DNAs.

No significant changes seen.

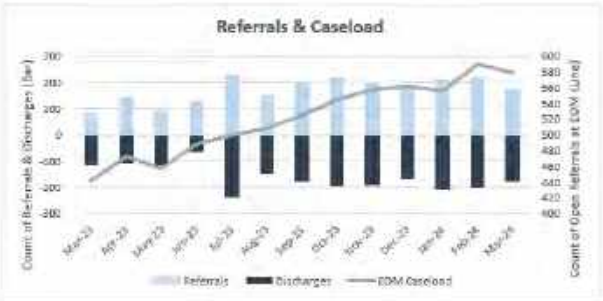
Their caseload numbers follows the trend of all Core CAMHS.

North Staffs CAMHS

Sum of patient facing roles where positions are filled (contracted) or vacant, and sum of actual people in post including bank & agency, by month.
*Patient Facing defined as anyone who has direct contact with the patient



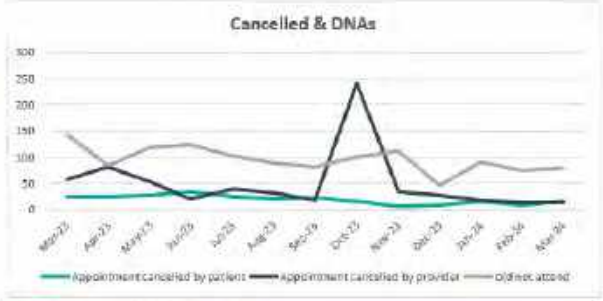
Count of Bank & Agency WTE in month.



Count of referrals in, discharges & caseload as at end of month.

Count of contacts split by consultation mechanism.

Sum of total hours of contact time in month split by consultation mechanism.



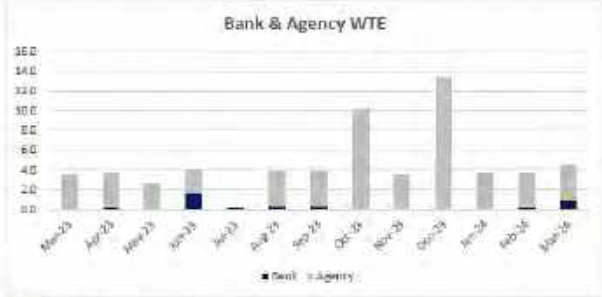
Count of Cancelled Contacts & DNAs.

North Staffs CAMHS vacancy rate has reduced from 1.6 to 0.4 WTE.

Their caseload numbers follows the trend of all Core CAMHS.

Adult CMHT

Sum of patient facing roles where positions are filled (contracted) or vacant, and sum of actual people in post including bank & agency, by month.
*Patient Facing defined as anyone who has direct contact with the patient

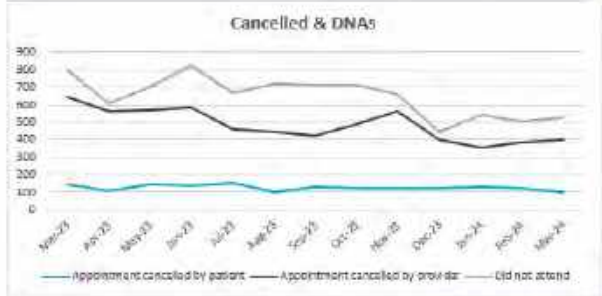


Count of Bank & Agency WTE in month.

Count of referrals in, discharges & caseload as at end of month.

Count of contacts split by consultation mechanism.

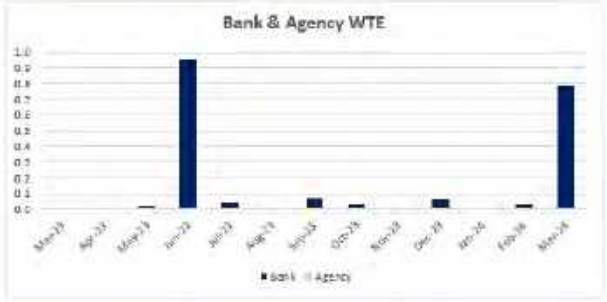
Sum of total hours of contact time in month split by consultation mechanism.



Count of Cancelled Contacts & DNAs.

City CMHT - Greenfields

Sum of patient facing roles where positions are filled (contracted) or vacant, and sum of actual people in post including bank & agency, by month.
*Patient Facing defined as anyone who has direct contact with the patient

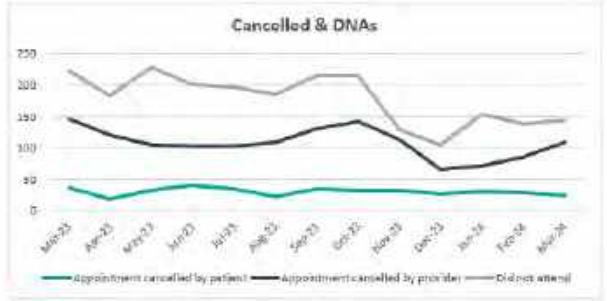


Count of Bank & Agency WTE in month.

Count of referrals in, discharges & caseload as at end of month.

Count of contacts split by consultation mechanism.

Sum of total hours of contact time in month split by consultation mechanism.

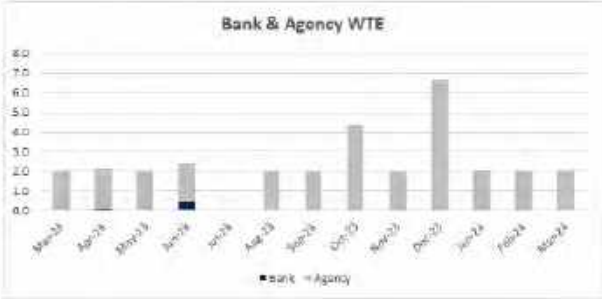


Count of Cancelled Contacts & DNAs.

Vacancy numbers have reduced again from 7.6 WTE in February to 6.6 WTE in March.

City CMHT - Sutherland

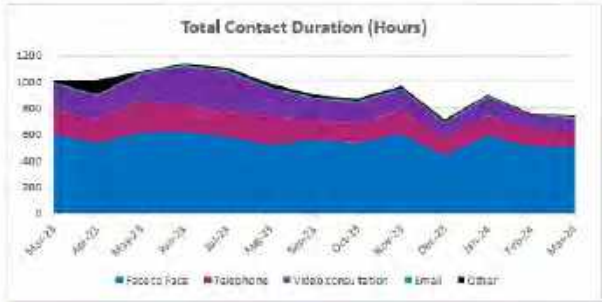
Sum of patient facing roles where positions are filled (contracted) or vacant, and sum of actual people in post including bank & agency, by month.
*Patient Facing defined as anyone who has direct contact with the patient



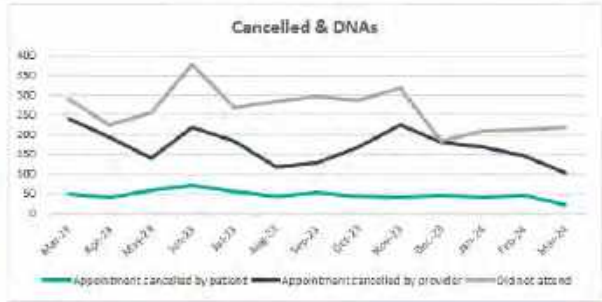
Count of Bank & Agency WTE in month.

Count of referrals in, discharges & caseload as at end of month.

Count of contacts split by consultation mechanism.



Sum of total hours of contact time in month split by consultation mechanism.



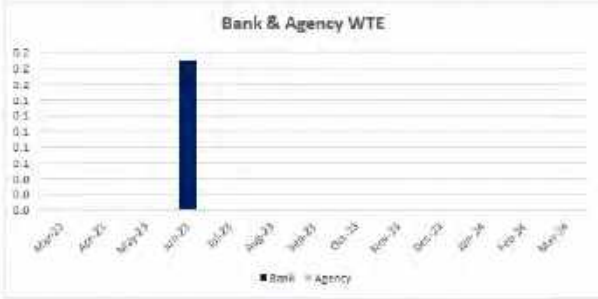
Count of Cancelled Contacts & DNAs.

Vacancy rates have increase from 8.8 WTE in February to 9.5 WTE in March

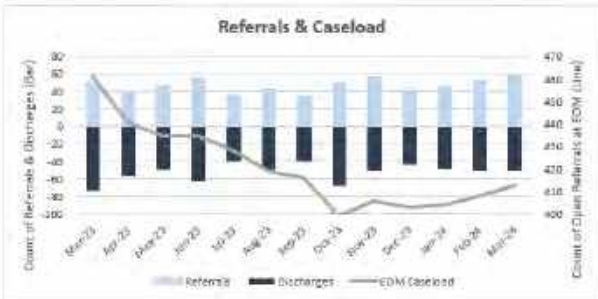
The number on caseload has increased slightly for the first time since October, with 1279 open referrals at the end of

COUNTY CMHT Moorlands

Sum of patient facing roles where positions are filled (contracted) or vacant, and sum of actual people in post including bank & agency, by month.
*Patient Facing defined as anyone who has direct contact with the patient



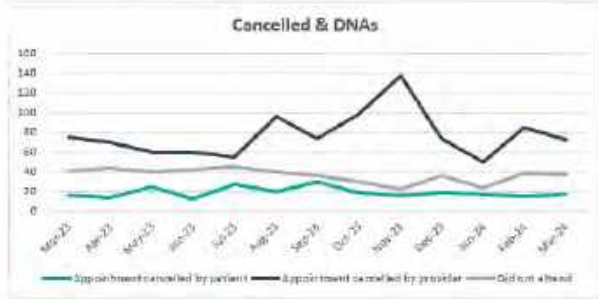
Count of Bank & Agency WTE in month.



Count of referrals in, discharges & caseload as at end of month.

Count of contacts split by consultation mechanism.

Sum of total hours of contact time in month split by consultation mechanism.

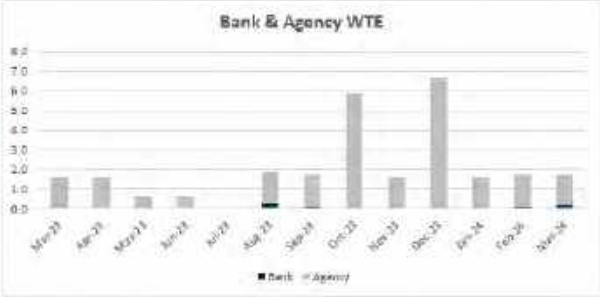


Count of Cancelled Contacts & DNAs.

Moorlands have had a further reduction in the number of vacancies from 0.8 WTE in February to a slight overstaffing of -0.2 WTE in March.

COUNTY CMHT Newcastle

Sum of patient facing roles where positions are filled (contracted) or vacant, and sum of actual people in post including bank & agency, by month.
*Patient Facing defined as anyone who has direct contact with the patient

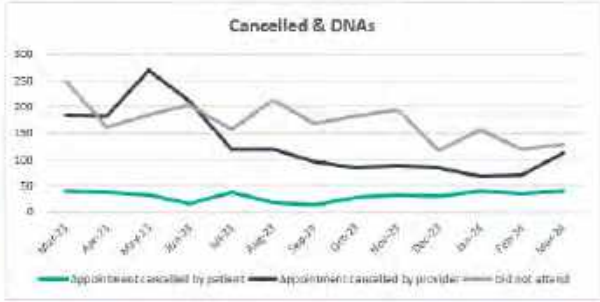


Count of Bank & Agency WTE in month.

Count of referrals in, discharges & caseload as at end of month.

Count of contacts split by consultation mechanism.

Sum of total hours of contact time in month split by consultation mechanism.



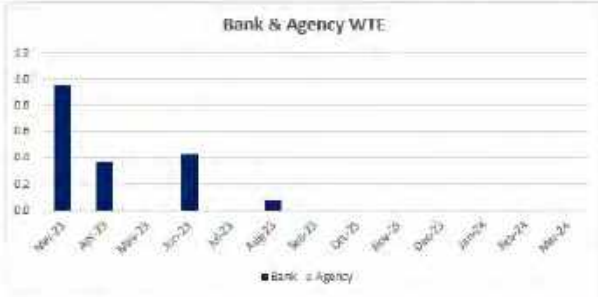
Count of Cancelled Contacts & DNAs.

There has been a reduction in the number of vacancies from 8.8 WTE in February to 8.2 WTE in March.

The number on caseload remains steady.

Older Adult CMHT

Sum of patient facing roles where positions are filled (contracted) or vacant, and sum of actual people in post including bank & agency, by month.
*Patient Facing defined as anyone who has direct contact with the patient



Count of Bank & Agency WTE in month.

Count of referrals in, discharges & caseload as at end of month.

Count of contacts split by consultation mechanism.

Sum of total hours of contact time in month split by consultation mechanism.

Count of Cancelled Contacts & DNAs.

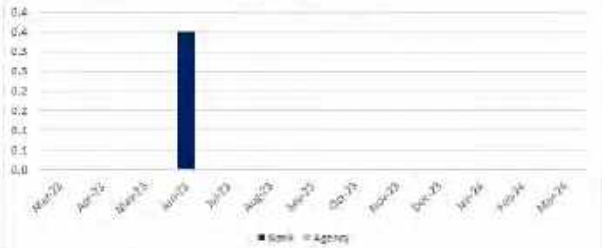
There has been an increase in contracted staff resulting in 2 WTE overstaffing. The number of open referrals on the Older Adult CMHT caseload has decreased slightly from 514 in February to 487.

NOAP City CMHT

Patient Facing* Workforce

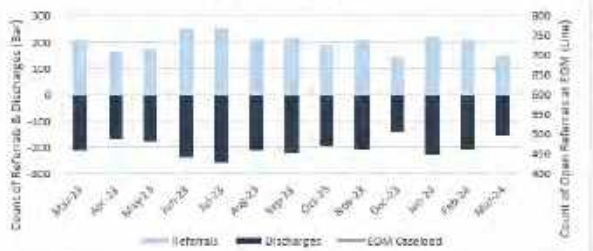
Sum of patient facing roles where positions are filled (contracted) or vacant, and sum of actual people in post including bank & agency, by month.
*Patient Facing defined as anyone who has direct contact with the patient

Bank & Agency WTE



Count of Bank & Agency WTE in month.

Referrals & Caseload



Count of referrals in, discharges & caseload as at end of month.

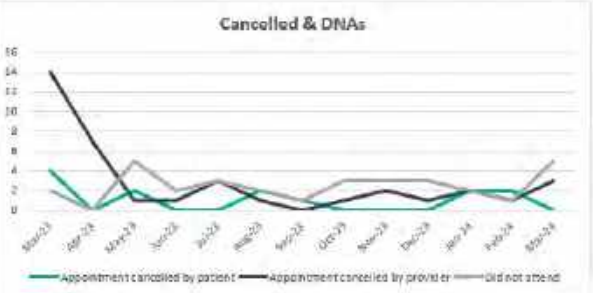
Total Contacts

Count of contacts split by consultation mechanism.

Total Contact Duration (Hours)

Sum of total hours of contact time in month split by consultation mechanism.

Cancelled & DNAs



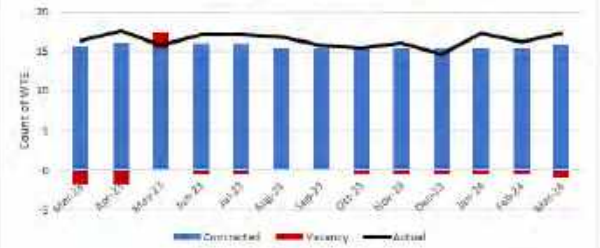
Count of Cancelled Contacts & DNAs.

There has been an increase in contracted staffing with a vacancies rate of -1 WTE.

The number of open referrals on caseload remains steady.

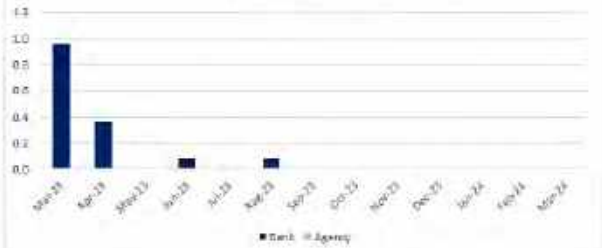
NOAP County CMHT

Patient Facing* Workforce



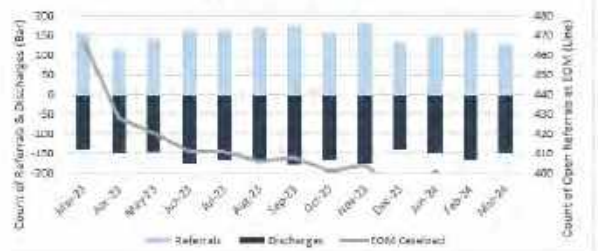
Sum of patient facing roles where positions are filled (contracted) or vacant, and sum of actual people in post including bank & agency, by month.
*Patient Facing defined as anyone who has direct contact with the patient

Bank & Agency WTE



Count of Bank & Agency WTE in month.

Referrals & Caseload



Count of referrals in, discharges & caseload as at end of month.

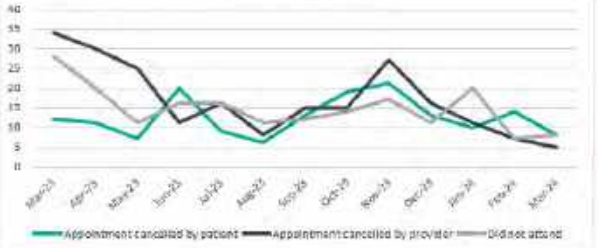
Total Contacts

Count of contacts split by consultation mechanism.

Total Contact Duration (Hours)

Sum of total hours of contact time in month split by consultation mechanism.

Cancelled & DNAs



Count of Cancelled Contacts & DNAs.

Vacancy rate in NOAP County has remained fairly steady this year, this the negative figures representing a slight over staffing which has increased from 0.6 to 1 WTE in March.