NHS
North Staffordshire
Combined Healthcare
NHS Trust

MEETING OF THE TRUST BOARD

TO BE HELD IN PUBLIC
ON THURSDAY 14TH MAY 2020, 10.00AM, Via MS Teams

	AGENDA	
1.	**APOLOGIES FOR ABSENCE** *To NOTE any apologies for absence*	Note
2.	**DECLARATIONS OF INTERESTS RELATING TO AGENDA ITEMS**	Note
3.	**MINUTES OF THE OPEN AGENDA – 12TH MARCH 2020** *To APPROVE the minutes of the meeting held on 12th March 2020*	Approve Enclosure 2
4.	**ACTION MONITORING SCHEDULE & MATTERS ARISING FROM THE MINUTES** *To CONSIDER any matters arising from the minutes*	Note Enclosure 3
5.	**CHIEF EXECUTIVE'S REPORT** *To RECEIVE a report from the Chief Executive to include:*	Note Enclosure 4
6.	**CHAIR'S REPORT** *To RECEIVE a verbal report from the Chair*	Note
7.	**PATIENT STORY FROM THE PATIENT EXPERIENCE TEAM** *To RECEIVE a Patient Story from Kevin Daley – Complaints Manager to be introduced by Kenny Laing, Executive Director of Nursing & Quality*	Verbal Presentation Enclosure 5
	QUESTIONS FROM MEMBERS OF THE PUBLIC	
8.	*To RECEIVE questions from members of the public*	Verbal
	TO ENHANCE SERVICE USER AND CARER COLLABORATION	
9.	**No items**	

	INSPIRE AND IMPLEMENT INNOVATION AND RESEARCH	
10.	**No items**	
	TO PROVIDE THE HIGHEST QUALITY, SAFE AND EFFECTIVE SERVICES	
11.	**NURSE STAFFING MONTHLY REPORT (February 2020 & March 2020)** *To RECEIVE the Nurse Staffing Monthly Reports presented by Kenny Laing, Director of Nursing and Quality*	Assurance Enclosures 6a & 6b
12.	**MORTALITY SURVEILLANCE QUARTER 4 REPORT** *To RECEIVE the Mortality Surveillance Quarter 4 Report presented by Dr Buki Adeyemo, Executive Medical Director*	Assurance Enclosure 7
13.	**SERIOUS INCIDENT QUARTER 4 REPORT** *To RECEIVE the Serious Incident Quarter 4 Report presented by Dr Buki Adeyemo, Executive Medical Director*	Assurance Enclosure 8
14.	**IMPROVING QUALITY PERFORMANCE REPORT (IQPR 2019/20) – Month 12** *To RECEIVE the Month 12 Performance Report presented by Lorraine Hooper, Executive Director of Finance, Performance and Estates*	Assurance Enclosure 9
15.	**ASSURANCE REPORT FOR QUALITY COMMITTEE** *To RECEIVE a Quality Committee Assurance report from the meeting held on 7th May 2020 presented by Patrick Sullivan, Chair / Non-Executive Director*	Assurance Enclosure 10
	EMBED AN OPEN AND LEARNING CULTURE THAT ENABLES CONTINUAL IMPROVEMENT	
16.	**Discussed under Items 7 and 8 of the Public Trust Board**	
	MAXIMISE AND USE OUR RESOURCES EFFECTIVELY	
17.	**FINANCE REPORT – MONTH 12 (2019/20)** *To RECEIVE the Month 12 Financial position presented by Lorraine Hooper, Executive Director of Finance, Performance and Estate*	Assurance Enclosure 11
18.	**ASSURANCE REPORT FOR FINANCE & RESOURCE COMMITTEE** *To RECEIVE a Finance & Resource Committee summary from the meeting held on the 30th April 2020 from Russell Andrews, Chair / Non-Executive Director*	Assurance Enclosure 12

19.	**ASSURANCE REPORT FOR EXTRAORDINARY AUDIT COMMITTEE** *To RECEIVE an Extraordinary Audit Committee summary from the meeting held on the 27th April 2020 from Phillip Jones, Chair / Non-Executive Director*	Assurance Enclosure 13
20.	**REGISTER OF BOARD MEMBERS DECLARED INTERESTS** *To RECEIVE the Register of Board Members Declared Interests from Tosca Fairchild, Assistant Chief Executive Officer*	Assurance Enclosure 14
21.	**BOARD ASSURANCE FRAMEWORK QUARTER 4** *To RECEIVE the Board Assurance Framework Quarter 4 presented by Tosca Fairchild, Assistant Chief Executive Officer*	Approval Enclosure 15
22.	**SELF CERTIFICATION G6 AND FT4 (PROVIDER LICENSE)** *To RECEIVE the Self Certification G6 & FT4 from Tosca Fairchild, Assistant Chief Executive Officer*	Approval Enclosure 16a and 16b
	ATTRACT , DEVELOP AND RETAIN THE BEST PEOPLE	
23.	**WORKFORCE DISABLITY EQUALITY STANDARD (WDES)** *To RECEIVE the Workforce Disability Equality Standard (WDES) presented by Shajeda Ahmed, Director of Workforce, Organisational Development and Inclusion*	Assurance Enclosure 17
24.	**ASSURANCE REPORT FOR PEOPLE, CULTURE & DEVELOPMENT COMMITTEE** *To RECEIVE a People, Culture & Development Committee update from the meeting held on the 7th May 2020 from Janet Dawson Chair / Non-Executive Director*	Assurance Enclosure 18
	TAKE A LEAD ROLE IN PARTNERSHIP WORKING AND INTEGRATION	
25.	**RESTORATION AND TRANSFORMATION FRAMEWORK** *To RECEIVE an update from Chris Bird, Director of Partnerships, Strategy and Digital on the Restoration and Transformation Framework that will be implemented to coordinate a wide range of recovery actions to support our post COVID-19 planning*	Approval Presentation Enclosure 19
	CONSENT AGENDA ITEMS	
26.	**TRUST BOARD EFFECTIVENESS REVIEW** *To RECEIVE the Trust Board Effectiveness Review from Tosca Fairchild, Assistant Chief Executive Officer*	Information Enclosure 20
	ANY OTHER BUSINESS	
	The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday 9th July 2020 at 10:00am.	

	MOTION TO EXCLUDE THE PUBLIC *To APPROVE the resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admissions to Meetings) Act 1960)*	
	THE REMAINDER OF THE MEETING WILL BE IN PRIVATE	
	DECLARATIONS OF INTEREST RELATING TO AGENDA ITEMS	Note
	SERIOUS INCIDENTS	Assurance
	PERFORMANCE	Assurance
	WORKFORCE AND AGENCY	Assurance
	ANY OTHER BUSINESS	

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TRUST BOARD

Minutes of the Open Section of the North Staffordshire Combined Healthcare NHS Trust Board meeting held on Thursday 12th March 2020 At 10:00am in the Boardroom, Lawton House, Bellringer Road, Trentham, Stoke-on-Trent, Staffordshire, ST4 8HH

Present:

Chairman:

David Rogers
Chairman

Directors:

Peter Axon
Chief Executive Officer

Tosca Fairchild
Assistant Chief Executive

Shajeda Ahmed [from 10.45am]
Director of Workforce, Organisational Development and Inclusion

Janet Dawson
Non-Executive Director

Lorraine Hooper
Executive Director of Finance, Performance and Estates

Patrick Sullivan
Non-Executive Director

Tony Gadsby
Associate Non-Executive Director

Phil Jones
Non-Executive Director

Kenny Laing
Executive Director of Nursing and Quality

Chris Bird
Director of Partnerships, Strategy and Digital

Dr Buki Adeyemo
Executive Medical Director

Russell Andrews
Non-Executive Director

Joan Walley
Non-Executive Director

Jonathan O'Brien
Executive Director of Operations

In attendance:

Lisa Wilkinson
Corporate Governance Manager

Jenny Harvey
Union Representative

Joe McCrea
Associate Director of Communications

Billie Lam
Trainee Non-Executive Director (NExT Director Programme)

Sue Tams
Interim Chair, Service User Care Council

REACH Recognition Team Award
Richard Priest
Racheal Birks
Pete Milgate
Sian Bensa
Claire March
Joanne Austin

Members of the public:
Sharon Black – Reverse Mentor
Michael Fenwick – CQC
Claire Newey- CQC
Lydia Marimo - CQC

Patient Story
Jane Lamb
Simon Newman
Ross Barber
Ben Hibbert
Sandie James
Rachel Wooliscroft

The meeting commenced at 10:05am.

30/2020	APOLOGIES FOR ABSENCE Dr Keith Tattum, GP Associate Director	Action

31/2020	**DECLARATION OF INTEREST RELATING TO AGENDA ITEMS** Tosca Fairchild was appointed as Chair of Show Racism the Red Card from the 21st February 2020. David Rogers was appointed as Governor of Stoke-on-Trent Further Education College.	
32/2020	**MINUTES OF THE OPEN AGENDA – 16TH JANUARY 2020** The minutes of the open session of the meeting held on 16th January 2020 were approved.	
33/2020	**ACTION MONITORING SCHEDULE AND MATTERS ARISING ASURING FROM THE MINUTES** The Board reviewed the action monitoring schedule and agreed the following:- ***19/2020 – Assurance Report for Primary Care Committee - 15th January 2020 - Shajeda Ahmed added that the Trust must meet minimum requirements there is an education piece with primary care colleagues and their understanding. The Trust needs to look at changing some perceptions and managing reputational issues. Shajeda Ahmed will look into this.*** *The Workforce Business Partners are working closely with PCN colleagues and being responsive to enquires around some of the processes that need to be adhered to as an NHS Employer. In addition to this the Recruitment Team have been working flexibly by going out to the GP practice site to support in the undertaking of ID / DBS clinic checks.* ***Received***	
34/2020	**CHIEF EXECUTIVES REPORT** The Chief Executive, Peter Axon updated the Board on activities undertaken since the last meeting and draw the Board's attention to other issues of significance or interest. Peter Axon welcomed members of the CQC who were present to observe the meeting. **COMBINED HEALTHCARE WINS NATIONAL PRAISE IN NEW CQC REPORT ON SUSTAINING IMPROVEMENT** Combined Healthcare is proud to have been singled out by the Care Quality Commission as an example for others to learn from in how to sustain improvements in high quality care and performance after receiving the CQC's highest possible rating – Outstanding. The praise from the CQC comes in a new Report – "Sustaining Improvement", published on 5th March 2020. The Report features case studies from four NHS Trusts exploring how each had sustained improvements and, in some cases, improved further. Combined Healthcare is the only one of the four to have sustained improvement after being rated Outstanding overall. The Trust is delighted that the CQC have recognised the central role played by the Trust's magnificent staff and partners in continuing to	

	improve and deliver services. **RECORD RESPONSES AND ENCOURAGING RESULTS FROM THE NHS STAFF SURVEY** Combined Healthcare is delighted to announce the standout results from the National NHS Staff Survey 2019, having received a record number of responses. This year, an impressive 52.6% of Combined employees took the time to respond to the NHS Survey – the highest figure for the Trust to date. This annual anonymous survey, which goes to all NHS Trusts in England, provides valuable data that provides an insight into how staff feel about Combined as a workplace. A huge thank you is due to colleagues who took the time to complete the survey. The Trust is proud of its approach to employee engagement and knows that, by listening and responding to staff, it will continue to cultivate a positive working environment. **"EXEC DROP IN' SESSIONS" DELIVER REAL INSIGHT** As part of the work initiated to review how the Trust can modernise its engagement approach with frontline teams, this month saw the first trial of the new "Exec Drop-In" sessions, which proved to be both popular with staff and a success in being able to hear ideas and perspectives from frontline staff in a more informal setting than other established channels. Some staff simply wanted to drop in to have a brief chat, others stayed for a longer period of time to be involved in chats across a range of topics. Posters around Harplands Hospital, produced by the Communications Team, advertised the event, as well as flagging that staff could raise items confidentially if they preferred. What was particularly encouraging was that the direction of travel and range of initiatives already in place within the Executive, workforce and communications teams appears to chime strongly with views and opinions on our 'shop floor'. This suggests they will land on fertile territory when completed and deployed. The overall Review of Frontline Feedback methods have progressed well and will be completed this month. Findings and recommendations from the review will be published in due course. **PREPARATIONS FOR STRATEGY LAUNCH** Preparations are underway for the launch of the updated Trust Strategy, which is planned for April. The enabling strategies for the Mental Health Implementation Plan and Long Term Financial Plan will also be presented to the April Board to allow for the contracting process to be concluded. The implementation plan for the Strategic Review of Communications, signed off by the Trust Board last Autumn, also dovetails with all of the above, in particular close integration with partnerships and stakeholder management plans. All strategies will be presented as a 'family' of documents, largely following the format of the recent Psychology Strategy which was very well received by the Board – by adopting this approach we will be able to have a cohesive thread across the strategies but equally be able to position them as stand-alone documents in their own right. **TOSCA FAIRCHILD ELECTED CHAIR OF 'SHOW RACISM THE RED CARD'** The Trust is delighted at the news of the election of its Assistant Chief	

	Executive, Tosca Fairchild, as Chair of Show Racism the Red Card. Show Racism the Red Card is the UK's leading anti-racism educational charity. One of its key campaign strategies is the national Wear Red Day usually held in October. Tosca was a Non-Executive Director at Show Racism the Red Card since May 2019. Her election as Chair will not affect her existing role as Assistant Chief Executive with Combined Healthcare. The Trust is proud of its track record in confronting and tackling racism head on. Having Tosca elected to this additional high profile national role is a further strong statement of the Trust's anti-racism values and commitment. ***Received***	
35/2020	**CHAIRS REPORT** David Rogers, Chairman provided a verbal update. Pauline Walsh, Executive Dean of Health at Keele University generously agreed to join the Trust as an Associate Non-Executive Director this underpins the Trust's ambitions to work closely with academic institutions. There are many benefits for example this will encourage research in joint projects and recruitment and closer links with the medical school to encourage graduates to stay in the area. In terms of the Trust's involvement with the system legislation is anticipated about how to structure the way systems take more responsibility in being be more strategic focussed. It was reported that Combined Healthcare as a relatively small Trust in the system had taken the view that rather than make a contribution to any financial deficit the Trust would develop capacity and ability to help formulate the way the system develops. David Rogers report that the Trust was delighted that Peter Axon is primarily responsible for leading and designing this for North Staffordshire. It was reported that Substantive leadership for the whole system is being looked at and it had been agreed that the Trust's Human Resources team will manage that process for the whole system. ***Noted***	
36/2020	**REACH RECOGNITION TEAM AWARD** **Greenfields Centre** Peter Axon, Chief Executive Officer introduced the Team. He advised that Greenfields had a highly skilled and compassionate workforce who are supportive and caring to service users, their carers and to each other who experience significant challenges to the rising demand for services, especially within our Community Mental Health Teams (CMHT's). The team is currently in the process of responding to the impact of losing social care colleagues and the interventions they deliver across services. The Greenfields Centre team respond to multiple issues on a daily basis that are associated with the complexity and co morbidity of service users.	

	The team deserve this recognition, as they have worked tirelessly to develop their positive multi-disciplinary team (MDT) culture and continue to make significant improvements in practice to deliver the best care to service users and their carers. The Greenfields Centre team provide mental health assessment and treatment and recognise the need to go the extra mile, particularly when service users disengage and are hard to reach. The team work closely with the crisis care centre to support service users who access the team in crisis on a daily basis. The team have also established excellent partnerships working with third sector providers as well as working in collaboration with Community Drug and Alcohol Service (CDAS), safeguarding and other Trust services, as there are a high number of service users who have multiple needs. The team are reviewing and improving treatment pathways for service users of which there is a high population who have experienced trauma. The Board received a presentation delivered by Rachael Birks, Service Manager that looked at workforce, performance and innovation within the team. The team were congratulated and presented with a REACH Recognition Certificate. ***Noted***	
37/2020	**PATIENT STORY – PEER MENTOR VOLUNTEERS** Kenny Laing, Executive Director of Nursing and Quality introduced the Volunteer Peer Mentors. The Trust wanted to have volunteer peer mentors, service users and carers who could support other service users and carers through their journey of recovery. An initial meeting was held in October 2018, current volunteers attended as they were interested in becoming Volunteer Peer Mentors. The meeting was held to discuss what they felt was needed and to then identify and develop a training package. Julie Richardson and Chris Malbon (Hillcrest Resettlement Team) developed a training package utilising some of the elements of the Community Mental Health Certificate that they had previously been delivering, as well as elements from a training pack from Scotland and the information from the previous meetings with service users and carers. There was a follow up meeting in February, 15 people were invited and 7 people attended to discuss the planned training programme which commenced on 4th April 2018 and ran for 10 weeks. Feedback was taken from participants at the end of the training and changes made. A further cohort completed in December 2019 this cohort included volunteers from Brighter Futures, who let us use the Observatory at no cost and Combined Healthcare staff who are Peer support workers from Parent and Baby Unit which included 2 staff from the Midlands Partnership Foundation Trust (MPFT). Difficulties experienced can often be physical illnesses or the stress of their own mental health which is something to be aware of also when	

	matching up and teams identifying appropriate mentees that can be matched, as people do need to be well enough to form a working relationship with their mentor. Teams also need to provide a named person to support the mentor. In inpatients teams have been organised to support the community group and build trust. Therefore initially it is more work for the teams but importantly they recognise the value of someone demonstrating recovery. Volunteer Peer Mentors are expected to have regular supervision as appropriate to how often they are meeting their mentee with their named person and 6 weekly group meeting with Patient Experience / Volunteer Coordinator. Mentors have been placed in Ward 1, Growthpoint, The Observatory (women's group and men's group), Carers Group Tunstall, Sutherland Centre, New Beginning Peer support and Edward Myers. In paid work there are Step On Peer support mentors x 2, Parent and Baby Unit and a HCSW Florence House / Summers View, Crisis Carer Centre. There are two more cohorts planned in 2020. The Board watched a video provided by participants from Cohort 1. Kenny Laing highlighted the vital work of the peer mentors adding they are people with experience working with teams which makes a real difference. The Volunteer Peer Mentors were thanked for providing the film and attending Board. Thanks were especially extended to Sandie James, Rachel Wooliscroft and Simon Newman ***Noted***	
38/2020	**QUESTIONS FROM MEMBERS OF THE PUBLIC** There were no questions from the public. ***Noted***	
39/2020	**SERVICE USER CARER COUNCIL** Sue Tams, Interim Chair provided an update. She confirmed she had been appointed as the Interim Chair for the Council and reported that the Council had been looking at ways of increasing membership, with the aim of having proportionate representation from across the Trust clinical directorates. The latest workshop in February agreed to develop information, posters and leaflets on what the council do prior to visiting the centres, meeting existing groups and proactively engaging and encouraging service users and carers to get involved. These resources are currently in development. The Terms of Reference for the Service User and Carer Council specify that the Directorates can nominate 3 members either service users or carers to represent the directorate on the council and the nursing & quality directorate supports this process. A member of the Service User Carer Council was involved as part of the	

	Trust team in the Sexual Safety Collaborative Project on Ward 1 and Ward 7. The project commenced in October 2019 and ran until March 2020 and they have attended two national meetings. The Sexual Safety Collaborative is part of a wider Mental Health Safety Improvement Programme (MHSIP) which was established by NHS Improvement (NHSI), in partnership with the Care Quality Commission (CQC), in response to a request made by the Secretary of State. Peter Axon extended thanks for the work the team undertake. ***Received***	
40/2020	**NURSE STAFFING MONTHLY REPORT (December 2019 & January 2020)** Kenny Laing, Executive Director of Nursing and Quality presented the reports. He advised that the performance relating to fill rate during December 2019 was 86% for registered staff and 97% for care staff on day shifts and 79% and 110% respectively on night shifts. Overall a 94% fill rate was achieved. It was reported there had been improvement in safe staffing levels during January 2020 with an overall fill rate of 96.1% being achieved. Although this had increased from December 2019 there had been no statistically significant change in this position during the past 18 months. Registered Nurse vacancies within ward inpatient areas improved slightly to 28.97 WTE in January 2020. HCSW vacancies increased to 3.61 WTE. 5 Registered Nurses (6.80 WTE) left the Trust in January 2020; none of these were from ward inpatient areas. 3 HCSW's (2.40 WTE) left the Trust during January 2020; of these, 2 posts were from ward inpatient areas. David Rogers queried the use of different graphs in both reports i.e. Registered Nurses fill rate in the December Report and overall fill rate within the January report. Kenny Laing assured the Chair SPC graphs will be contained within reports going forward. Kenny added there is an intention to roll out safer staffing into the community teams to provide assurance. The Board will be kept informed as methodology evolves, data collection will commence this month. Janet Dawson asked how the Trust can ensure there is not an impact on some individuals more than others in terms of training and staff breaks. Kenny provided assurance that through good operational management, measurements, processes and policies we can ensure time does not accrue in terms of time owing. There is a Task and Finish group for ward managers where these issues are discussed. David Rogers acknowledged the importance of peer review involvement and asked if the Trust could look at the distribution of peer reviewers through the organisation. Kenny advised he would bring back a more detailed report to include the spread of people working within Trust services as there is a very formal governance arrangement in terms of service user involvement.	**KL**

	Tony Gadsby asked in terms of staffing numbers if there was any update on the 100 expressions of interest received during the recruitment campaign. Shajeda Ahmed confirmed there had in fact been 200 applicants and she would follow up progress with the recruitment team and fed back to the Board. ***Received***	**SA**
41/2020	**SERIOUS INCIDENTS QUARTER 3 REPORT** Dr Buki Adeyemo, Executive Medical Director presented the report. The report covers the period from 1st October 2019 to 31st December 2019 (Quarter 3, 2019/20). • There were 5 serious incidents reported for the Specialist Services Directorate. There were 4 unexpected, potentially avoidable deaths and a serious self- harm attempt: all incidents occurred in the community. • There were 5 serious incidents reported for the Acute & Urgent Care Directorate. This includes 2 unexpected, potentially avoidable deaths. • In the Stoke Community Directorate, there was 1 incident of unexpected, potentially avoidable death. • There were 2 incidents of unexpected, potentially avoidable deaths in the North Staffordshire Community Directorate. During Q3, there was one incident which was determined to have met the criteria for reporting under the Duty of Candour requirements. The incident involved the physical health care of a person admitted to one of the wards at the Harplands. The physical health of the person deteriorated whilst on the ward and he later required transfer and treatment at RSUH. The process by which staff review and react to physical health monitoring had been strengthened as a result of the incident. Patrick Sullivan highlighted that time frames had been altered to bring the Trust in line with other Trusts in terms of patients in contact within 6 months rather than 12. Patrick asked if this had had any impact on the trend line. Dr Adeyemo advised the trend had continued to be a downward and the change will have more of an impact. Joan Walley asked if there was anything in place to evaluate what the impacts of the Stoke-on-Trent council cuts are. Dr Adeyemo advised this would be looked at within the next quarterly report. David Rogers noted there would also be impacts from Staffordshire County Council cuts the Trust had stressed the implications of those cuts and will be keeping an eye on what the trends are and what they have been. ***Received***	

42/2020	**MORTALITY SURVEILLANCE QUARTER 3 REPORT** Dr Buki Adeyemo, Executive Medical Director presented the report. During Quarter 3 the Mortality Surveillance Group reviewed the care of 11 people. The Trust reported the deaths of 5 people to the National Reviewing Board. However the majority of these deaths are still to be allocated to external reviewers. In December 2019, the Trust was contacted by an external reviewer with regards to the review of care for 2 people which were reported in 2018. In the deaths reviewed during Quarter 3, there was no evidence of deficits in the healthcare provided by the Trust which may be considered to have contributed to the death of any individuals. Dr Adeyemo advised that she had been tasked by the Board to look into this specifically two years ago. It took a while to gain approval from the Clinical Commissioning Group (CCG) and Staffordshire County Council as they did not wish to be part of the review. It was agreed the Centre for Mental Health would carry out the review which coincided with Stoke-on-Trent City Council's review. There was no point in the Trust reviewing its internal data but we do continue to push. Joan Walley felt evidence base was very important and suggested this be followed up with Keele University. Janet Dawson added during a period of change it is sometimes helpful to widen the net. Should the Trust anticipate services may deteriorate it might be interesting to look at what happened to people in the last 6 months who no longer accessed Trust services can we continue to watch that? It would be sad to suddenly discover that people leave our services and their incident rate increased. Peter Axon suggested Dr Adeyemo discuss with Keele in the first instance then methodology can be devised in the absence of data sets. Patrick Sullivan referred to patient 27255 advising there was a number of actions more likely to be found in an investigation after a serious untoward incident and asked if this incident had been investigated as a serious untoward incident and if an incident can become part of both processes. Dr Adeyemo confirmed this does happen although not often and was not the case for this incident particularly as the patient had co-morbidities. We try to look at the mental health aspect but also the full care. If there was a broader issue it would be escalated. Tony Gadsby suggested if adequate care is determined to be care where the basic standards of expected support are given the Trust should be looking to eliminate adequate care and progress to good. All were in agreement. Dr Adeyemo advised findings are fed back to the team and the directorate with an improvement plan that is monitored as we would a serious incident. Outstanding care is required all round the Trust will not tolerate basic as that is not good enough. ***Received***	**BA**

43/2020	**MHA COMPLAINCE QUARTER 3 REPORT** Dr Buki Adeyemo, Executive Medical Director presented the report. The results showed an average compliance of 79% against the total audit, with 100% scored against 10 standards and 90-99% scored against a further 6. Areas of good practice included initial detention paperwork and Approved Mental Health Practitioners (AMHP) report recorded correctly on Lorenzo, a valid Section 17 form being present which had been completed by the Responsible Clinician, and reasons and date of Section 17 revocation being recorded on the Section 17 leave form where appropriate. Areas for improvement included rights being repeated regularly during the first 14 days of detention and then weekly thereafter for patients detained on a Section 2, rights being repeated every 2 weeks for the first 3 months of detention and then monthly thereafter for patients detained on a Section 3, and evidence that the Responsible Clinician had recorded details of the discussion held with the patient in order to determine capacity to consent. Following the quarterly audit, individual action plans were produced for each ward and progress against these actions continue to be monitored by Mental Health Law Governance Group (MHLGG). A further audit will take place at Quarter 4 to determine any change in compliance. Patrick Sullivan acknowledged having set a goal of 100% compliance the Trust disappointingly continues to have problems with this. Section 2 is results are also disappointing which is concerning. Dr Adeyemo advised that rights are being repeated every 2 weeks for the first 3 months of detention but sadly if it had not been documented in the correct place then it was considered as not done. Clarity is required around where this needs to be recorded the Mental Health Law Team are working on this and improvement is anticipated. Dr Adeyemo advised there are times when people had missed it but a majority of the time the main issue had been where it had been documented. Patrick recognised a documentation issue will be easier to rectify than a culture issue. ***Received***	
44/2020	**MEDICAL STRATEGY** Dr Buki Adeyemo, Executive Medical Director presented the strategy. The Strategy was cited at the People, Culture and Development Committee. Senior medical staff came together over a series of development days to discuss key issues and what differences could be made going forward. Five key strategic themes have been agreed. The next stage will be to develop the work plan. The Board were happy with the presentation and format of the strategy. ***Approved***	
45/2020	**ASSURANCE REPORT FOR QUALITY COMMITTEE**	

	Patrick Sullivan, Non-Executive Director / Chair presented assurance reports from the meetings held on the 6th February 2020 and the 5th March 2020 and highlighted the following: The February Committee was strategic / corporate focused compared to the March Committee meeting which was operational focused. The February report is available for information only as a verbal exception report was provided at the February Board meeting. EVO Presentation, Stoke Directorate - The Committee received a presentation from Dr Becky Chubb. The presentation was regarding a clinically led quality improvement project focused on the memory service in Stoke. The work had been undertaken as part of a programme of work – Engage, Value and Outcome (EVO). The project linked clinical, performance and financial factors in developing an improved experience for the patient. It forms part of a wider piece of work around service line reporting. Directorate Reports / Balance Scorecards – Each Clinical Director (or nominated deputy) presented the report and the balanced scorecard for their area of responsibility. Areas of good practice were highlighted, challenges to services identified and areas of continued improvement noted. The board should note: • Continued challenges in relation to Section 136 Mental Health Act • Admission of a young person aged under 18 to an adult acute inpatient unit • Significant challenges around the vacancy rates and turnover in the CMHTs in both the county and the city. This is having a negative impact on both performance and staff experience – service transformation may resolve some of these difficulties but this is a longer term programme of work • Some teams experiencing problems in addressing waiting time pressures particularly in the specialist services directorate • Impact of the Section 75 funding position in Stoke-on-Trent • Pressures around the neuropsychiatry service • Wider piece of work being undertaken to review bed occupancy in Darwin and quality and financial implications • Good progress in addressing issues identified at previous CQC or internal Trust compliance visits The following policies were approved for 3 years • Olanzapine SOP • Assistance and PAT Dog Policy • In-Patient Admission, Transfer and Discharge Policy • 3.43 Clinical Placements Policy • 1.82 Pressure Ulcer Prevention and Management • Incident Response Guide V5 • 4.08 Claims Handling • MHA26 Voting Rights for Mental Health Patients Policy • PICU Operational Policy • NSCHT Pandemic Flu Plan The following policies were removed from the portfolio of policies	

	• 1.82 Treatment and Management of Pressure Ulcers • 3.43 Serious Placement Issues Policy • 6.0 Incident and Recovery Plan V36.0 One policy was extended to July 2020 • MHA09 S117 Aftercare The Committee was also briefed regarding the development of the Trust's Quality Strategy and the latest position in relation to coronavirus. Kenny Laing advised there was an under 18 admission to the Assessment and Treatment Unit (A&T). The individual was a 12 year old boy who was being managed in the community with great difficulty for the family and the police became involved. The Stoke-on-Trent City Council were supporting this young person and looking for a hospital placement for him as he had a learning disability and complex needs. A pragmatic decision was made on the 31st January 2020 to admit him A&T, the unit was split into half to provide care for the young person with the intention to source a specialist placement which proved to be difficult. Discharge took place at the end of February following lots of support, treatment and engagement and a residential placement was found in the County. The admission was not ideal but in terms of the outcome for the child it was for the best. ***Received / Ratified***	
46/2020	**COVID-19** Jonathan O'Brien, Executive Director of Operations presented the report. He confirmed that the Trust is following all national guidance. Weekly meetings are taking place with wide representation from across the Trust. The Pandemic Flu Plan was recently reviewed, approved and ratified through appropriate governance processes. It was reported that the Incident Management room at the Harplands Hospital had been staffed Monday to Friday and may include weekends in the near future. In terms of staff absence and sickness, management guidance had been issued to all teams. Specific guidance will be shared with inpatient teams following health guidance.Weekly communications had been circulated to staff and will continue to do so. Jonathan O'Brien highlighted there had been a lot of focus on agile working in the event of a significant number of staff self-isolating stocks of laptops / pads etc. have been made available to undertake other work from home. It is anticipated that events will move very quickly over the next few days in terms of social distancing and how the Trust responds to this. There are plans in place for isolating large numbers of patients should this be required. All On Call Managers and teams are briefed regularly. Peter Axon fed back from a Staffordshire Chief Executive Officer Session. The Department of Health were present and heavily involved in	

	discussions. It was reported that there are 4 confirmed cases in Staffordshire 0 in Stoke. Peter felt there was a small window to learn from how other Trusts are managing and coping with bigger numbers to enable the Trust to better prepare. Chris Bird gave absolute assurance that primary care services were part of the Emergency Preparedness Resilience and Response (EPRR). The Trust had received guidance separately around the arrangements for general practice increasing triage and reducing footfall into the practice. Those presenting to the practice with respiratory issue are receiving separate service provision. From a primary care perspective specifically some of the payment arrangements are contingent on Quality Outcomes Framework (QAF) and Quality Improvement Framework (QIF) which necessitates people attending the practice for checks. It is anticipated separate guidance will be received from the Clinical Commissioning Group (CCG) around this. Jenny Harvey highlighted the biggest fear for staff will be the pressure of the Sickness and Absence Management Policy especially if a member of staff is under a Stage 2. Jenny suggested a message be circulated to all staff as soon as possible indicating triggers within the policy will not count should staff self-isolate otherwise this could impact on whether staff come into work. The Board were in agreement. Tosca Fairchild advised it had been confirmed today that staff self-isolating will be paid sick leave. Joan Walley thanked Jonathan O'Brien and everyone involved in the COVID-19 work acknowledging the rapidly changing situation. Joan endorsed the input of Trade Unions and asked what the Trust's approach will be in terms of wider communications in the community given there will be a lot of demand in the local media about how the figures are progressing. Jonathan O'Brien confirmed NHS communications and care leads have held regular conversations. The Trust website had been updated with overall public guidance and a Coronavirus advice page had been developed which directs people to up to date information from NHS England. Kenny Laing advised from a clinical perspective most people who contract the virus will have symptoms of a mild influenza type illness and will experience within 24-48 hours a dry cough, mild temperature and muscle fatigue. Kenny reiterated the message that staff should not be heroes and should not come into work if feeling unwell. The whole purpose is to keep the most vulnerable people safe and over 70's with multiple co-morbidities. For the most fit and healthy this will be a very mild illness. Children do not seem to be symptomatic. Tony Gadsby highlighted the need to minimise the amount of time people travel between sites and conference facilities need to be utilised where possible. Exec and board visits need to be suspended for the time being and only essential travel undertaken. Phil Jones asked what the pressure points would be for the Trust. Jonathan O'Brien advised staffing would be the main concern. The Trust is	

	well prepared should there be a loss of 20% or more of the workforce at a time of self-isolation or sickness then team arrangements to manage that would be the main concern. Jonathan acknowledged Exec and Board visits would be suspended. The incident room at the Harplands Hospital will be open to respond to guidance but also effectively manage an outbreak of the virus in the hospital implement protocols should there be a substantial reduction in staff. ***Received***	
47/2020	**IMPROVING QUALITY PERFORMANCE REPORT (IQPR 2019/20) – Month 10** Lorraine Hooper, Executive Director of Finance, Performance and Estates highlighted the following: There are 16 RAG rated measures that have achieved target and 4 that have not achieved. There are 4 special cause variations signifying concern. The 4 orange flags are: Delayed Transfers of Care, IAPT Recovery, Use of Agency and Sickness (taking into account the updated November and December data refresh). There are 5 special cause variations signifying improvement Peter Axon advised the Finance, Performance and Estates Committee need to understand the projection out for 2020/2021 given the Quarter 4 position. Lorraine Hooper confirmed this is being actioned. ***Received***	
48/2020	**BOARD ASSURANCE FRAMEWORK QUARTER 3** Tosca Fairchild, Assistant Chief Executive presented the report. The report can be taken as read. There are seven objectives in total. Work is being undertaken to revise the BAF in line with the strategies. ***Received***	
49/2020	**ANNUAL REPORT & QUALITY ACCOUNT REPORTING TIMELINES AND KEY MILESTONES** Tosca Fairchild, Assistant Chief Executive presented the report. The report provides the timetable to provide the Annual Report and Quality Account. Board approval was sought to delegate authority to Audit Committee and Quality Committee respectively. David Rogers advised the format was impressive but felt it required more	

	impact. Tosca advised the Trust is guided by the template that comes from the guidance but how the Trust presents at the Annual General Meeting (AGM) is entirely up to the Trust. Joan Walley felt the AGM would be an opportunity for the Trust to present future ambition and look at partnerships and how they can be part of that future. Peter Axon agreed as well as the statutory items the AGM should showcase what the Trust is about and its ambition. The finance video produced a few years ago was a fantastic example of this. The Board approved delegated authority to Audit and Quality Committees. ***Approved / Received***	
50/2020	**NORTH STAFFORDSHIRE COMBINED TRUST STRATEGIC PLAN** Chris Bird, Director of Partnerships, Strategy and Digital advised a bridging note had been included in the Public Board papers to contextualise the transition of the papers from Public to Private Board sessions. The publication of the NHS Operating Planning & Contracting Guidance 2020/21 (published February 2020) sets a deadline for contract signature between commissioners and providers of 27th March 2020. The agreement of the contractual arrangements for 2020/21, including the application of the Mental Health Investment Standard, will have a direct material effect on the final version of both the Mental Health Implementation Plan and the Long Term Financial Plan. Consequently these two enabling strategies are now scheduled to be presented to the April 2020 meeting of the Trust Board. ***Noted***	
51/2020	**MONTH 10 FINANCE REPORT** Lorraine Hooper, Executive Director of Finance, Performance and Estates presented the reports and noted that Month 7 was circulated for information only. The Trust Board are asked to receive the Month 10 position noting: • The reported year to date surplus of £733k against a planned surplus of £717k. This is a favourable variance to plan of £16k. • The M10 internal CIP achievement of £1,808k; an adverse variance of £315k to plan • The cash position of the Trust as at 31st January 2020 with a balance of £9,653k; £748k lower than plan. • Total Agency expenditure of £2,028k against the agency cap of £1,857k; an adverse variance of £171k to plan. • Use of resource rating of 2 against a plan of 2. • Price cap breaches for Medics and off-framework use at M10. Approve: • M10 expenditure on Agency of £2,028k reported to NHSI; • M10 year-end agency forecast of £2,528k which is £341k over the agency cap.	

	Joan Walley talked of mitigations in terms of loss of business and asked how the Trust will ensure there is governance oversight going forward following the disbanding of Business Development Committee. Lorraine Hooper confirmed that terms of reference had been transferred into other Committees. Standing Financial Instructions and the Scheme of Delegation policy have been updated to reflect changes. Patrick Sullivan asked what regulatory implications the agency breach would have. Lorraine Hooper advised it would change the use of resources score possibly to 2 rather than a 1. A strident response had been received from NHSI to deliver the agency ceiling they are assured by the processes in place. Phil Jones asked if there was a specific difference between medical than nursing. Jonathan O'Brien explained that medics are expensive often £120 an hour which can be costly. There are two consultant vacancies out to advert for inpatient wards. ***Approved / Received***	
52/2020	**ASSURANCE REPORT FROM THE FINANCE, PERFORMANCE & ESTATES COMMITTEE** Russell Andrews, Non-Executive Director / Chair, presented the report for assurance from the meeting that took place on the 30th January 2020 for information only and provided highlights from the meeting that took place on the 27th February 2020: Estates Workstream – The Director of Finance updated the Committee on work that had commenced to develop an Estates group to meet monthly to develop the Estates Strategy including an assessment of current condition of the estate and key requirements and aspirations for the future. The draft estates strategy will be developed over the coming months for review by the committee which was acknowledged. EVO next steps - Following the success of EVO in late 2019 the Medical Director and Finance Director have been discussing how to embed the positive aspects of the process into the organisation to support transformational change and quality improvement. The aim is to deploy the process in each service over a period of time. The Director of Finance advised the Committee that this will be supported by the development of SLR reporting which will in future become part of the regular updates at FPE. The Committee acknowledged this updates. Operational Planning 2020/21 - The Director of Finance presented the Committee with an update paper detailing the progress made on the financial planning for 2020/21 and an updated risk position. Good progress had been made in terms of progressing the contract gap and general discussions with commissioners. The Committee were advised that the plan been subject to robust testing of all assumptions and a list of risks & potential mitigations are included in the paper. Assurance can be given at this stage that the Trust plan allows a route to a breakeven position within its own gift and a reliance on system savings would be required to achieve the planned control total of £1.2m surplus. The Director of Finance advised that the plans didn't currently include the	

	outcomes of the Stoke-on-Trent Local Authority (SOTLA) budget proposals but these had been considered in the risks. The committee were advised of the underlying position and that the plan assumed this would improve during 2020/21. The Committee acknowledged the challenge around delivery of planned CIP will be difficult but acknowledged changes to the process and additional focus being placed on CIP going forwards. The Committee approved the draft plan going forward for 5h March submission. Finance Update **-** The Committee received an update on the financial position which is on track to deliver the 2019/20 plan against all key metrics, with the exception of recurrent CIP and achievement of the Agency cap which had been previously discussed. Cost Improvement Programme (CIP) - The Committee received an update on the new governance process for CIP and a summary of the 2 year CIP programme for 2019/20 to 2020/21. The Cost Improvement position for 2019/20 is forecasting to deliver £3.0m against the £3.5m target for 2019/20. The recurrent value of these schemes is £2.7m, representing a £0.8m shortfall including system savings. The Committee were assured that there was sufficient focus being placed on Cost Improvement via the new governance processes; they were not assured around recurrent delivery of 2019/20 programme and noted the £800k shortfall on the Trust recurrent CIP position. A piece of work will be undertaken going forward. Terms of Reference - The Associate Director of Governance presented an updated draft of the terms of reference for consideration and comments were received from committee to take forward. It was agreed that the name of the committee will be changed to Finance and Resources Committee. ***Received / Ratified***	
53/2020	**ASSURANCE REPORT FOR PRIMARY CARE COMMITTEE** Russell Andrews, Non-Executive Director / Vice Chair, presented the report from the meeting that took place on the 6th February for information only and provided highlights from the meeting that took place on the 5th March 2020: Clinical Model & Workforce - A summary of the headlines in relation to the clinical model were received. A comparison had been undertaken between Moorcroft Medical Centre and the Clinical Director's own practice in Leek with respect to staffing structures and numbers. This identified potential for service redesign of administrative and nurse support and will be taken forward in 2020/21. The Committee supported a proposal from the Clinical Director to trial video consultations to support delivery of the NHS Operating Planning Guidance 2020/21. The DOPS agreed to work with the Clinical Director and other Executive Director colleagues to develop the proposal further. The Committee received an update on the latest developments for Primary Care Networks. A national agreement had now been reached and increased funding will be made available to support PCNs deliver the	

	national service specifications as well as remove the requirement for some PCN-related posts to be funded at local level. CQC Action Plan - The Committee received an update on the preparedness of the service ahead of an anticipated CQC review later this year. It was reported that a working group had been established across Trust Corporate Services and Primary Care Services to ensure that all CQC lines of enquiry are captured, a position documented and any resultant actions identified and progressed. The Committee were advised that there are currently no RED rated items for escalation and there is a strong level of confidence that the alignment of CQC preparedness with the Trust's existing arrangements would support the service to in an improved position at the point of inspection. The Committee were advised that our estimate for the CQC inspection had now been revised to late March 2020. Tosca Fairchild confirmed the CQC Team Lead Inspector for Primary Care had been absent from work and therefore the inspection will not take place until their return to work. Finance - The Committee received the Month 10 Finance Report which showed a favourable year to date (YTD) position of £10k. The Forecast Outturn position was agreed as break-even. This includes provision for the Agenda for Change (AfC) harmonisation offer. Consistent with previous months, the main drivers of the financial position are an over-spend on agency staff offset somewhat by an underspend on the medical & nursing budget lines due to vacancies. The Practice developed a plan to reduce locum use in the second half of the year. This was reflected in the forecast outturn which includes a residual contingency for the latter half of the year to provide for temporary need for locum staff linked to recent resignations and seasonal variation throughout Winter. The run-rate on agency was reduced relative to the earlier part of the year however this is insufficient to avoid out turning slightly above the NHSI agency ceiling of £300k at £306k. Tony Gadsby advised the Committee had received Mark Williams (Clinical Directors) view on the comparison between practices but felt in many respects he was compromised as he works for the Trust and therefore asked if a peer review of the changes within the practice could be undertaken. The Board were in agreement. ***Received***	**CB**
54/2020	**ASSURANCE REPORT FOR BUSINESS DEVELOPMENT COMMITTEE** Joan Walley, Non-Executive Director / Vice Chair, presented an assurance report from the meeting that took place on the 6th February 2020. Joan highlighted that the CAMHS digital portal went live on 10th March 2020 with a launch event at St Thomas More High School (Longton). This will be followed by further launches before Easter at Burnwood Primary School (Tunstall) and Watermill School (Chell). A broader launch progamme will be delivered post-Easter. This will mark the first service to benefit from a 'channel shift' of delivery onto a digital platform.	

	Received	
55/2020	**NATIONAL STAFF SURVEY HEADLINE REPORT 2020** Shajeda Ahmed, Director of Workforce, Organisational Development and Inclusion provided a presentation. North Staffs Combined Healthcare Trust saw a 53% response rate. The benchmarking median response rate shows only 1% higher as 54% for 2019. The highest scoring themes were: • Equality, diversity and inclusion • Safe environment – Bullying and harassment • Team working The above average scoring themes were: • Health and wellbeing • Immediate manager • Morale • Quality of appraisals • Quality of care • Safety culture • Staff engagement The theme matching the average score was Safe Environment – Violence The Trust's largest improvements were: • Recommend as place to work • Making adjustments for you to work • Clear objectives in appraisals The Trust's three areas of focus for 2020 are: • Culture • Health and wellbeing • Retention In terms of next steps the staff survey successes will be celebrated and communicated to staff. The staff survey findings will be broken into local activity level, identifying areas of improvement for each Directorate. Work will be undertaken with the Quality Improvement (QI) leads, this year will see the introduction of a standardised Plan, to ensure any reported progress is collated using a consistent approach. QI leads have already began creating staff forums, will be responsible for providing monthly progress to the Staff Survey Lead, will be responsible for ensuring action to support progress against their innovation and improvement plans is regularly shared at team meetings and will be encouraged to involve staff from their forum groups to disseminate information on progress to their teams. Training Needs Analysis (TNA) is a good example of how things can be done differently. The imminent realise of the people plan is expected to grow a huge number of nurses and doctors. Shajeda Ahmed felt the Trust needed to look at the younger generation and recruit through social demographics.	

	Russell Andrews questioned whether the results are meaningful when only half the workforce had taken part in the survey highlighting the need to address the reasons for non-engagement. Typically staff believe the survey is not anonymous and if this is a genuine reason that could be masking some real issues Peter Axon highlighted that periodically information is triangulated across various sources there is the Freedom to Speak Up Guardian (FTSU) for example and many other mechanisms that are looked at on a regular basis. Shajeda Ahmed advised some of the feedback received had been that it is cumbersome to people to complete and that staff do not believe change will happen. As an organisation we are heading in the right direction. Full surveys will be launched to test the temperature of the organisation twice yearly to provide a more holistic understanding of what action is required. Janet Dawson felt the results were encouraging and suggested the perception should be that everyone else is deeply upset then the Trust can start to do things that makes that group happier. Joan Walley questioned what more could be done to incentivise people to take part and suggested trade unions be involved to improve the return rate. Joan commented from a recent visit she undertook there had been a concern about the ways actual complaints had been handled which suggested retention and recruitment of staff needed to be linked to that. Shajeda Ahmed provided assurance this would feed through directorate action plans. Jonathan O'Brien added prior to the restructure of the organisation there had almost been acceptance as a Board that the staff survey results would reduce therefore to see them maintained and in many areas improved was confirmation the Trust had done well particularly around equality and diversity. The Trust needs to look at areas where further improvement and focus is required. ***Received***	
56/2020	**ASSURANCE REPORT FOR PEOPLE, CULTURE & DEVELOPMENT COMMITTEE** Janet Dawson, Non-Executive Director / Chair, presented an assurance report from the meeting that took place on the 5th March 2020 highlighting the following: Staff Story - The Committee received a presentation from the Specialist Perinatal Mental Health Service - Parent and Baby Unit. The 7-day service operates between 8.30am and 4.30pm, and consists of specialist perinatal mental health nurses, nursery nurses, psychology, psychiatry, occupational therapy and peer support workers. The service, based within the Stoke Directorate also covers Newcastle and Staffordshire Moorlands, working closely with local community mental health teams, IAPT service and other agencies. The service provides assessment, treatment and care to women who are within the perinatal period and become mentally unwell. The presentation covered the perinatal related issues in the NHS Long Term Plan, which includes reducing stillbirths and mother and child deaths during birth by 50% and expanding support for perinatal mental health conditions.	

	The NHS England 5 year forward plan aims to improve access to evidence-based psychological therapies for women and their partners, in addition to providing support through mental health checks for partners of those accessing specialist PMH community services and signposting as required. Multi-agency working is central to the work of the service. Challenges to the service include staffing, an outdated building with limited parking, limited room availability to carry out individual support, and an additional crèche required in order to deliver increased support. The People Plan will be published after the budget in March with a key focus on deliverables and 50,000 additional nursing staff. Access to Annual Leave and Time off in Lieu (TOIL) - The council sub-group produced draft guidance on annual leave and separate guidance on TOIL. Provisionally agreed by the NHS Staff Council Executive it is subject to final engagement with the employer representative on the NHS Staff Council. The aim is to formally sign these guidance documents off at the NHS Staff Council Plenary meeting on the 4th March 2020, and for these to be published shortly after. NHS Pensions Update - NHS Employers published guidance on the temporary, optional measures employers may implement to support staff and service delivery during this financial year, in advance of a national solution being implemented from April 2020. Apprenticeship Pay – It was reported despite extensive negotiations, no national agreement had been reached on apprenticeship pay. Moving forward, employers are encouraged to work in their ICS/STP patches on collaborative solutions to apprenticeship pay. The High Potential Scheme (HPS) - The Together we're Better project team will be focusing on working with our partner organisations across the system to identify suitable stretch opportunities and co-ordinate this process over the coming months. Development of Our People Strategy - The refreshed Our People Strategy which is aligned to the national NHS People Plan was presented and endorsed at the Committee, ahead of presentation at Trust Board under the Trust's enabling strategies. Key Workforce Metrics Summary - Vacancy: January's reported vacancy rate was improved at 11%, with a significant increase in staff post figure against December's position and the best position for 12 months. Turnover: The Trust continues to fall below the MH&LD benchmark group (13.6%) for annual turnover at 11%. However, concerted efforts remain ongoing to achieve the Trust target of 10%. Janet Dawson highlighted the need to do something different and ensure focus on the Trust is a priority. WRES Recruitment Update - In order to meet the nationally set aspirational targets for 2028, the Trust will need to attract, develop and support recruitment of the following BAME staff x1 Band 8a, 2 x Band 8b and 1 x Band 8c. Over the next 2 years, the Trust is expected to recruit the following BAME staff 1 x Band 8b (2019-20) and1 x Band 8c (2020-21). Of the offered positions from April 2019 – January 2020, 274 positions were offered to the white population against 39 offered to the BAME	

	population. As the Trust is not a large an organisation as some of our partners, the figures will be reviewed in a more cumulative manner for senior leadership roles to ensure the target allocation is reflective of the size of our organisation with the Director of Workforce, OD & Inclusion review this. The WRES metrics are also being reviewed as part of a system wide target. Gender Pay Gap - The Trust's gender pay gap for 2019 is 17.7% (median 9.1%), with the level of gender equality improving slightly between 2017 and 2018. The balance of male and female employees at different levels of the organisation remained broadly static, a continuing situation of over-representation of women in the lowest paid roles, but under-represented in the highest roles. Terms of Reference were approved. Tony Gadsby asked in terms of the apprentice levy whether it would be sensible to have a briefing pack for MPs and ask them to lobby the chancellor. The new MPs would want to make their mark and this would be an opportunity. An update was requested for the next board meeting. ***Received / Ratified***	**SA / JD**
57/2020	**STOKE-ON-TRENT CITY COUNCIL 2020 BUDGET PLANS CONSULTATION RESPONSE** Chris Bird, Director of Partnerships, Strategy and Digital presented the report. A report was received at January and February 2020 Trust Boards around the proposed Stoke City Council Budgets Proposals 2020-21. The Council formally consulted on the proposals, the budget was out for consultation until 19th February 2020. Attached is North Staffordshire Combined Healthcare's response. The response was circulated for information. This was the final response that went to the city council. The council had their budget setting meeting to look at the 33 proposals which were not supported. In particular there was one area which related to terms and conditions for city council staff. There was some re-work undertaken on the proposals and an extraordinary meeting took place where they were re-presented with that item withdrawn and therefore the proposals were then passed. Substance Misuse and Section 75 proposals were voted through. Others were of indirect impact to the Trust. Joan Walley felt this would be a recurring feature possibly in next year's budget and felt one course of action could be to look at ways to ensure whenever there is another discussion it is an informed discussion as to what the cuts made amount to and the importance of evaluation and having evidence base as this current discussion did not take place in the context of informed decision making. Peter Axon agreed that largely the information in the consultation was not sufficient to make any decision it was a consultation on a consultation. Detail is still fundamentally unknown.	

	Tony Gadsby felt the City Council could try to recover the £934K through further savings in year and warned the Trust should be prepared for that. ***Received***	
58/2020	**ANY OTHER BUSINESS** No other business was discussed.	
59/2020	**DATE AND TIME OF NEXT MEETING** The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday 14th May 2020 at 10.00am, in the Boardroom, Lawton House, Bellringer Road, Trentham, Stoke-on-Trent, Staffordshire, ST4 8HH	
60/2020	**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 2.45pm

Signed: _____ Date_____
Chairman

Board Action Monitoring Schedule (Open Section)

Trust Board - Action monitoring schedule (Open)

Action	Meeting Date	Minute No	Action Description	Responsible Officer	Target Date	Progress / Comment
1	12th March 2020	40/2020	**Nursing Staffing Monthly Report December 2019 & January 2020 (1)** - David Rogers acknowledged the importance of peer review involvement and asked if the Trust could look at the distribution of peer reviewers through the organisation. Kenny advised he would bring back a more detailed report to include the spread of people working within Trust services as there is a very formal governance arrangement in terms of service user involvement.	Kenny Laing	14-May-20	A paper detailing the current process and position in relation to peer mentor programme and service engagement in the programme at the Quality Committee in June.
2	12th March 2020	40a/2020	**Nursing Staffing Monthly Report December 2019 & January 2020 (2)**- Tony Gadsby asked in terms of staffing numbers if there was any update on the 100 expressions of interest received during the recruitment campaign. Shajeda Ahmed confirmed there had in fact been 200 applicants and she would follow up progress with the recruitment team and fed back to the Board.	Shajeda Ahmed	14-May-20	131 expressions of interest were received at the event of which 69 people applied for vacancies, primarily within support roles. As at 1st May, of the 69 people, 9 people have been offered posts across a variety of roles such OT, qualified 131 nursing roles and Health Care Support Workers. 28 people are currently progressing through the selection process. 36 people were unfortunately not successful due to not meeting the criteria for the roles they expressed an interest in and 4 people withdrew their application. As part of improving our recruitment proposition for the future, the process will be evaluated to shape our future recruitment campaigns to ensure we are attracting more people that meet both our values based assessment and job role criteria.
3	12th March 2020	42/2020	**Mortality Surveillance Quarter 3 Report** - Joan Walley felt evidence base was very important and suggested this be followed up with Keele University. Peter Axon suggested Dr Adeyemo discuss with Keele in the first instance then methodology can be devised in the absence of data sets.	Dr Buki Adeyemo	14-May-20	Complete
4	12th March 2020	53/2020	**Assurance Report for Primary Care Committee** - Tony Gadsby advised the Committee had received Mark Williams (Clinical Directors) view on the comparison between practices but felt in many respects he was compromised as he works for the Trust and therefore asked if a peer review of the changes within the practice could be undertaken. The Board were in agreement.	Chris Bird	14-May-20	Delayed through prioritisation of service delivery during COVID-19 response. Discussions taking place with GP Federation colleagues on options to progress. Expecting review to take place in Q2 as part of wider recovery programme.

Board Action Monitoring Schedule (Open Section)

Action	Meeting Date	Minute No	Action Description	Responsible Officer	Target Date	Progress / Comment
5	12th March 2020	56/2020	**Assurance Report for People, Culture and Development Committee** - Tony Gadsby asked in terms of the apprentice levy whether it would be sensible to have a briefing pack for MPs and ask them to lobby the chancellor. The new MPs would want to make their mark and this would be an opportunity. An update was requested for the next board meeting.	Shajeda Ahmed	14-May-20	Briefing pack drafted. Shajeda Ahmed to discuss and agree with Tony Gadsby.

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REPORT TO PUBLIC TRUST BOARD

Enclosure No: 4

Date of Meeting:	14th May 2020		
Title of Report:	CEO Board Report		
Presented by:	Peter Axon, Chief Executive Officer		
Author:	Peter Axon, Chief Executive Officer		
Executive Lead Name:	Peter Axon, Chief Executive Officer	**Approved by Exec**	☒

Executive Summary:		**Purpose of report**	
This Report updates the Board on recent activities, developments and news of interest across Combined and the wider STP.		**Approval**	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☒ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People, Culture & Development Committee ☐ • Charitable Funds Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration.☒ 2. To provide the highest quality, safe and effective services ☒ 3. Inspire and implement innovation and research. ☒ 4. Embed an open and learning culture that enables continual improvement. ☒ 5. Attract, develop and retain the best people. ☒ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☒		
Risk / legal implications: Risk Register Reference	N/A		
Resource Implications: Funding Source:	N/A		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	Includes details of our resources made available to promote health and wellbeing of our BAME workforce during COVID, plus launch of a national NHS/football collaboration to combat racism		
STP Alignment / Implications:	N/A		
Recommendations:	Note contents		

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Chief Executive's Report to the Trust Board
14th May 2020

PURPOSE OF THE REPORT

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

1. COVID-19

Combined Healthcare continues to rise to the challenge of Covid-19. A detailed item is on the Board Agenda, but in this report I would like to summarise what we have been doing at a macro level.

We have continued to provide support, information and advice to our frontline staff via regular Covid updates from our Deputy Chief Executive and Chair of Incident Management Group, Jonathan O'Brien. I have also used my CEO Blog to reinforce our support and admiration for the fantastic efforts of our staff.

We have continued to develop the range of advice and resources available to our staff via dedicated sections on our CAT Intranet. This now encompasses standard operating procedures and circulars, health and wellbeing support, OD initiatives and workforce. We have produced specific advice and guidance on support for our BAME workforce, recognising the specific impact of Covid-19 on this group. All of these new channels and resources have been well received by our staff.

Reinforcing our commitment to transparency and openness, we have made as much of this information as possible also available via our public website. We have used our website to provide our local communities with the most up to date advice and guidance from the Government, NHS England and Public Health England. We have also published guidance and resources for our local communities to enable them to understand Covid and how they can keep themselves safe, with specific advice for older people, parents, children and young people, and those with a learning disability or autism.

Of course, the most obvious priority has been organising our day-to-day operations, making sure they are delivered safely, excellently and in line with requirements from the NHS and national guidelines. The work of colleagues on the Incident Management Group, as well as all of the back office staff supporting them, has been superb.

We have also fully participated in system-wide groups and networks on strategic, operational and communications fronts. We have provided support to the wider system where requested, consistent with maintaining the safety and integrity of our own services, for example opening up Ward 4 to admissions from UHNM.

In terms of trends such as staff absence rates, these have started to reduce and the improved access to staff testing is helping this. Infection rates across the Trust are variable, but we are now testing patients on admission to our wards and finding few, if any positive test results.

2. SUPPORTING HEALTH AND WELLBEING

Protecting the health and wellbeing of our staff is one of the most important duties of the Trust as a whole and for myself as Chief Executive. That is true in normal times and even more important in the uniquely challenging times like we are currently living and working through.

Our Executive Director of Workforce, OD and Inclusion, Shajeda Ahmed, has been supported by her team, our Communications Team and the Trust's Head of Psychology, Matt Johnson, to produce a whole range of advice and resources to enable our staff to support themselves and those in their teams who they line manage.

In addition, for those staff who don't have easy access to our Intranet, we have highlighted the further fabulous advice, support and links to resources available via our national NHS England People portal. I was struck by one particular piece of advice used by NHS England - "With uncertainty and challenges of COVID situation, it's completely normal to feel unsettled, anxious and worried. As NHS staff, we are often portrayed as heroes – and can be. However, it's unrealistic to be heroic all the time and even heroes need help."

Sometimes, our staff may simply need to speak to someone. We have flagged up that the NHS has introduced a confidential staff support line, operated by the Samaritans and free to access from 7am–11pm, seven days a week. Call: 0300 131 7000 alternatively, they can text FRONTLINE to 85258 for support 24/7 via text.

Or there is also our own fantastic staff counselling service available. We have set up a specific COVID Support Helpline so staff can speak to members of the team as and when they require. This service operates Mon-Fri, 9am–4pm. They can contact the service on 0300 124 0104 to access the Support Helpline. During lockdown, the counselling service is following social distancing guidance and conducting counselling sessions virtually through video calls. Those that don't have access or feel comfortable using this technology can also carry out sessions over the telephone.

3. COMBINED HEALTHCARE SUPPORTS BAME COLLEAGUES DURING COVID-19

The Trust has applied additional measures to protect its staff from BAME (Black, Asian and Minority Ethnic) backgrounds during the coronavirus pandemic.

This is to protect BAME staff in response to reports from Public Health England, which show that these groups of people are more likely to be adversely affected by COVID-19.

Since the outbreak, the Trust has implemented various changes to support and protect all staff, and has strengthened its infection prevention procedures, including offering single-use prayer mats and disposable religious headwear.

Changes announced to support BAME staff in particular include offering Risk Assessments to identify any potential factors which may increase their risk, free health check appointments with occupational health, and dedicated health and wellbeing resources on the intranet.

4. RESTORATION AND RECOVERY

'Restoration and Recovery' is a topic we'll be hearing a lot about in the coming weeks and months. It's a rather grand phrase which is being adopted by senior leaders across the local system to describe something which is actually quite simple, but also exciting.

At its heart, it can be summed up as saying that, when we come through the current crisis, things should not simply go back to how they were before. And it's a commitment to recognise and take long-term advantage of all of the enormous energy, innovation, ideas and solutions that have been introduced in recent weeks - as I said in my previous blog, recognising that often "necessity is the mother of invention".

Our current thinking is that there are four stages to Restoration and Recovery:

- **Manage the immediate issues** – which is what we are now in;
- **Restore** – bring back essential services that may have reduced and ensure that patients are confident to engage with the NHS;
- **Recovery** – addressing the backlog of need that may have accrued. Developing our approach to new ways of working; and
- **The New NHS** – from April 2021 move forward with the transformation agenda to fundamentally reduce inequalities and improve effectiveness of our healthcare system offer.

In this respect, I think it is worthwhile to reflect on just some of the innovations we've introduced in recent weeks:

- moving significant parts of our business from a largely buildings- and desk-based operation to virtual and cloud-based;
- replacing staff face-to-face meetings with online and digital;
- introducing video consultations between service users and clinicians;
- equipping our teams with the most up-to-date laptops and mobile devices to facilitate federated working;
- significantly reducing our carbon footprint as a number of people work remotely
- introducing Exec Drop-Ins Online to maintain the momentum and welcome for our new Exec Drop-In face to face sessions;
- introducing online “Ask the Board” to enable the public and stakeholders to ask questions of the Board via a webform up to 48 hours before our Open Trust Board meetings, maintaining the innovation in transparency and openness we began at the start of this year through video archives of key sections of our Open Trust Board proceedings; and
- introducing enhanced service user risk assessment processes to ensure we maximise the effectiveness of our service offer.

Doing all of the above has been a massive undertaking and has given us the opportunity to really 'think big' about what we can achieve when we combine confidence with determination. We are, of course, conscious that many of these ideas are being trialed and piloted and we will wish to learn from what works and adjust where necessary. This would not have been possible without the hard work and dedication from our excellent staff. I would want to thank them all for the way in which they have adapted and adopted very quickly to ensure that we continue to support people who need our services

We also need to be aware that be aware that coming out of the current situation and returning to a "new business as usual" will not be without significant risk. So we also need to be thinking now about what those risks are and how we can mitigate them.

That's a conversation I want everyone to have together over the coming weeks.

5. COMBINED UNITED BUILDING A LASTING RECORD OF TRIBUTES AND RECOGNITION

Our health and wellbeing approach is directly linked to staff morale, as there is no better way to boost morale than to recognise and celebrate our amazing achievements during difficult times.

At the start of the Covid challenge, we launched our Combined United initiative with the aim that “over the coming days and weeks we hoped to build a lasting tribute and record of the extraordinary things we are doing and all we are going to do.”

Six weeks in, we are meeting this aim fully. There are now over 100 tributes available on the Combined United Hall of Fame, received from frontline staff, managers, stakeholders and service users.

'Combined…United' is freely available on our public website and open to anyone – whether they work for Combined or not. Anyone who wants to do so can use an online form to provide their own message of appreciation for something being done by an individual or a team. It can be anything they like, big or not so big. It could be that they simply want to say “I really value what you do and how you do it” or a message of support and encouragement. Or maybe they want to give a public profile for something being done that otherwise might go unnoticed.

Each message or tribute is reviewed by the Communications Team, before being included in the Hall of Fame. We look to ensure this happens as quickly as possible, as we know people will wish it to be shared. We have asked everyone to please make sure that they have permission from anyone in any pictures or videos that they share. We ask them to confirm that you are happy for the material to appear on our public website and across our social media channels. We also ask them to ensure that any photo or video they take complies with the Government’s advice on social distancing.

It really has been heartening for me and the Executive Team to be able to read the messages that are being exchanged with each other and shared with the wider world. We have had great traction on social media, in particular Twitter and the Trust Facebook Page, where staff and service users have been able to further share and amplify their admiration and support for one another. The Communications Team has also been assiduously using LinkedIn to spread the word of what we are doing far and wide as an example of what an Outstanding place our Trust is.

The words of support and admiration for each other on Combined United are a continuing testament to what a great place Combined Healthcare is. If anyone needs their batteries recharging or hope restoring, can I suggest you simply take five minutes to have a browse. You won't regret it. And, of course, anyone can feel free to add their OWN tribute to what you see.

The Communications team has also produced an analysis that summaries the key words and phrases people are using to each other. Not surprisingly, amongst the highest appearing words are:

- NHS
- team

- staff
- support
- patients
- care
- ward
- service
- working
- challenging

6. TOSCA FAIRCHILD HEADS NATIONAL NHS/FOOTBALL COLLABORATION TO COMBAT RACISM

At our last Open Trust Board, I explained we were delighted at the news of the election of our Assistant Chief Executive, Tosca Fairchild, as Chair of Show Racism the Red Card.

Show Racism the Red Card is the UK's leading anti-racism educational charity. One of its key campaign strategies is the national Wear Red Day usually held in October. It provides educational workshops, training sessions, multimedia packages, and a whole host of other resources, all with the purpose of tackling racism in society.

On 1st May, it launched a new video which follows the stories of frontline NHS staff as they recount their experience of racial discrimination at work.

The charity is dedicated to combating racism in society through education, and utilises the high-profile status of football and football players to publicise its message. After survey findings showed that 11% of people have experienced racist behaviour at work, it knew it needed to take action.

Commenting on the new campaign, Tosca said:

“Racism is an issue that sadly continues to exist in today’s society and it the responsibility is upon all of us to challenge and fight it.

“As Chair of Show Racism the Red Card and Assistant CEO in the NHS, it is a privilege to bring the two organisations together in a collaboration to highlight and challenge racism in the NHS.

“I have worked in the NHS for a long time and not only experienced racism myself but have also seen the devastating effects it has on hard working colleagues from a BAME background. The NHS is dependent on its workforce and simply cannot deliver the high quality care it does without its diverse workforce.

“We only need to look at the staff demographics being highlighted during COVID-19 to appreciate how diverse the NHS workforce is and how NHS staff from a BAME background contribute and dedicate their lives to the NHS – to care for the people of the United Kingdom; with some sadly paying the ultimate price and losing their lives.

“It is my hope that through this work, we will all challenge racism in the NHS, honour those that have lost their lives and remember them when the new normal is here.

“We must remember that the NHS needs its diverse BAME workforce. Remember that BAMEs working in the NHS contribute to the NHS. Remember that BAME staff in the NHS are humans. We are all humans. We are the human race. Show love not hate. Show racism the red card in the NHS.”

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Patient Experience Team

Patient Story
April 2020

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The person involved in this story has been known to our services for a very long time. He is middle-aged and receives regular support from our Community Mental Health Team.

He has always had very difficult relationship with medication of any type. The thought of taking medication makes him extremely anxious and he requires constant reassurance that his medication is necessary and correct.

A letter to his GP from a Junior Doctor stated that in his opinion the combination of medication that he was prescribed posed a potentially fatal risk; an extremely unfortunate choice of words given that this was not discussed with the patient during the consultation and the patient was then copied into the GP letter.

This caused severe anxiety for the patient who immediately stated he wasn't going to continue taking any medication - medication that was keeping him stable and well.

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He contacted the Patient Experience Team (PET) because he was experiencing extreme anxiety as he had learned from a letter to his GP that his current medication regime could pose a significant threat to his physical health.

He had an appointment for a medical review, however this was three months away which he felt was too long given the risks identified.

The patient contacted PET to ask if anything could be done to facilitate an earlier appointment.

PET contacted care team and outlined the anxieties and stress the patient and his partner were currently experiencing. After a discussion regarding the request and the mitigating factors the care team were able to arrange an earlier appointment for a medical review.

Patient contacted PET to express thanks for help securing a sooner appointment, patient was really appreciative of the efforts made by all to assist him.

PROUD TO CARE

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REPORT TO PUBLIC TRUST BOARD

Enclosure No: 6a

Date of Meeting:	14th May 2020		
Title of Report:	February 2020 Monthly Safer Staffing Report		
Presented by:	Kenny Laing, Executive Director of Nursing & Quality		
Author:	Alastair Forrester, Deputy Director of Nursing & Quality		
Executive Lead Name:	Kenny Laing, Executive Director of Nursing & Quality	**Approved by Exec**	☒

Executive Summary:	**Purpose of report**	
Purpose: This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during February 2020 in line with the National Quality Board requirements. Key Findings: During February 2020 an overall fill rate of 95.4% was achieved. Although this has slightly decreased from January 2020 there has been no statistically significant change in this position during the past 18 months. Registered Nurse vacancies within ward inpatient areas increased by 1.34 WTE to 30.31 WTE in February 2020. HCSW vacancies decreased to just 1.07 WTE. 7 Registered Nurses (6.04 WTE) left the Trust in February 2020. 1.04 WTE were from within ward inpatient areas; 5.00 WTE were from Community based services. There is little evidence that the Coronavirus (Covid-19) has impacted on our ability to provide safe staffing levels in February 2020; this situation may change during future weeks and months. Emergency planning measures are in place and are reviewed on a daily basis in line with the changing local and national picture and government advice. Recommendations: The Quality Committee and Trust Board are asked to note the challenges in filling shifts and the challenges with recruitment to nurse vacancies and to also acknowledge and support the mitigations that are currently in place. The Trust Board should be assured that safe staffing levels have been maintained.	**Approval**	☐
	Information	☐
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☒ Execs ☐ Date: 31st March 2020	Document Version No.	V2
Committee Approval / Review	• Quality Committee ☒ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration. ☐ 2. To provide the highest quality, safe and effective services ☒ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☐ 5. Attract, develop and retain the best people. ☒ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☐		

Risk / legal implications: Risk Register Reference	Delivery of safe nurse staffing levels is a key requirement to ensuring that the Trust complies with National Quality Board standards.	
Resource Implications: Funding Source:	Temporary staffing costs. Budgeted establishment and temporary staffing spend.	
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	None	
STP Alignment / Implications:	None	
Recommendations:	To receive the report for assurance	
Version	Name/group	Date issued
	SLT	31 March 2020
	Quality Committee	2 April 2020
	Trust Board	9 April 2020

1 Introduction

This report details the ward daily staffing levels during the month of February 2020 following the reporting of the planned and actual hours of both Registered Nurses (RN) and Health Care Support Workers (Care Staff) to NHS Digital. Additionally from April 2018 Care Hours per Patient Day (CHPPD) have also been required to be reported to NHS Digital. The CHPPD calculation is based on the cumulative total number of patients daily over the month divided by the total number of care hours (appendix 1).

2 Background

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

In addition to the monthly reporting requirements the Executive Director of Nursing & Quality is required to review ward staffing on a 6 monthly basis and report the outcome of the review to the Trust Board of Directors. A comprehensive annual report for 2018 was presented to April 2019 Board and the recommendations relating to safer staffing reviews are progressed and monitored through the Safer Staffing Group.

3 Trust Performance

During February 2020 the Trust achieved a staffing fill rate of 83.2% for Registered Nurses and 105% for care staff on day shifts and 75.4% and 109% respectively on night shifts. Taking skill mix adjustments into account an overall fill-rate of 95.4% was achieved. This is a slight decrease from the 96.1% fill rate reported in January 2020.

Where 100% fill rate was not achieved, staffing safety was maintained on inpatient wards by nurses working additional unplanned hours, cross cover, Ward Managers and the multi-disciplinary team (MDT) supporting clinical duties and the prioritising of direct and non-direct care activities. Established, planned (clinically required) and actual hours alongside details of vacancies, bed occupancy and actions taken to maintain safer staffing are provided in Appendix 1. A summary from Ward Managers of issues, patient safety, patient experience, staff experience and mitigating actions is set out below.

The Safer Staffing Group oversees the safer staffing work plan on a monthly basis; recommendations are followed and recorded within a Safer Staffing Action Plan.

4 Care Hours per Patient Day (CHPPD)

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

5 Impact

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

5.1 Impact on Patient Safety

There were six reported incidents in relation to ward nurse staffing levels during February 2020. Two incidents were reported by the PICU, this was due to the unavailability of staff due to last minute sickness. Summers View also reported one occasion of staff sickness for which they were unable to identify cover. The Darwin Centre reported one occasion when staffing during a night shift was below the planned requirement due to an agency member cancelling a shift. Ward 2 experienced a reduction in staffing on one shift to support another ward area and Assessment and Treatment reported a shortfall during a night-shift due to a care home withdrawing their planned staffing support. All incidents were reported to the Site Manager to ensure that additional staff could be redeployed if required. None of these incidents impacted on our ability to provide safe patient care.

5.2 Impact on Patient Experience

Staff prioritise patient experience and direct patient care. During February 2020 there was 1 occasion, when patient activities had to be cancelled and 3 occasions when activities were shortened as a result of shortfalls in nurse staffing levels. All of these incidents occurred at Ward 6 and all cancelled activity time was successfully rescheduled.

5.3 Impact on Staff Experience

In order to maintain safe staffing levels the following actions were taken by Ward Managers during February 2020:

- 110 staff breaks were cancelled (equivalent to approximately 2.5% of total breaks). This remained unchanged from January 2020. Darwin Centre, Ward 6 and PICU reported the highest number of missed breaks; this was predominantly due to short notice increases in acuity. Potential solutions are being explored with Ward Managers. Any time

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

- There were no occasions reported during February 2020 when staff supervision sessions had to be cancelled to support staffing levels.
- One staff appraisal was cancelled during February 2020 to support staffing levels. This was rescheduled.
- There were no occasions during February 2020 when attendance at mandatory training sessions was cancelled to support safe staffing levels.

5.4 Mitigating Actions

Ward Managers and members of the multi-disciplinary team have clinically supported day shifts to ensure safe patient care. A total of 427 RN shifts were covered by HCSW's where RN temporary staffing was unavailable. A total of 64 HCSW shifts were covered by RN staff where HCSW temporary staffing was unavailable. Additionally, as outlined in section 5.3, staff breaks have been shortened or not taken (time is given in lieu) and wards have cross-covered to support safe staffing levels.

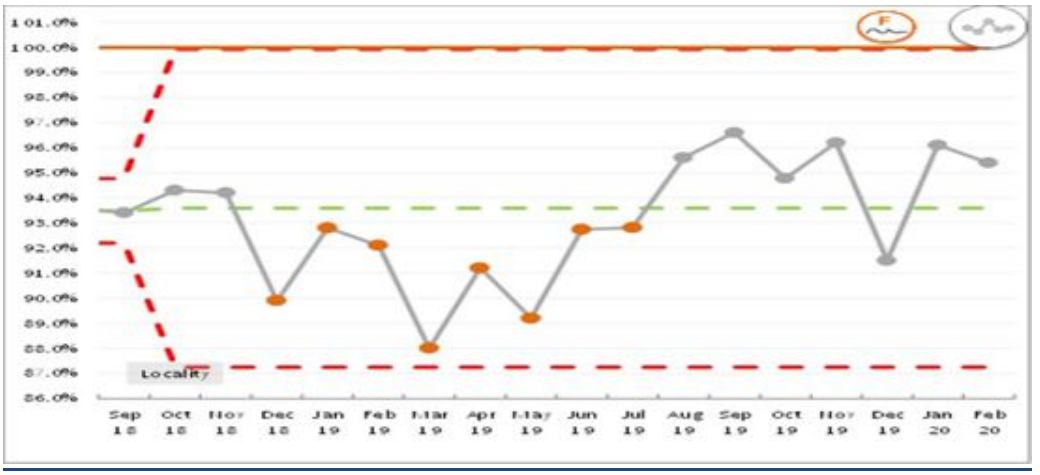
Three areas (Wards 1, 6 and PICU) reported 5 occasions (25.5 hours total) when additional support was provided by members of the multi-disciplinary team to maintain safe staffing levels.

There were 3 occasions when staff worked additional unplanned hours to cover shortfalls in nurse staffing levels; these incidents occurred at Wards 1, 6 and PICU and have a combined total of 10 hours.

5.5 Overall Fill Rate

Overall staffing fill rate during February 2020 was 95.4%. Although this has decreased slightly from 96.1% reported in January 2020, there has been no significant change in this position during the past 18 months. Actions taken to mitigate this position are outlined in section 5.6.

Overall Fill-Rate September 2018 – February 2020



5.6 Recruitment

In line with the national picture, RN recruitment remains challenging.

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

The Trust is continuing to explore a number of initiatives to support the recruitment of staff, these include specialised events for difficult to fill vacancies; the use of computer software to monitor the number of applicants from website submissions and the potential use of assessment centres to support some of our more popular vacancies.

The Trust continues to support national return to practice campaigns. These campaigns target former registered nurses who have left practice and allowed their nurse registration to lapse; providing academic and placement support to enable them to re-register with the NMC.

We continue to deliver a robust programme of preceptorship to our newly qualified nurses as well as supporting a number of academic programmes which run alongside significant work based and placement learning.

The Trust is continuing to strength the nursing career pathway. Through our partnership work with Staffordshire and Keele Universities we have continued to support the recruitment of Trainee Nursing Associates and Advanced Nurse Practitioners.

The Trust is also supporting an STP wide rotational apprenticeship scheme with two posts, one at Ward 3 and one at Ward 7; these positions commenced

in September 2019. More recently we have successfully recruited a further 4 HCSW apprentices to our ward inpatient areas.

We are continuing to support a number of nurses who trained overseas, to undertake further qualifications to enable their registration to be recognised in the UK.

5.6 Registered Nurse Retention

During February 2020 there were 7 Registered Nurses (6.04 WTE) who left the Trust. Two members of staff took promotion opportunities elsewhere and the others took age related retirement, voluntary resignation or left to support their work life balance. Two of our RN leavers (totalling 1.04 WTE) were from within ward inpatient areas; 5.00 WTE were from Community based service or management positions.

In addition 2 HCSW's (2.00 WTE) left the Trust during February 2020. Both staff left to support their work life balance and each worked within our ward inpatient areas.

6. Summary

The fill rate for RN shifts decreased from 85.3% in January 2020 to 83.2% in February 2020. As a result safe staffing reporting continues to highlight a number of challenges in the staffing of wards.

RN vacancies within ward inpatient areas increased by 1.34 WTE from 28.97 WTE in January 2020 to 30.31 WTE in February 2020. HCSW vacancies decreased from 3.61 WTE in January 2020 to 1.07 WTE in February 2020, these remain well managed with a number of ward areas increasing their HCSW establishment to support safe staffing levels.

We are continuing to employ a number of strategies with the support of the HR and the Communication Team to attract both RNs and HCSW's during this time of national shortage. We are hopeful that the recent recruitment event will prove successful in filling some of these posts.

The Trust Recruitment and Retention Action Plan continues to be monitored via the Safer Staffing Group; we also remained fully engaged with the NHSI Retention Support Programme.

7. Recommendations

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 February
- Be assured that safe staffing levels have been maintained.

Appendix 1 February 2020 Safer Staffing

Feb-20	Registered Nurses						Care Staff						Registered Nurse		Care Staff		Total Nursing Staffing		
Ward	Day Establishment Hours	Day Clinically Required	Day Actual	Night Establishment	Night Clinically Required	Night Actual	Day Establishment Hours	Day Clinically Required	Day Actual	Night Establishment	Night Clinically Required	Night Actual	Day Fill Rate (%)	Night Fill Rate (%)	Day Fill Rate (%)	Night Fill Rate (%)	Overall RN %	Overall Care Staff %	Overall Staffing
Assessment & Treatment	862.50	862.50	849.42	643.80	643.80	333.00	1435.50	1728.00	1213.23	643.80	1065.60	1381.40	98.5%	51.7%	70.2%	129.6%	78.5%	92.9%	87.8%
Darwin Centre	1237.50	1237.50	814.98	643.80	643.80	501.75	1087.50	1087.50	1418.00	643.80	643.80	706.90	65.9%	77.9%	130.4%	109.8%	70.0%	122.7%	95.3%
Edward Myers Unit	889.50	889.50	877.83	321.90	321.90	321.90	739.50	739.50	706.36	643.80	643.80	611.75	98.7%	100.0%	95.5%	95.0%	99.0%	95.3%	97.0%
Florence House	585.00	585.00	555.23	310.88	310.88	310.88	870.00	870.00	769.75	310.88	310.88	310.88	94.9%	100.0%	88.5%	100.0%	96.7%	91.5%	93.7%
Summers View	870.00	870.00	706.75	310.88	310.88	310.78	870.00	870.00	800.23	621.76	621.76	609.35	81.2%	100.0%	92.0%	98.0%	86.2%	94.5%	90.8%
PICU	933.00	933.00	792.79	643.80	643.80	518.70	783.00	1293.00	1432.98	643.80	1032.30	1008.70	85.0%	80.6%	110.8%	97.7%	83.2%	105.0%	96.2%
Ward 1	1237.50	1237.50	925.75	321.90	321.90	321.90	1087.50	1140.00	1027.02	643.80	677.10	662.90	74.8%	100.0%	90.1%	97.9%	80.0%	93.0%	87.0%
Ward 2	1237.50	1237.50	1144.13	643.80	643.80	399.60	1087.50	1117.50	1229.00	643.80	699.30	881.30	92.5%	62.1%	110.0%	126.0%	82.1%	116.2%	98.8%
Ward 3	1237.50	1237.50	1256.50	643.80	643.80	483.90	1087.50	1087.50	1171.89	643.80	688.20	785.05	101.5%	75.2%	107.8%	114.1%	92.5%	110.2%	101.1%
Ward 4	1387.50	1387.50	1197.00	321.90	321.90	324.60	1087.50	1087.50	1535.71	965.70	965.70	941.47	86.3%	100.8%	141.2%	97.5%	89.0%	120.6%	106.3%
Ward 5	1237.50	1237.50	736.44	643.80	643.80	334.80	1087.50	1492.50	1706.43	643.80	943.50	1199.20	59.5%	52.0%	114.3%	127.1%	56.9%	119.3%	92.1%
Ward 6	1237.50	1237.50	1081.75	643.80	643.80	344.10	1261.50	2041.50	2037.76	643.80	1221.00	1468.58	87.4%	53.4%	99.8%	120.3%	75.8%	107.5%	95.9%
Ward 7	1237.50	1237.50	872.50	321.90	321.90	332.40	1087.50	1132.50	1427.73	965.70	999.00	957.30	70.5%	103.3%	126.1%	95.8%	77.3%	111.9%	97.3%
Totals	14190.00	14190.00	11811.07	6415.96	6415.96	4838.31	13572.00	15687.00	16476.09	8658.24	10511.94	11524.78	83.2%	75.4%	105.0%	109.6%	80.8%	106.9%	95.4%
Dragon Square	1020	1020	690.75	290	290	284.52	1087.5	1087.5	992.27	290	330	332	67.70%	98.10%	91.20%	100.60%	74.40%	93.40%	84.30%

Feb-20	Total Hours Per Day	Patients	CHPPD	Safe staffing was maintained by	RN Vacancies	HCSW Vacancies	Bed occupancy October	Movement
Ward								
Assessment & Treatment	3964.55	140.00	28.32	Nurses working additional unplanned hours and altering the skill mix	2.76	-0.12	83%	↑
Darwin Centre	3772.13	284.00	13.28	Nurses working additional unplanned hours and altering the skill mix	5.96	1.94	80%	↑
Edward Myers Unit	2517.84	270.00	9.33	Nurses working additional unplanned hours and altering the skill mix	2.49	0.02	85%	↑
Florence House	2060.24	177.00	11.64	Nurses working additional unplanned hours and altering the skill mix	-0.08	1.50	92%	↓
Summers View	2569.62	239.00	10.75	Nurses working additional unplanned hours and altering the skill mix	0.79	2.00	101%	↑
PICU	3985.67	169.00	23.58	Nurses working additional unplanned hours, altering the skill mix and support from the MDT.	3.74	0.10	101%	↑
Ward 1	3147.57	254.00	12.39	Nurses working additional unplanned hours and altering the skill mix and support from the MDT.	0.92	0.39	64%	↑
Ward 2	4020.03	397.00	10.13	Nurses working additional unplanned hours and altering the skill mix	1.94	-1.66	72%	↑
Ward 3	4215.09	365.00	11.55	Nurses working additional unplanned hours, altering the skill mix.	1.02	1.50	59%	↓
Ward 4	4486.28	423.00	10.61	Nurses working additional unplanned hours and altering the skill mix	1.84	-1.92	99%	↓
Ward 5	4207.19	324.00	12.99	Nurses working additional unplanned hours and altering the skill mix	3.89	-0.79	76%	↑
Ward 6	5285.69	368.00	14.36	Nurses working additional unplanned hours, altering the skill mix and support from the MDT.	2.71	-2.93	85%	↓
Ward 7	4030.93	470.00	8.58	Nurses working additional unplanned hours and altering the skill mix	2.33	1.04	90%	↓
Totals	48262.83	3880.00	12.44		30.31	1.07		
Dragon Square	2299.54	129	17.83	Nurses working additional unplanned hours and altering the skill mix	0.00	0.96	76%	↑

10

Appendix 2 Staffing Issues

- At the end of February 2020, there were 30.31 WTE RN vacancies in ward in-patient areas; this is an increase from the January 2020 position. The Darwin Centre and Ward 5 continue to have the highest number of RN vacancies. The overall vacancy figure continues to show a positive reduction throughout this financial year, demonstrating that we have not only been able to successfully recruit new Registered Nurses but, we have also retained a large proportion of these RNs. The Trust continues to advertise for the remainder of the vacancies in a variety of part and whole time roles.

- HCSW vacancies decreased in February 2020 to 1.07 WTE. Many wards continue to over-establish HCSW posts to support safer staffing levels.

- RN day shift cover remained challenging during February 2020. Ward 5 had the lowest RN day shift cover in February with 59.5% fill-rate being achieved; this was due to an increase in RN vacancies.

- RN night shift cover also remained challenging during February 2020; this decreased from 78.3% in January 2020 to 75.4% in February 2020. It should be noted also that it is the 2nd night shift RN that continues to impact on the night RN fill-rate.

- Ward teams continue to be supported by Quality Improvement Lead Nurses, Nurse Practitioners and a Site Manager who is further supported by an On-Call Manager out of hours.

- Eight wards experienced an increase in occupancy with all of the other ward areas seeing occupancy decreasing during February 2020. Patient acuity remained high within the Adult Acute wards where there have been high levels of enhanced observations.

- Staffing data for Dragon Square Specialist Children's Short Breaks Service is included in this report for information purposes and is reported independently to the NHS Digital submission. This is due to the differences between this service and an inpatient ward and will ensure the reliability of data reporting for our inpatient areas. Occupancy levels for the Short Breaks Service fluctuate frequently, this can often occur at very short notice. As a result staffing levels are always managed to reflect the level of support required and it is not always possible to flex the requirement downward in the report when these changes occur.

- The delivery of safe staffing levels remains of paramount importance within all of our services. As a result we are currently working with Dr Keith Hurst to undertake an audit and review of the staffing levels required within our Adult Community Mental Health Teams (CMHT's). Data gathering which was originally scheduled to

place in March 2020 will be postponed until after the Coronavirus (Covid-19) outbreak has receded; this is due to the impact that Trust current contingency planning will have on the true position of community staffing.

- There is little evidence that Coronavirus (Covid-19) has impacted on our ability to provide safe staffing levels in February 2020; this situation may change within the coming weeks and months. Emergency planning measures are in place and are reviewed on a daily basis in line with the changing local and national picture and government advice.

NHS
North Staffordshire Combined Healthcare NHS Trust

REPORT TO PUBLIC BOARD AGENDA

Enclosure No: 6b

Date of Meeting:	14th May 2020		
Title of Report:	March 2020 Monthly Safer Staffing Report		
Presented by:	Kenny Laing, Executive Director of Nursing & Quality		
Author:	Alastair Forrester, Deputy Director of Nursing & Quality		
Executive Lead Name:	Kenny Laing, Executive Director of Nursing & Quality	Approved by Exec	☐

Executive Summary:	Purpose of report	
Purpose: This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during March 2020 in line with the National Quality Board requirements. Key Findings: • During March 2020 an overall fill rate of 91.7% was achieved; this is a decrease from the February 2020 position. • The coronavirus emergency planning response has resulted in a significant reduction in our ward occupancy levels reducing the requirement to meet our usual safe staffing levels. • Registered Nurse vacancies within ward inpatient areas increased by 0.64 WTE to 30.95 WTE in March 2020. HCSW vacancies increased to 1.41 WTE. • To support recruitment the Trust has secured the employment of a number of 'Aspirant Nurses'. These are year 2 and year 3 Student Nurses who have agreed to opt-in to an arrangement whereby they will move into clinical practice to support our coronavirus emergency planning. Recommendations: The Quality Committee and Trust Board are asked to note the challenges in filling shifts, the challenges with recruitment to nurse vacancies and to acknowledge and support the mitigations that are currently in place. The Trust Board should be assured that during this time of national emergency planning we are continuing to maintain safe staffing levels within our ward inpatient areas.	**Approval**	☐
	Information	☐
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☒ Virtually	Document Version No.	1
Committee Approval / Review	• Quality Committee ☒ • Finance & Resource Committee ☐ • Audit Committee ☐ • People, Culture & Development Committee ☐ • Charitable Funds Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration. ☐ 2. To provide the highest quality, safe and effective services ☒ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☐ 5. Attract, develop and retain the best people. ☒ 6. Maximise and use our resources effectively. ☒		

	7. Take a lead role in partnership working and integration. ☐	
Risk / legal implications: Risk Register Reference	Delivery of safe nurse staffing levels is a key requirement to ensuring that the Trust complies with National Quality Board standards.	
Resource Implications: Funding Source:	Temporary staffing costs. Budgeted establishment and temporary staffing spend.	
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	None	
STP Alignment / Implications:	None	
Recommendations:	To receive the report for assurance	
Version	Name/group	Date issued
1	Quality Committee	23.4.20

1 Introduction

This report details the ward daily staffing levels during the month of March 2020 following the reporting of the planned and actual hours of both Registered Nurses (RN) and Health Care Support Workers (Care Staff) to NHS Digital. Additionally from April 2018 Care Hours per Patient Day (CHPPD) have also been required to be reported to NHS Digital. The CHPPD calculation is based on the cumulative total number of patients daily over the month divided by the total number of care hours (appendix 1).

2 Background

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

In addition to the monthly reporting requirements the Executive Director of Nursing & Quality is required to review ward staffing on a 6 monthly basis and report the outcome of the review to the Trust Board of Directors. A comprehensive annual report for 2018 was presented to April 2019 Board and the recommendations relating to safer staffing reviews are progressed and monitored through the Safer Staffing Group.

3 Trust Performance

During March 2020 the Trust achieved a staffing fill rate of 76.8% for Registered Nurses and 105% for care staff on day shifts and 80.2% and 99.3% respectively on night shifts. Taking skill mix adjustments into account an overall fill-rate of 91.7% was achieved. This is a decrease from the 95.4% fill rate reported in February 2020.

The current coronavirus pandemic and the Trusts subsequent response planning has resulted in a significant decrease in ward occupancy levels during March 2020.

Details of the actions taken to maintain safer staffing 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 1.

The impact of unfilled shifts alongside the additional contributory factors are also provided below and are summarised in Appendix 2.

The Safer Staffing Group continues to oversee the safer staffing work plan and recommendations are followed and recorded within a Safer Staffing Action Plan.

4 Care Hours per Patient Day (CHPPD)

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

5 Impact

WMs report the impact of unfilled shifts on a shift by shift basis.

5.1 Impact on Patient Safety

There were four reported incidents in relation to ward nurse staffing levels during March 2020. Two incidents were reported by the Assessment and Treatment Unit, both were due to sickness absence. One incident was reported by Ward 4 where staff sickness absence impacted on night staffing levels; this was compounded by a patient requiring support to attend the Royal Stoke University Hospital. Similarly, a reduction in night staff at Ward 7 due to staff sickness required support from other areas. The Site Manager provided support to all of these incidents, none of which impacted on our ability to provide safe patient care.

5.2 Impact on Patient Experience

Staff prioritise patient experience and direct patient care. During March 2020 there were 2 occasions, when patient activities had to be cancelled as a result of shortfalls in nurse staffing levels. Ward 2 cancelled 30 hours of patient activity, this could not be rescheduled. PICU cancelled 4 hours of patient activity which was successfully rescheduled.

5.3 Impact on Staff Experience

In order to maintain safe staffing levels the following actions were taken by Ward Managers during March 2020:

- 110 staff breaks were cancelled (equivalent to approximately 2.3% of total breaks). This remained unchanged from February 2020. PICU and Ward 3 reported the highest number of missed breaks; this was predominantly due to short notice increases in acuity. Any time accrued due to missed breaks is taken back with agreement of the Ward Manager.

- There were two occasions reported during March 2020 when staff supervision sessions had to be cancelled to support staffing levels. This occurred at the PICU.

- One staff appraisal was cancelled during March 2020 to support staffing levels. This also occurred at the PICU.

- Face to face mandatory training sessions have been suspended during the current coronavirus pandemic. All mandatory training is being provided using the web-based Learning Management System, therefore no mandatory training sessions were cancelled in March 2020 to support safe staffing levels.

5.4 Mitigating Actions

Ward Managers and members of the multi-disciplinary team have clinically supported day shifts to ensure safe patient care. A total of 458 RN shifts were covered by HCSW's where RN temporary staffing was unavailable. A total of 81 HCSW shifts were covered by RN staff where HCSW temporary staffing was unavailable. Additionally, as outlined in section 5.3, staff breaks have been shortened or not taken (time is given in lieu) and wards have cross-covered to support safe staffing levels.

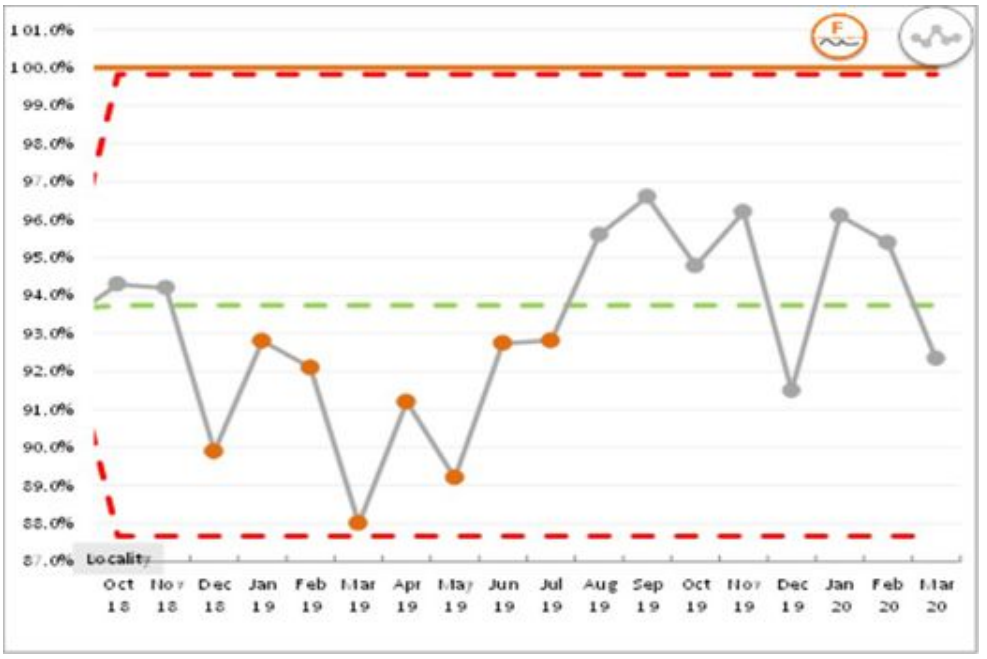
The PICU reported 4 occasions (4 hours total) when additional support was provided by members of the multi-disciplinary team to maintain safe staffing levels.

There were 11 occasions when staff worked additional unplanned hours to cover shortfalls in nurse staffing levels; these incidents occurred at Ward 1 and PICU and have a combined total of 15.5 hours.

5.5 Overall Fill Rate

Overall staffing fill rate during March 2020 was 91.7%. Although this has decreased from 95.4% reported in February 2020, there has been no significant change in this position during the past 18 months. Actions taken to mitigate this position are outlined in section 5.6.

Overall Fill-Rate September 2018 – March 2020



5.6 Recruitment

In line with the national picture, RN recruitment remains challenging.

In agreement with NHS England and the NMC and working in partnership with local universities, the Trust has secured the employment of a number of 'Aspirant Nurses'. These staff are year 2 and year 3 Student Nurses who have agreed to opt-in to an arrangement whereby they will move into clinical practice during the emergency period of the covid-19 outbreak.

The year 3 students will no longer have supernumerary status. They will be included in ward staffing levels and will be paid an NHS Agenda for Change Band 4 salary. They will also be able to choose to join the NMC's new Emergency covid-19 Temporary Register as part of a transition to their Registered Nurse positions. Year 2 students will maintain their supernumerary status. All students are still required to complete the educational requirements of their course, including all final assessments.

The Trust is also engaging at a regional level with the NHS 'Bringing Back Staff' scheme. This scheme was introduced in response to anticipate staffing shortfalls and additional staffing requirements to light of the Covid-19 pandemic

response procedures. The aim is to facilitate the return of Nurses and Drs to NHS practice.

The Trust continues to participate in the NHSI Retention Support Programme. This includes a number of initiatives including, involvement with national return to practice campaigns; the strengthening of the nursing career pathway through our partnership work with Staffordshire and Keele Universities; and the ongoing development of our HCSW apprenticeship programmes including the recruitment to a number of ward based apprenticeships.

Furthermore, we are continuing to support a number of nurses who trained overseas, to undertake further qualifications to enable their registration to be recognised in the UK.

We continue to deliver a robust programme of preceptorship to our newly qualified nurses as well as supporting a number of academic programmes which run alongside significant work based and placement learning. These programmes have been adapted in response to the coronavirus pandemic and our Practice Education Team have been working with students and our local universities to ensure an optimal level of support, supervision and preceptorship during this time.

5.7 Registered Nurse Retention

During March 2020 there were 13 Registered Nurses (10.47 WTE) who left the Trust. Of these, 1 RN (1.00 WTE) was from a ward inpatient area; 11 RN's (8.47 WTE) were from community based services and 1 RN (1.00 WTE) worked as a Practice Nurse. 3 RN's took age related retirement, 3 took voluntary resignation or left to support their work life balance and 7 staff were part of a service transfer TUPE arrangement.

In addition 2 HCSW's (2.00 WTE) left the Trust during March 2020. One from our community services and one from a ward inpatient area.

6. Summary

The fill rate for RN shifts decreased from 85.3% in February 2020 to 77.8% in March 2020. Although it should be noted that the pandemic emergency planning response required a significant reduction in our ward occupancy levels (these are reflected in Appendix 1) and as a result there was a reduced requirement to provide the usual staffing levels within every area.

RN vacancies within ward inpatient areas increased by 0.64 WTE from 30.31 WTE in February 2020 to 30.95 WTE in March 2020. HCSW vacancies increased from 1.07 WTE in February 2020 to 1.41 WTE in March 2020, these

remain well managed with a number of ward areas increasing their HCSW establishment to support safe staffing levels.

We are continuing to employ a number of strategies with the support of the HR and the Communication Team to attract both RNs and HCSW's during this time of national shortage. Recent recruitment events have proved successful in filling some of these posts.

The Trust Recruitment and Retention Action Plan continues to be monitored via the Safer Staffing Group; we also remained fully engaged with the NHSI Retention Support Programme.

7. Recommendations

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 have been maintained.

Appendix 1 March 2020 Safer Staffing

Mar-20	Registered Nurses						Care Staff						Registered Nurse		Care Staff		Total Nursing Staffing		
Ward	Day Establishment Hours	Day Clinically Required	Day Actual	Night Establishment	Night Clinically Required	Night Actual	Day Establishment Hours	Day Clinically Required	Day Actual	Night Establishment	Night Clinically Required	Night Actual	Day Fill Rate (%)	Night Fill Rate (%)	Day Fill Rate (%)	Night Fill Rate (%)	Overall RN %	Overall Care Staff %	Overall Staffing
Assessment & Treatment	929.10	929.10	733.70	688.20	688.20	378.90	1534.50	1549.50	958.70	688.20	710.40	787.60	79.0%	55.1%	61.9%	110.9%	68.8%	77.3%	73.7%
Darwin Centre	1327.50	1335.00	975.25	688.20	710.40	574.92	1162.50	1177.50	1357.73	688.20	710.40	755.30	73.1%	80.9%	115.3%	106.3%	75.8%	111.9%	93.1%
Edward Myers Unit	955.50	955.50	915.00	344.10	344.10	346.60	790.50	790.50	799.75	685.10	685.10	654.15	95.8%	100.7%	101.2%	95.5%	97.1%	98.5%	97.8%
Florence House	630.00	630.00	667.94	332.32	332.32	332.32	930.00	930.00	747.25	332.32	332.32	331.57	106.0%	100.0%	80.3%	99.8%	103.9%	85.5%	93.5%
Summers View	930.00	930.00	687.25	332.32	332.32	333.32	930.00	930.00	867.37	664.64	664.64	656.00	73.9%	100.3%	93.3%	98.7%	80.8%	95.5%	89.0%
PICU	1002.00	1002.00	982.42	688.20	688.20	650.80	837.00	1842.00	1853.18	688.20	1420.80	1258.77	98.0%	94.6%	100.6%	88.6%	96.6%	95.4%	95.8%
Ward 1	1327.50	1327.50	857.96	344.10	344.10	345.00	1162.50	1162.50	1104.23	688.20	821.40	692.23	64.6%	100.3%	95.0%	84.3%	72.0%	90.6%	82.1%
Ward 2	1327.50	1327.50	919.50	688.20	688.20	399.60	1162.50	1162.50	1339.00	688.20	699.30	874.40	69.3%	58.1%	115.2%	125.0%	65.4%	118.9%	91.1%
Ward 3	1327.50	1327.50	1156.00	688.20	688.20	617.50	1162.50	1162.50	1158.61	688.20	688.20	680.20	87.1%	89.7%	99.7%	98.8%	88.0%	99.4%	93.4%
Ward 4	1492.50	1492.50	1060.71	344.10	344.10	359.95	1162.50	1162.50	1833.86	1032.30	1032.30	980.80	71.1%	104.6%	157.8%	95.0%	77.4%	128.2%	105.1%
Ward 5	1327.50	1327.50	829.02	688.20	688.20	355.20	1162.50	1590.00	1800.43	688.20	999.00	1266.95	62.4%	51.6%	113.2%	126.8%	58.7%	118.5%	92.3%
Ward 6	1327.50	1327.50	1006.05	688.20	688.20	477.30	1162.50	1650.00	1936.99	1032.30	1398.60	1257.90	75.8%	69.4%	117.4%	89.9%	73.6%	104.8%	92.4%
Ward 7	1327.50	1327.50	905.25	344.10	344.10	346.90	1162.50	1522.50	1710.75	1032.30	1287.60	1169.90	68.2%	100.8%	112.4%	90.9%	74.9%	102.5%	92.2%
Totals	15231.60	15239.10	11696.05	6858.44	6880.64	5518.31	14322.00	16632.00	17467.85	9596.36	11450.06	11365.77	76.8%	80.2%	105.0%	99.3%	77.8%	102.7%	91.7%

Mar-20								
Ward	Total Hours Per Day	Patients	CHPPD	Safe staffing was maintained by	RN Vacancies	HCSW Vacancies	Bed occupancy October	Movement
Assessment & Treatment	3029.15	69.00	43.90	Nurses working additional unplanned hours and altering the skill mix	2.76	-0.12	35%	↓
Darwin Centre	4001.20	173.00	23.13	Nurses working additional unplanned hours and altering the skill mix	5.96	1.94	59%	↓
Edward Myers Unit	2715.50	237.00	11.46	Nurses working additional unplanned hours and altering the skill mix	2.13	0.02	80%	↑
Florence House	2208.58	171.00	12.92	Nurses working additional unplanned hours and altering the skill mix	-1.08	1.5	78%	↓
Summers View	2701.44	249.00	10.85	Nurses working additional unplanned hours and altering the skill mix	1.79	2.20	90%	↓
PICU	4805.17	130.00	36.96	Nurses working additional unplanned hours and altering the skill mix and support from the MDT.	3.74	-0.10	69%	↓
Ward 1	3423.42	244.00	14.03	Nurses working additional unplanned hours, altering the skill mix.	-0.08	0.39	56%	↓
Ward 2	4018.75	400.00	10.05	Nurses working additional unplanned hours and altering the skill mix and support from the MDT.	2.94	-0.66	53%	↓
Ward 3	4178.31	433.00	9.65	Nurses working additional unplanned hours and altering the skill mix	1.02	1	59%	↔
Ward 4	4964.65	380.00	13.06	Nurses working additional unplanned hours, altering the skill mix.	1.84	-1.08	78%	↓
Ward 5	4468.10	276.00	16.19	Nurses working additional unplanned hours and altering the skill mix	4.89	-1.79	62%	↓
Ward 6	5158.99	359.00	14.37	Nurses working additional unplanned hours and altering the skill mix	2.71	-2.93	79%	↓
Ward 7	4832.05	465.00	10.39	Nurses working additional unplanned hours, altering the skill mix.	2.33	1.04	77%	↓
Totals	50505.31	3586.00	14.08		30.95	1.41		
Dragon Square	1724.19	92.00	18.74	Nurses working additional unplanned hours and altering the skill mix	0.40	0.48	48%	↓

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Appendix 2 Staffing Issues

- At the end of March 2020, there were 30.95 WTE RN vacancies in ward in-patient areas; this is an increase of 0.64 WTE from the February 2020 position. The Darwin Centre, PICU and Ward 5 continue to have the highest number of RN vacancies. The overall vacancy figure continues to show a positive reduction throughout this financial year, demonstrating that we have not only been able to successfully recruit new Registered Nurses but, we have also retained a large proportion of these RNs. The Trust continues to advertise for the remainder of the vacancies in a variety of part and whole time roles.

- HCSW vacancies increased in March 2020 to 1.41 WTE. Many wards continue to over-establish HCSW posts to support safer staffing levels.

- RN day shift and night shift cover continues to remain challenging however, as highlighted previously the pandemic emergency planning response has required a significant reduction in our ward occupancy levels and as a result there was a reduced requirement to provide the usual pre agreed levels of safe staffing within every area.

- Ward teams continue to be supported by Quality Improvement Lead Nurses, Nurse Practitioners and a Site Manager who is further supported by an On-Call Manager out of hours. Furthermore, during the current coronavirus pandemic we have introduced daily Safer Staffing Huddles. The Incident Control Centre, based within the Harplands Hospital is also available to provide additional advice and support with staffing levels.

- All wards, with the exception of Ward 6 experienced a decrease in occupancy during March 2020. This was a planned reduction in occupancy and formed part of our emergency planning arrangements.

- Staffing data for Dragon Square Specialist Children's Short Breaks Service is included in this report for information purposes and is reported independently to the NHS Digital submission. This is due to the differences between this service and an inpatient ward and will ensure the reliability of data reporting for our inpatient areas. Occupancy levels for the Short Breaks Service fluctuate frequently, this can often occur at very short notice. As a result staffing levels are always managed to reflect the level of support required and it is not always possible to flex the requirement downward in the report when these changes occur.

- It should be noted that the Dragon Square Specialist Children's Short Breaks Service was closed from 23rd March 2020, this was again part of our emergency planning measures.

- Staffing levels continue to remain under constant review as part of our response to the coronavirus pandemic. The function of all Trust services has been reviewed to ensure that we are as responsive as possible to a changing situation and to make certain that we can maintain safe staffing levels within our ward inpatient areas, these being our most critical services.

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NHS Trust

REPORT TO PUBLIC TRUST BOARD

Enclosure No: 7

Date of Meeting:	14th May 2020		
Title of Report:	Q4 2019-2020 Mortality Surveillance Report		
Presented by:	Dr B Adeyemo, Executive Medical Director		
Author:	Jackie Wilshaw. Head of Patient and Organisational Safety		
Executive Lead Name:	Dr B Adeyemo, Executive Medical Director	**Approved by Exec**	☒

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

1. Introduction

In 2017 the National Quality Board published new guidance on learning from deaths. As a result there is a need to ensure that the Trust can be confident that all unexpected deaths are reported and investigated appropriately. Additionally, information contained within its databases must be accurate and comply with the Trust standard of transparency and accountability. This report is for the Q4 reporting period 2019/20 and provides information for the time frame January to March 2020.

2. Trust reporting and data collection

During Q4 the mortality surveillance group reviewed the care of 29 people (meetings took place on14th January and 4th February). The analysis of these deaths is shown in the table below.

Meeting Date	Identifier	Death category	Level of care	Death occurred as a result of problems in healthcare?	DoC applies	Domain
January 2020	25413	UN2 Unexpected Natural	4. Good Care	No	No	Drugs and alcohol
	26623	UN2 Unexpected Natural	4. Good Care	No	No	Drugs and alcohol
	27295	UN2 Unexpected Natural	4. Good Care	No	No	Drugs and alcohol
	27605	UN1 Unexpected Natural	4. Good Care	No	No	Physical health
	27883	UN2 Unexpected Natural	4. Good Care	No	No	Drugs and alcohol
	28273	UN2 Unexpected Natural	4. Good Care	No	No	Physical health
	28037	EN1 Expected Natural	4. Good Care	No	No	Physical health (Learning Disability)
	28043	UN1 Unexpected Natural	4. Good Care	No	No	Drugs and alcohol
	28524	UN1 Unexpected Natural	4. Good Care	No	No	Physical health
	28849	UU Unexpected Unnatural (RTA)	4. Good Care	No	No	Physical health
	30017	EN1 Expected Natural	4. Good Care	No	No	Physical health
	21425	EN1 Expected Natural	4. Good Care	No	No	Physical health (Learning Disability)
	28441	UN1 Unexpected Natural	4. Good Care	No	No	Physical health
February 2020	22297	UN1 Unexpected Natural	4. Good Care	No	No	Physical health
	24354	EN1 Expected Natural	4. Good Care	No	No	Physical health (Learning Disability)
	25241	UN2 Unexpected Natural	4. Good Care	No	No	Physical health
	26036	UN2 Unexpected Natural	4. Good Care	No	No	Drugs and alcohol
	27570	UN1 Unexpected Natural	4. Good Care	No	No	Physical health + Drugs and

						alcohol
	28529	UN2 Unexpected Natural	4. Good Care	No	No	Drugs and alcohol
	29284	UN2 Unexpected Natural	4. Good Care	No	No	Physical health + Drugs and alcohol
	29589	UN2 Unexpected Natural	4. Good Care	No	No	Drugs and alcohol
	29658	UN1 Unexpected Natural	4. Good Care	No	No	Physical health + Drugs and alcohol
	30394	UN1 Unexpected Natural	4. Good Care	No	No	Physical health
	30698	UN1 Unexpected Natural	4. Good Care	No	No	Physical health
	30791	EN1 Expected Natural	4. Good Care	No	No	Physical health
	30771	EN1 Expected Natural	4. Good Care	No	No	Physical health
	31170	UN1 Unexpected Natural	4. Good Care	No	No	Physical health
	31171	EN1 Expected Natural	4. Good Care	No	No	Physical health
	31399	UN2 Unexpected Natural	4. Good Care	No	No	Drugs and alcohol

The definitions for the death category are shown below:

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

There is no national guidance on the criteria for the level of care determination. However the mortality surveillance group considered that good care had been provided where there was evidence of the staff providing a good level of support, had responded quickly and appropriately to situations where deterioration in physical health was noted. Adequate care is determined to be care where the basic standards of expected support are given. Poor Care is determined where the group consider that the actions of the clinicians did not meet the standards required by the Trust. However in part these determinations are dependent upon the quality of the documentation contained within the mortality surveillance review tools and the electronic patient records. Feedback to the directorate/team on the quality of documentation is sent to the clinical teams in order to improve future entries in the patient records.

Of the reviews undertaken during this timeframe, care was rated to be good in all cases; it was agreed by the group that there was evidence of care being provided in a timely manner and that the actions taken by Trust staff demonstrated their support to people who were physically unwell.

New and underlying physical health issues were responsible for 20 out of the 29 (69%)of the deaths reviewed; this also includes 15% where the person had alcohol related issues in addition

to poor physical health. In the remaining 9 cases (31%), alcohol abuse was determined to be the principle cause of the person's death.

3. LeDeR

The Trust is required to report all deaths of people with Learning Disabilities to a national reviewing board based at the University of Bristol. The deaths are then allocated to regional offices for review. To ensure oversight of all deaths of people known to the Trust, the decision was made to include the deaths of people with Learning Disabilities in the mortality surveillance process.

In December 2019, the Trust was contacted by an external reviewer with regards to the review of care for 2 people which were reported in 2018. However the Trust is still to receive feedback regarding these reviews.

4. Conclusion

The Trust continues to monitor the deaths of people whose deaths are outside of the Serious Incident process. The monthly Mortality Surveillance Group receives and reviews investigations in order to provide assurance as to the quality of the care provided by the Trust. The group identifies any learning from the reviews and offers recommendations for practice when required. In the deaths reviewed during Q4, there was no evidence of deficits in the healthcare provided by the Trust which may be considered to have contributed to the death of any individuals.

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REPORT TO PUBLIC TRUST BOARD

Enclosure No: 8

Date of Meeting:	14th May 2020		
Title of Report:	Q4 Serious Incident Report		
Presented by:	Dr Buki Adeyemo, Executive Medical Director		
Author:	Jackie Wilshaw, Head of POST		
Executive Lead Name:	Dr Buki Adeyemo, Executive Medical Director	Approved by Exec	☒

Executive Summary:	Purpose of report	
This report provides the Trust with Assurance relating to the nature and status of SI's currently open and the trend data for Q3 2019/20 and Q4 2019/20. The report also includes information regarding themes, learning and change arising from Serious Incident investigations. There is also a Duty of Candour report included.	Approval	☐
	Information	☐
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☒ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee • Charitable Funds Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration. ☐ 2. To provide the highest quality, safe and effective services. ☒ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☒ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☐		
Risk / legal implications: Risk Register Reference	Nil		
Resource Implications: Funding Source:	Nil		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	Consideration of Diversity and Inclusion issues is given during the SI investigation processes and the analysis provided in this report. There have been no issues raised with regards to D+I during these processes.		
STP Alignment / Implications:	Nil		
Recommendations:	To receive for assurance		

Version	Name/group	Date issued
1		

1. Purpose of the report

This report provides assurance to the Quality committee of the Trust processes relating to Serious Incidents (SIs) and Duty of Candour. The report covers the period from 1st January 2020 to 31st March 2020 (Quarter 4, 2019/20) and details the following:

- The status of SIs currently open and trend data for Q3 2019/20 and Q4 2019/19.
- Serious Incidents by category reported by quarter.
- Themes, learning and change arising from Serious Incident investigations.
- The quarterly Duty of Candour report.

2. Serious Incidents Q4

SI investigations are undertaken following incidents involving people in receipt of services or who have been in receipt of services in the previous 12 months. Discussions with commissioners to alter this to only capture people in receipt of services or who have been in receipt of services in the previous 6 months have been agreed. Investigations are completed for incidents where death, serious injury or serious event has occurred. For the purposes of this report, investigations are not completed for those service users whose deaths are determined by HM Coroner to be the result of natural causes. The table below illustrates the total number of SIs reported by quarter for the period April 2018 to March 2020.

StEIS Incident category	Q1	Q2	Q3	Q4	Total 2018/19	Q1	Q2	Q3	Q4	Total 2019/20
Apparent/actual abuse	2	0	0	1	3	1	0	0	0	1
Unexpected potentially avoidable injury causing serious harm: this is subdivided as shown below										
Apparent/actual/suspected self-harm criteria meeting SI criteria	2	2	3	2	9	2	1	3	2	8
Slip, trip, fall	1	6	1	2	10	1	2	2	4	9
Unexpected potentially avoidable injury causing serious harm	3**	0	0	0	3	0	0	0	0	0
Disruptive, aggressive behaviour meeting SI criteria	1	1	0	0	2	0	0	0	0	0
Unexpected/Potentially avoidable serious assault (inc Suspected Homicide)	0	0	1	0	1	2	1	0	1	4
Under 18 admission	0	0	1	0	1	0	0	0	0	0
Incident demonstrating existing risk	0	0	1	0	1	0	0	0	0	0
Contact/collision with a stationary object	0	0	0	0	0	0	0	0	1	1
Unexpected potentially avoidable death: This is subdivided as shown below										
Pending review	7	14	10	20	51	9	5	6	11	31
Apparent/actual/suspected self-harm criteria meeting SI criteria (suspected suicide)	10	3	4	11	28	4	6	2	6	18
Total	26	26	21	36	109	19*	15	13	25	72

*this figure is changed from that reported during Q1 due to a number of investigations being downgraded from SI investigations in the event of HM Coroner determining a natural cause death. Reviews of these deaths have therefore been transferred to the mortality surveillance process.

The table below shows the incidents reported in Q4 by team.

Team	Jan 20	Feb 20	Mar 20	Total
Access			1	1
Ashcombe		1		1
CDAS	3	2	2	7
Early Intervention	1			1
Greenfields		1		1
Greenfields*/ wards 1+3	1			1
Mental Health Liaison Team			1	1
One Recovery	3	2		5
South Stoke CAMHS			1	1
Sutherland Centre		1		1
Ward 1		1		1
Ward 2	1			1
Ward 4			1	1
Ward 6		2		2
Ward 7			1	1
Grand Total	**7**	**10**	**7**	**24**

*Indicates lead team for purposes of SI investigation

The table below shows the incidents reported in Q4 by Directorate.

Directorate	Jan 20	Feb 20	Mar 20	Total
Acute and Urgent care	1	3	4	8
N Staffs Community	1	1	0	2
Specialist Services	4	4	2	10
Stoke Community	1	2	1	4
Total	**7**	**10**	**7**	**24**

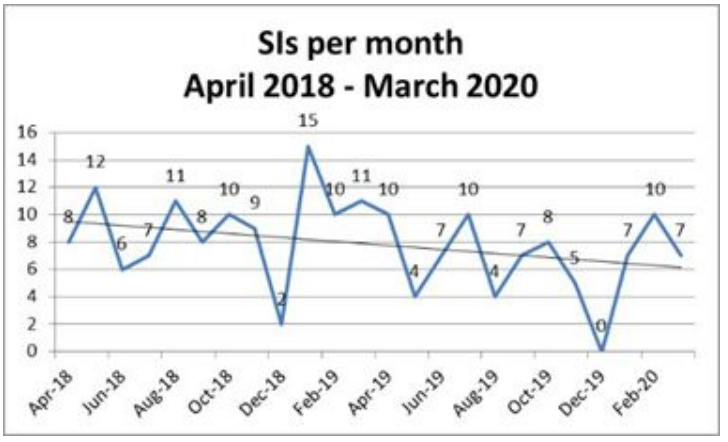
During Q4, 24 incidents were reported into StEIS and have undergone or are in the process of undergoing SI investigation. The main points to note are:

- There were 10 serious incidents reported for the Specialist Services Directorate. These were all classified as unexpected, potentially avoidable deaths.
    - In 8 cases, the classification is currently stated as ‘pending review’ and 2 cases are ‘suspected suicide’.
- There were 8 serious incidents reported for the Acute & Urgent Care Directorate.
    - This includes 2 unexpected, potentially avoidable deaths: the deaths appear to be as a result of deliberate overdose. Requests for toxicology have been made by HM Coroner.
    - There was 1 serious self-harm attempt (non-fatal) where a person on unescorted ward leave was involved in an road traffic accident. This person had significant injuries and required care and treatment at RSUH.
    - There were 4 slip, trip, falls that resulted in fractures (3 incidents related to unwitnessed falls and 1 incident where a person absconded from staff whilst on escorted leave and later returned with a fractured arm).

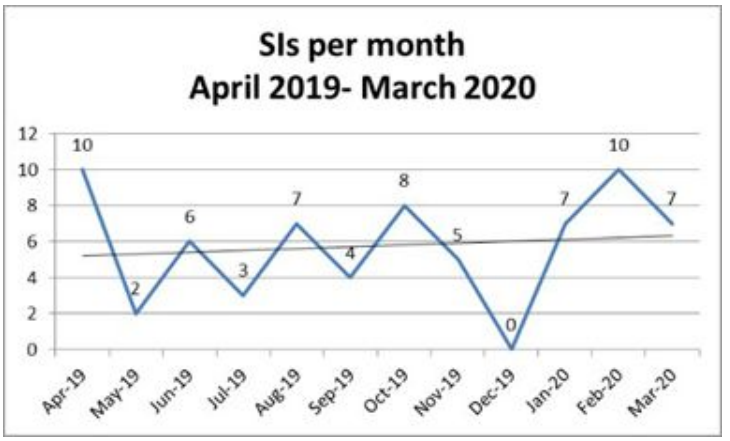
  - There was 1 incident where the person fractured their wrist by accidently hitting their arm against a door frame.
- In the Stoke Community Directorate, 4 serious Incidents were reported.
  - There were 3 incidents of unexpected, potentially avoidable death.
  - There was one incident of serious self –harm reported by the CAMHS team.
- There were 2 incidents of unexpected, potentially avoidable deaths in the North Staffordshire Community Directorate.
  - 1 incident relates to a suspected suicide.
  - 1 incident related to a suspected homicide by a person who had been in receipt of services within the last 6 months

3. Themes and Trends

The graph below shows the number of Serious Incidents reported monthly over a 2 year period, where a clear reduction in the number of SI's reported by the Trust.



When viewed over a shorter timeframe (see graph below) the decreasing trend for serious incidents is no longer evident; this is due to an increased number of incidents reported during Q4. However the number of incidents reported in Q4 (24) during 2019/20 is a third less than the number reported during the same period in 2018/19 (36).



4. Learning from Serious Incidents

Recommendations and learning from investigations are disseminated upon completion of the SI investigation. The learning that was found from closed SI's during Q3 and Q4 included the following:

- The investigation reports from the Substance Misuse teams continued to show issues relating to poor or non-engagement with services. However these reports also demonstrated the teams ongoing commitment to promoting support and engagement with this client group.
- The Home Treatment Team updated their patient information leaflet in order to provide additional support that people may find useful to access.
- The rehab teams enhanced their understanding of the care needs of people with epilepsy, including the referral process into the Specialist Epilepsy Services. Epilepsy training sessions are available on CAT.
- Issues in relation to timely reallocation of care coordinators following staff leaving and subsequent handover to new care coordinators have been evident in more than one investigation. All directorates are working to improve this issue.
- The adult acute wards were reminded of the need to complete the falls multifactorial risk assessment should the patient meet the criteria outlined in the initial risk assessment.
- The Home Treatment Team changed their process to ensure that the core risk assessments were reviewed by a consistent team of senior registered practitioners when determining the ongoing care plans. In line with the service operating procedure, this review takes place within 72 hours of the assessment period and a monthly audit is in place to provide assurance that these reviews are being held in accordance with the service timeframes.

During Q4, the panel review of the inpatient death has concluded its draft report. There have been a number of recommendations made and the report is currently in the next stages of governance. The report has been shared with the directorate and the family of the deceased for their review. Following directorate agreement, the report will be forwarded to the Medical Director for final sign off before submission to the Trust commissioners.

Following a serious incident involving a person admitted from out of area (South Staffordshire), a review of the early learning identified a need for improved information handover between staff from Combined Healthcare and Midlands Partnership (MPFT) teams. The areas of concerns included the need for up to date risk assessments and care plans from the current treating team (from outside of Combined Healthcare). The Trust had already expressed a wish for joint learning events with MPFT and has approached MPFT to this effect; these joint events will be facilitated post the Coronavirus limitations.

As in previous reports, documentation and communication issues can be found across a range of investigation reports. Action plans for improvements are in place for individuals and teams in relation to specific incidents. We continue to monitor that learning is embedded and that the messages are cascaded across the organisation.

As in previous reports there were a number of investigations where no recommendations for change were made.

This action plans are reviewed at 6 and 12 monthly intervals post incident in order to ensure that the learning from investigations has been embedded into practice. Assurance from this process will be through the Clinical Improvement and Safety Group (CSIG).

Whilst changes to the SI policy were expected to be made during 2020/21 following the completion of a review of the SI Framework by NHS Improvement, it is expected that this updated framework will not be published during this current health crisis. At the present time, NHSE have stated that all SI reporting and investigation should be suspended, whilst Trusts are dealing with the Coronavirus crisis. However the directorates have decided that they will continue to report and investigate Serious Incidents, where possible, in order to avoid a potential backlog once the Coronavirus limitations have been lifted.

5. Duty of Candour (Quarter 4 report)

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

In the case of SIs, it is not always possible to immediately determine which, if any of the deaths under investigation meet the Duty of Candour requirements. Letters are issued by the Directorate of the treating team, expressing the Trust condolences and explaining that the Trust will be undertaking a review of the care provided. However should any investigation identify causal links between patient harm and service delivered, the Duty of Candour process would be initiated and a letter outlining the issues sent to the patient or next of kin. The current ongoing SI investigations may identify issues that meet the DoC criteria and therefore the requirements for DoC would be met through the SI process.

During Q4, there have been no incidents which met the criteria for reporting under the Duty of Candour requirements.

6. Conclusion

- The Trust continues to monitor all incidents on a weekly basis and this report demonstrates compliance with Trust policies and processes.
- The number of unexpected, potentially avoidable deaths has risen during Q4 however the total for 2019/20 has reduced by 38% over the previous 2018/19 reporting period.
- The learning from investigations, as outlined above, is cascaded across the Trust through a variety of governance processes. From the internal team and directorate processes across to full Trust cascade and through the Learning Lessons framework. This is to ensure that the learning from investigations is not completed in isolation and that a positive learning culture is maintained, through supporting staff with the opportunity to reflect and share learning.

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REPORT TO PUBLIC TRUST BOARD

Enclosure No: 9

Date of Meeting:	14th May 2020		
Title of Report:	Improving Quality & Performance Report [IQPR] Month 12		
Presented by:	Lorraine Hooper, Director of Finance, Performance & Estates		
Author:	Victoria Boswell, Associate Director of Performance		
Executive Lead Name:	Lorraine Hooper, Director of Finance, Performance & Estates	**Approved by Exec**	☒

Executive Summary:	**Purpose of report**	
In M4 the Trust implemented its new Improving Quality and Performance Report (IQPR). This is designed to use both traditional measures regarding meeting a target as well as measure for improvement via the use of Statistical Processing Charts (SPC). SPCs measure variation and establish, by using statistical techniques, whether this variation is within normal expectations or outside of them. It allows the Trust to move to improvement measurement, identifying where there are positive changes as well as enabling the early detection of any issues which can then be worked on and resolved. This method of measurement is very different to the way the Trust has previously reported. The current coronavirus incident means significant changes to services and service provision. There have been two new metrics included in this report to provide additional assurance during the Covid-19 incident: • the number of serious incidents • the number of patient safety incidents reported There are 17 RAG rated measures that have achieved target and 5 that have not achieved target and highlighted in red as exceptions. There are 2 special cause variation (orange variation flags - signifying concern). This is agency spend and sickness. There are 7 special cause variations (blue variation flags - signifying improvement). There are 12 metrics flagged with a common cause variation (grey variation flag). A grey shaded icon signifies no data or a zero value.	**Approval**	☐
	Information	☐
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☐ Performance Review – 28/04/20	Document Version No.	1.1
Committee Approval / Review	• Quality Committee ☒ • Finance & Resource Committee ☒ • Audit Committee ☐ • People, Culture & Development Committee ☒ • Charitable Funds Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration. ☐ 2. To provide the highest quality, safe and effective services ☒ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☒ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☐		

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Risk / legal implications: Risk Register Reference	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. The PIPs require directorates to set out the issues, actions and a trajectory for improvement to mitigate any risks in achieving compliance and maintaining the standard required. There have been no PIPs issued in M12.	
Resource Implications: Funding Source:	A Data Quality Improvement Plan is agreed with commissioners as part of the 2019/20 Contract to address data quality issues that may impact on performance.	
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.	
STP Alignment / Implications:	None at present time	
Recommendations:	The Board is asked to: • Receive the report as outlined • Note the Management actions	
Version	Name/group	Date issued
1.1	Public Board	29/04/20

Front Sheet Template V12 01.04.20

North Staffordshire Combined Healthcare NHS Trust

IQPR

Improving Quality & Performance Report

Board Report

Month 12: March 2020

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1. 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.

2. Highlights and Exceptions

There are 17 RAG rated measures that have achieved target and 5 that have not achieved target and highlighted in red as exceptions. There have been two new metrics included in this report to provide additional asurance during the Covid-19 incident:

- the number of serious incidents
- the number of patient safety incidents

There are 2 special cause variation (orange variation flag) – agency spend and sickness. There are 7 special cause variations (blue variation flags - signifying improvement). There are 12 metrics flagged with a common cause variation (grey variation flag). A grey shaded icon signifies no data or a zero value.

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.

The PIPs require directorates to set out the issues, actions and a trajectory for improvement to mitigate any risks in achieving compliance and maintaining the standard required. No PIPs were issued in M12.

Measure	Met/Not Met	Assurance	Variation	Exception	Narrative
1 - Referral to Treatment within 18 weeks	G				The target has been achieved during M12 with performance at 98.9% which is the highest level of performance during this financial year. ***PIP in place in Specialist Service Directorate.***
2 - CYP: Eating Disorders - Referral to Assessment (Urgent) 1 Week	N/A				There have been no urgent referrals for Children and Young People with Eating Disorders during Quarter 4.
3 - CYP: Eating Disorders - Referral to Assessment (Routine) 4 Weeks	G				The standard has been achieved in over the last 12 months with performance in Quarter 4 at 100%.
4 - Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment	G				90% of those referred in M12 commenced treatment within two weeks a slight decrease from M11 against a target of 53%.
5 - MH Liaison 1 Hour Response (Emergency)	G				Performance has consistently been met during the last 12 months, with only one exception in May 2019.
6 - MH Liaison 4 Hour Response (Urgent)	G				Performance has consistently been met during the financial year. 100% of urgent referrals were assessed within 4 hours in M12.
7 - MH Liaison 24 Hour Response (Urgent from General Hospital Ward)	G				Performance against the 24 hour response has improved from 96% in M11 to 97.9% in M12. Performance has been maintained for the last eight months.

8 - IAPT: Referral to Treatment (6 weeks)	G				The Trust continues to be highly performing against IAPT standard including the 6 weeks standard. Performance against the 6 week referral to treatment standard is 100% in M12.
9 - IAPT: Referral to Treatment (18 weeks)	G				The Trust continues to be highly performing with performance at 100% in M12.
10 - Care Programme Approach (CPA) 7 day Follow Up	G				The national standard has been met in M12 with performance at 97.9%
11 - Delayed Transfers of Care (DTOC)	G				Performance remains within target during M12 at 2.8%, reducing from 4.2% in M11. ***PIP in M10 in Acute and Urgent Care***
12 - Under 18 Admissions to Adult Acute Wards	G				There has been no under 18 year olds admitted to an adult acute ward during M12.
13 - CPA 12 Month Review Compliance	G				The target has been achieved during M12 and has been sustained for the last four months.
14 - IAPT : Recovery	G				Performance has decreased to 58.8% in M12 when compared to 63.3% in M11. Although performance has decreased the 50% recovery standard has been consistently achieved throughout the year.

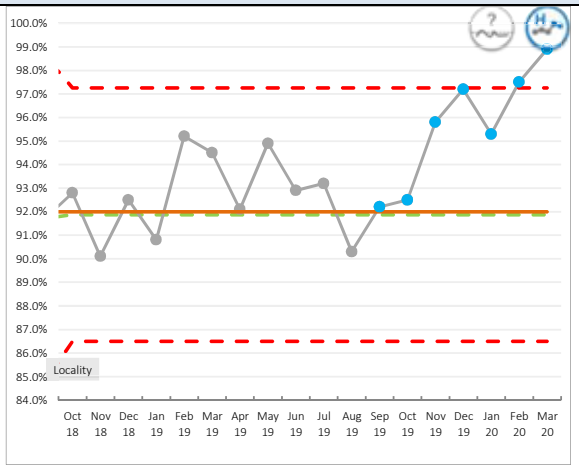
Measure	Assurance	Variation	Exception	Narrative	
15 - Service Users on CPA in settled accommodation	G				Performance during M12 has dipped to 45%, although continues to exceed the 31.4% standard.
16 - Service Users on CPA in Employment	G				Performance has dipped to 10.2% in M12: however it remains above the 7.8% standard.
17 - Sickness Absence	R			*	Sickness levels for December, January and February have been refreshed. March figure is currently reported at 5.49%
18 - Vacancy Rate	R			*	Performance in M12 has slightly increased to 10.7%.
19 - Staff Turnover	R			*	Staff turnover has decreased throughout the year and has further improved from 12.3% in M11 to 11.8% in M12, although remains over the 10% threshold.
20 - % Year to Date Agency Spend compared to Year to Date Agency Ceiling	R			*	The agency spend has remained at 11% greater than the ceiling during M12 and has steadily been increasing since June 2019. As anticipated the agency cap has not been achieved this year.
21 - Clinical Supervision	R			*	Performance has dipped under standard at 80% in M12.
22 - Appraisal	G				Performance has dipped slightly to 92.0% during M12 but remains well above target.
23 - Statutory & Mandatory Training	G				Performance has improved during M12 to 92.0% and the standard has consistently been met across all directorates throughout the year.

Access and Waiting Times

G - Referral to Treatment within 18 weeks ↗

A Higher Value Is Better

Actual	98.9%	M12	**Exec. Director of Operations**	Responsive
Target:	92.0%	Monthly	CCG	



12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
92.1%	94.9%	92.9%	93.2%	90.3%	92.2%	92.5%	95.8%	97.2%	95.3%	97.5%	98.9%

Trust	North Staffs Community	Stoke Community	Specialist Services
✓	✓	✓	✗
98.9%	98.9%	100.0%	90.2%

-- Context --
CCG and Trust indicator 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) --
The target has been achieved during M12 with performance at 98.9% which is the highest level of performance during this financial year. The target remains challenging for Specialist Services and closer monitoring is ongoing through the performance improvement plan.

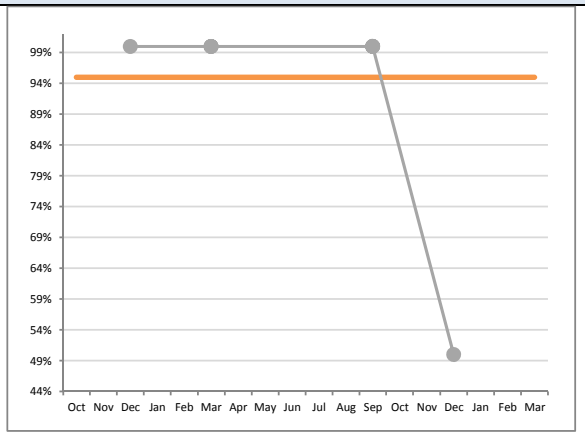
1

FPE,	Board,	Board (Private)	People,	Quality,

- CYP: Eating Disorders - Referral to Assessment (Urgent) 1 Week

A Higher Value Is Better

Actual	N/A	M12	**Exec. Director of Operations**	Responsive
Target:	95.0%	Quarterly	National	



12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
					100.0%			50.0%			

Trust
#N/A

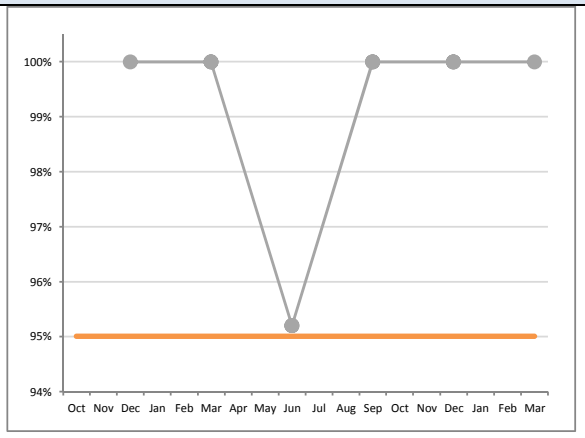
-- Context --
National target - 1 week or less from referral to entering a course of treatment under urgent ED cases is considered the benchmark due to the time sensitive nature of the service and the link between clinical outcomes and timeliness of service. Treatment is classed as 2nd successful contact.

-- Monthly Narrative (Key Issues and Actions) --
There have been no urgent referrals for Children and Young People with Eating Disorders during Quarter 4.

2

FPE,	Board,	Board (Private)	People,	Quality,

G - CYP: Eating Disorders - Referral to Assessment (Routine) 4 Weeks ↔ A Higher Value Is Better	Actual 100.0% M12	Exec. Director of Operations Responsive
	Target: 95.0% Quarterly	National



12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
		95.2%			100.0%			100.0%			100.0%

Trust
✓
100.0%

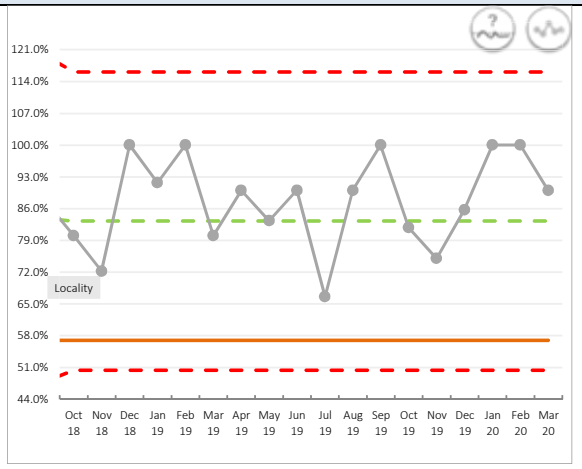
-- Context --
National target - 4 weeks or less from referral to entering a course of treatment under routine ED cases is considered the benchmark due to the time sensitive nature of the service and the link between clinical outcomes and timeliness of service. Treatment is classed as 2nd successful contact.

-- Monthly Narrative (Key Issues and Actions) --
The standard has been achieved in over the last 12 months with performance in Quarter 4 at 100%.

3

FPE,	Board,	Board (Private)	People,	Quality,

G - Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment ↘ A Higher Value Is Better	Actual 90.0% M12	Exec. Director of Operations Responsive
	Target: 57.0% Monthly	National



12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
90.0%	83.3%	90.0%	66.6%	90.0%	100.0%	81.8%	75.0%	85.7%	100.0%	100.0%	90.0%

Trust
✓
90.0%

-- 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 2nd successful contact.

-- Monthly Narrative (Key Issues and Actions) --
It is positive to note that 90% of those referred in M12 commenced treatment within 2 weeks a slight decrease from M11.

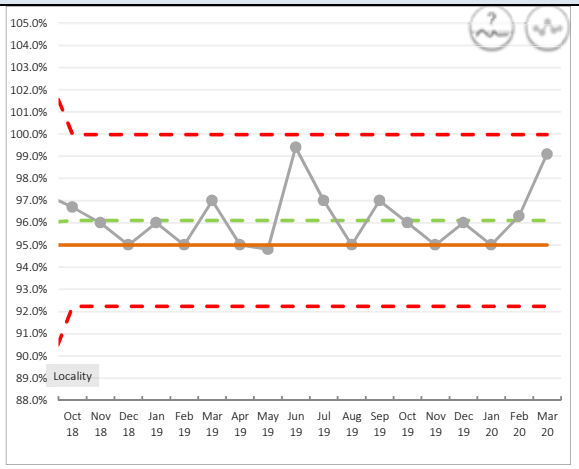
4

FPE,	Board,	Board (Private)	People,	Quality,

G - MH Liaison 1 Hour Response (Emergency) ↗

A Higher Value Is Better

Actual	99.1%	M12	**Exec. Director of Operations**	Responsive
Target:	95.0%	Monthly	CCG	



-- Context --
CCG 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 has consistently been met during the last 12 months, with only one exception in May 19.

12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
95.0%	94.8%	99.4%	97.0%	95.0%	97.0%	96.0%	95.0%	96.0%	95.0%	96.3%	99.1%

Trust
✓
99.1%

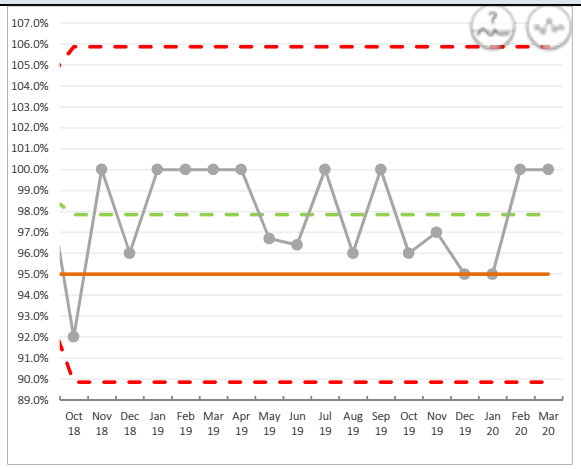
5

FPE,	Board,	Board (Private)	People,	Quality,

G - MH Liaison 4 Hour Response (Urgent) ↔

A Higher Value Is Better

Actual	100.0%	M12	**Exec. Director of Operations**	Responsive
Target:	95.0%	Monthly	CCG	



-- Context --
CCG 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 has consistently been met during the financial year. 100% of urgent referrals were assessed within 4 hours in M12.

12 Month Trend

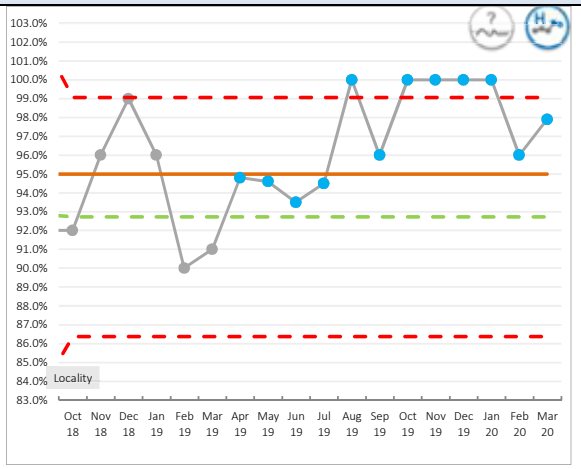
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
100.0%	96.7%	96.4%	100.0%	96.0%	100.0%	96.0%	97.0%	95.0%	95.0%	100.0%	100.0%

Trust
✓
100.0%

6

FPE,	Board,	Board (Private)	People,	Quality,

G - MH Liaison 24 Hour Response (Urgent from General Hospital Ward) ↗	Actual 97.9% M12	Exec. Director of Operations	Responsive
A Higher Value Is Better	Target: 95.0% Monthly	CCG	



12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
94.8%	94.6%	93.5%	94.5%	100.0%	96.0%	100.0%	100.0%	100.0%	100.0%	96.0%	97.9%

-- Context --
CCG 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.

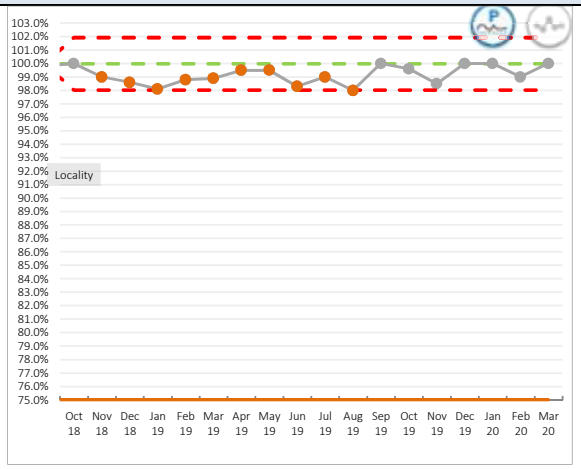
-- Monthly Narrative (Key Issues and Actions) --
Performance against the 24 hour response has improved from 96% in M11 to 97.9% in M12. Performance has been maintained above target level for the last eight months.

Trust
✓
97.9%

7

FPE,	Board,	Board (Private)	People,	Quality,

G - IAPT: Referral to Treatment (6 weeks) ↗	Actual 100.0% M12	Exec. Director of Operations	Safe
A Higher Value Is Better	Target: 75.0% Monthly	National	



12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
99.5%	99.5%	98.3%	99.0%	98.0%	100.0%	99.6%	98.5%	100.0%	100.0%	99.0%	100.0%

-- 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) --
The Trust continues to be highly performing against IAPT standards including the 6 week standard and compares favourably when benchmarked nationally.
Performance against the 6 week referral to treatment standard is 100% in M12.

Trust
✓
100.0%

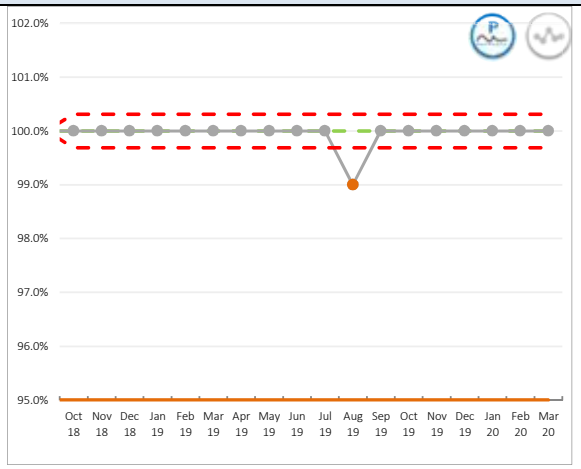
8

FPE,	Board,	Board (Private)	People,	Quality,

G - IAPT: Referral to Treatment (18 weeks) ↔

A Higher Value Is Better

Actual	100.0%	M12	Exec. Director of Operations	Safe
Target:	95.0%	Monthly	National	



-- 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) --
The Trust continues to be highly performing against IAPT standards including 18 week standards with performance at 100% in M12.

12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
100.0%	100.0%	100.0%	100.0%	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Trust
✓
100.0%

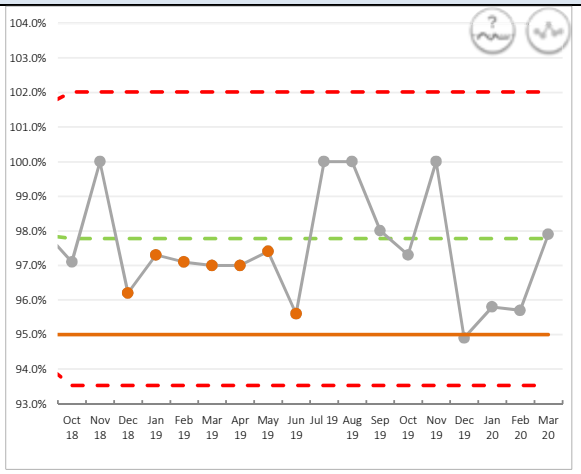
9

FPE,	Board,	Board (Private)	People,	Quality,

G - Care Programme Approach (CPA) 7 day follow up ↗

A Higher Value Is Better

Actual	97.9%	M12	Exec. Director of Operations	Safe
Target:	95.0%	Monthly	National	



-- 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) --
The national standard has been met in M12 with performance at 97.9%. Performance has been maintained throughout the year with the exception of December 2019.

12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
97.0%	97.4%	95.6%	100.0%	100.0%	98.0%	97.3%	100.0%	94.9%	95.8%	95.7%	97.9%

Trust	North Staffs Community	Stoke Community	Specialist Services	Acute and Urgent Care
✓	✗	✓	✓	✓
97.9%	94.4%	100.0%	100.0%	100.0%

10

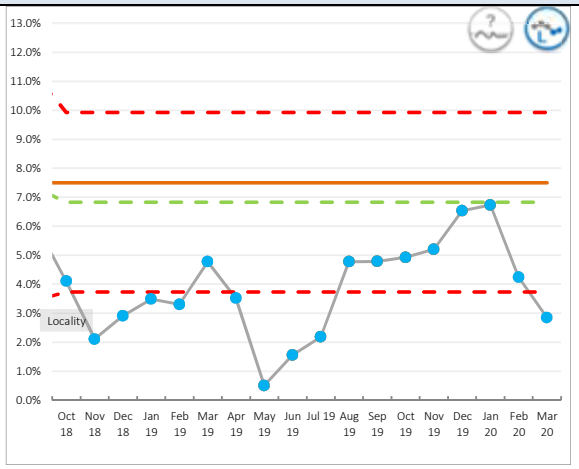
FPE,	Board,	Board (Private)	People,	Quality,

Inpatient and Quality Metrics

G - Delayed Transfers of Care (DTOC) ↗

A Lower Value Is Better

Actual	2.8%	M12	**Exec. Director of Operations**	Responsive
Target:	7.5%	Monthly	Trust Measure	



12 Month Trend

3.5%	0.5%	1.6%	2.2%	4.8%	4.8%	4.9%	5.2%	6.5%	6.7%	4.2%	2.8%
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

Trust	Specialist Services	Acute and Urgent Care
✓	✓	✓
2.8%	0.0%	3.7%

-- Context --
To understand the number of patients who have been declared medically fit for discharge but remain in inpatient service - has care quality and resource use implications.

-- Monthly Narrative (Key Issues and Actions) --
Performance remains within target during M12 at 2.8%, reducing from 4.2% in M11, as a result of preparations for management of covid19 response across the system.

Ongoing validation work continues to be undertaken to ensure that delayed transfer data is recorded appropriately within Lorenzo.

Closer monitoring in the Acute and Urgent Care directorate has been undertaken.

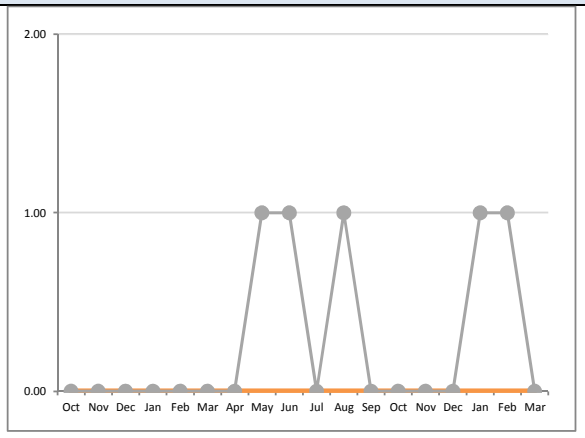
11

FPE,	Board,	Board (Private)	People,	Quality,

G - Under 18 Admissions to Adult Acute Wards ↗

A Lower Value Is Better

Actual	0.00	M12	**Exec. Director of Operations**	Safe
Target:	0.00	Monthly	National	



12 Month Trend

0	1	1	0	1	0	0	0	0	1	1	0
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

Trust
✓
0.00

-- Context --
The number of children and young people who are admitted to an adult inpatient ward. This is a count of people, aged under 18, who were on an adult ward at any point during the month.

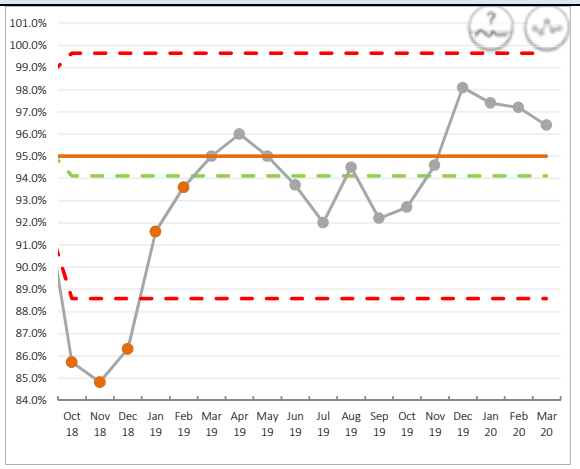
-- Monthly Narrative (Key Issues and Actions) --
The have been no under 18 year olds admitted to an adult acute ward during M12.

12

FPE,	Board,	Board (Private)	People,	Quality,

Community and Quality Metrics

G - CPA 12 Month Review Compliance ↘	Actual 96.4% M12	Exec. Director of Operations Safe
A Higher Value Is Better	Target: 95.0% Monthly	CCG



12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
96.0%	95.0%	93.7%	92.0%	94.5%	92.2%	92.7%	94.6%	98.1%	97.4%	97.2%	96.4%

Trust	North Staffs Community	Stoke Community	Specialist Services
✓	✓	✓	✓
96.4%	97.4%	95.1%	97.5%

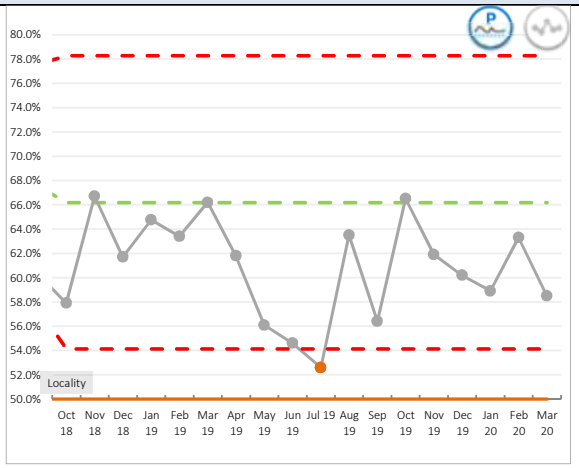
-- Context --
There is a requirement for all services users on a CPA pathway to receive a review of their care plan as a minimum within 12 months of the care plan being agreed.

-- Monthly Narrative (Key Issues and Actions) --
Following the implementation of Performance Improvement Plans, all directorates have achieved the 95% standard for the last four months. Performance has been sustained at 96.4% during M12.

13

FPE,	Board,	Board (Private)	People,	Quality,

G - IAPT: Recovery ↘	Actual 58.5% M12	Exec. Director of Operations Safe
A Higher Value Is Better	Target: 50.0% Monthly	National



12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
61.8%	56.1%	54.6%	52.6%	63.5%	56.4%	66.5%	61.9%	60.2%	58.9%	63.3%	58.5%

Trust
✓
58.5%

-- Context --
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 has decreased to 58.5% in M12 from 63.3% in M11, although the 50% recovery standard has been consistently achieved throughout the year.

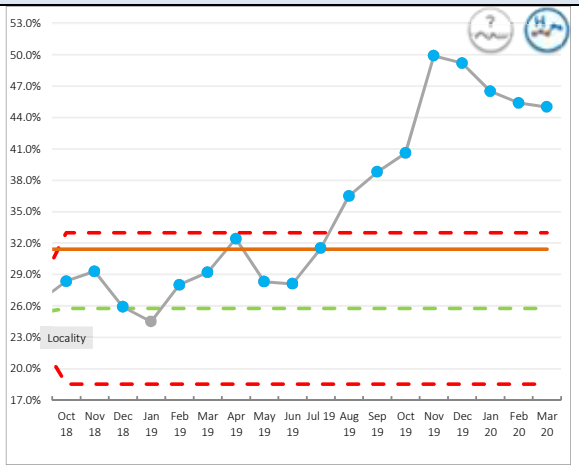
14

FPE,	Board,	Board (Private)	People,	Quality,

G - Service Users on CPA in settled accommodation ↘

A Higher Value Is Better

Actual	45.0%	M12	**Exec. Director of Operations**	Safe
Target:	31.4%	Monthly	National	



12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
32.4%	28.3%	28.1%	31.5%	36.5%	38.8%	40.6%	49.9%	49.2%	46.5%	45.4%	45.0%

Trust	North Staffs Community	Stoke Community	Specialist Services	Acute and Urgent Care
✓	✗	✓	✓	✓
45.0%	20.4%	65.6%	36.7%	100.0%

-- Context --

National metric - 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 during M12 has dipped to 45% and continues to exceed the 31.4% standard. The special cause variation has been operating outside of the upper control limit for seven months. This will be reviewed as part of the Q4 change control process.

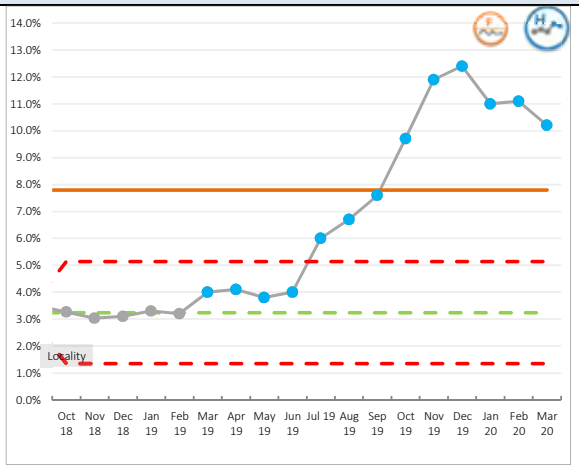
15

FPE,	Board,	Board (Private)	People,	Quality,

G - Service Users on CPA in Employment ↘

A Higher Value Is Better

Actual	10.2%	M12	**Exec. Director of Operations**	Safe
Target:	7.8%	Monthly	National	



12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
4.1%	3.8%	4.0%	6.0%	6.7%	7.6%	9.7%	11.9%	12.4%	11.0%	11.1%	10.2%

Trust	North Staffs Community	Stoke Community	Specialist Services	Acute and Urgent Care
✓	✗	✓	✗	✗
10.2%	3.4%	18.5%	1.4%	0.0%

-- Context --

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 has dipped to 10.2% in M12 but remains above the 7.8% standard.

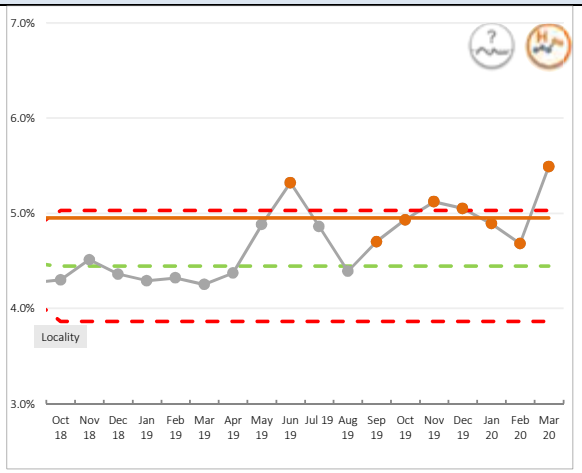
The special cause variation has been operating outside of the upper control limit for some time and will be reviewed as part of the Q4 change control process.

16

FPE,	Board,	Board (Private)	People,	Quality,

Organisational Health and Workforce

R- Sickness Absence	Actual 5.49% M12	Executive Director of Workforce	Organisational Health
A Lower Value Is Better	Target: 4.95% Monthly	Trust Measure	



12 Month Trend

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
4.37%	4.88%	5.32%	4.86%	4.39%	4.70%	4.93%	5.12%	5.05%	4.89%	4.68%	5.49%

-- 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) --
December figures have now been confirmed and sickness levels are reported above the 4.95% standard. January and February figures have been updated and suggest sickness absence is currently within the 4.95% standard, although it should be noted that this may change when refreshed.

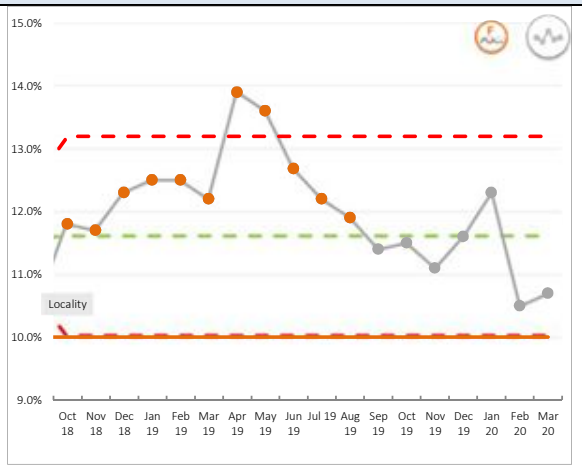
March's figure is currently reported at 5.49%. It is expected that sickness levels will dramatically increase in the coming weeks/months as a result of Covid-19.

The HR Advisory Team Is supporting Directorate's to ensure that all absences are managed in accordance with the national guidance and Trust policy.

17

FPE,	Board,	Board (Private)	People,	Quality,

R - Vacancy Rate ↘	Actual 10.7% M12	Executive Director of Workforce	Organisational Health
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
13.9%	13.6%	12.7%	12.2%	11.9%	11.4%	11.5%	11.1%	11.6%	12.3%	10.5%	10.7%

Trust	North Staffs Community	Stoke Community	Specialist Services	Acute and Urgent Care
✗	✓	✗	✗	✗
10.7%	5.9%	14.4%	12.5%	10.8%

-- 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 target was rebased to 10% in M7. Performance in M12 has increased slightly to 10.7%.

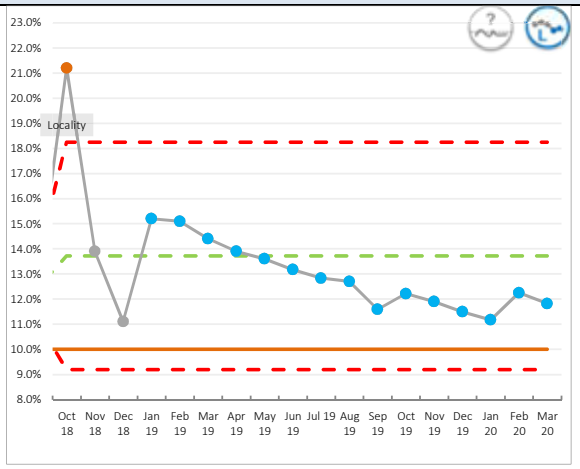
The vacancy standard has been achieved in North Staffs, with the other Directorates over target in M12. The Trust is incorporating a number of strategies to recruit and retain staff to reduce the vacancy rate.

Furthermore, the National Schemes such as the Bring Back Scheme and early release of Student Nurses is expected to significantly inject additional workforce supply into the Trust to support both COVID-19 activity and baseline vacancies.

18

FPE,	Board,	Board (Private)	People,	Quality,

R - Staff Turnover ↗	Actual 11.8% M12	Executive Director of Workforce	Organisational Health
A Lower Value Is Better	Target: 10.0% Monthly	Trust Measure	



12 Month Trend

13.9%	13.6%	13.2%	12.8%	12.7%	11.6%	12.2%	11.9%	11.5%	11.2%	12.3%	11.8%
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

Trust	North Staffs Community	Stoke Community	Specialist Services	Acute and Urgent Care
✗	✗	✓	✗	✓
11.8%	18.1%	9.1%	11.1%	9.9%

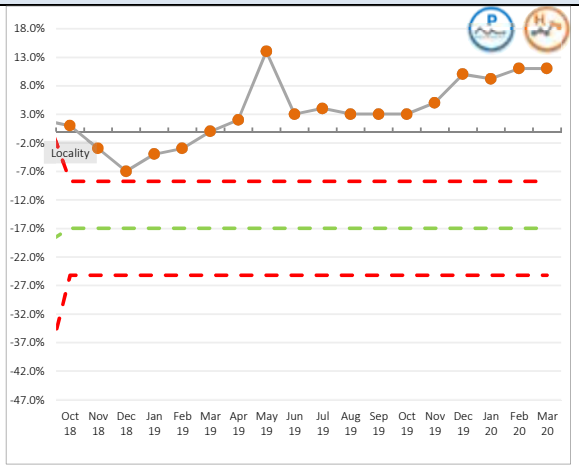
-- Context --
Trust measure - High turnover represents an unstable workforce with high costs associated with turnover - retention represents a more stable organisation that is a positive place to work and provides continuity of care to service users.

-- Monthly Narrative (Key Issues and Actions) --
Staff turnover has decreased throughout the year and has further improved from 12.3% in M11 to 11.8% in M12 although remains over the 10% threshold.

19

FPE,	Board,	Board (Private)	People,	Quality,

R - % Year to Date Agency Spend compared to Year to Date Agency Ceiling ↔	Actual 11.0% M12	Exec. Director of Operations	Organisational Health
A Lower Value Is Better	Target: 0.0% Monthly	National	



12 Month Trend

2.0%	14.0%	3.0%	4.0%	3.0%	3.0%	3.0%	5.0%	10.0%	9.2%	11.0%	11.0%
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

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

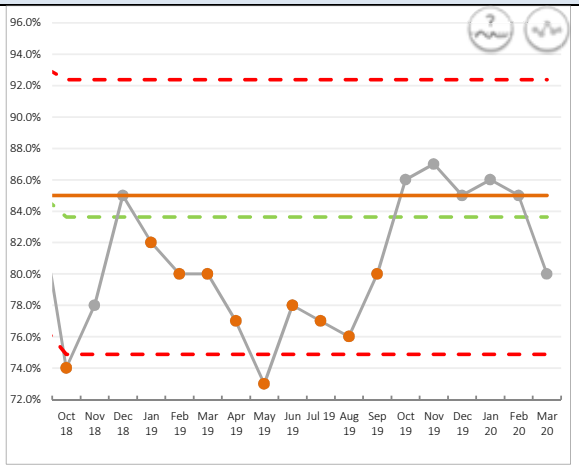
-- Monthly Narrative (Key Issues and Actions) --
The agency spend has remained static at 11.0% greater than the ceiling during M12 and performance has been increasing since June 2019.

As anticipated the agency cap has not been achieved this year.

20

FPE,	Board,	Board (Private)	People,	Quality,

R - Clinical Supervision ↘	Actual 80.0% M12	Executive Director of Workforce	Organisational Health
A Higher Value Is Better	Target: 85.0% Monthly	Trust Measure	



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

-- Monthly Narrative (Key Issues and Actions) --
The 85% target has not been achieved during M12 Trust side and in the Specialist Services and Stoke Locality Directorate.

12 Month Trend

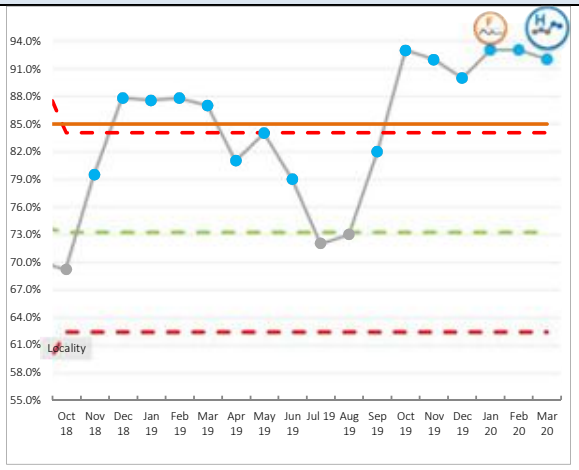
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
77.0%	73.0%	78.0%	77.0%	76.0%	80.0%	86.0%	87.0%	85.0%	86.0%	85.0%	80.0%

Trust	North Staffs Community	Stoke Community	Specialist Services	Acute and Urgent Care
✗	✓	✗	✗	✓
80.0%	90.0%	74.0%	75.0%	85.0%

21

FPE,	Board,	Board (Private)	People,	Quality,

G - Appraisal ↘	Actual 92.0% M12	Executive Director of Workforce	Organisational Health
A Higher Value Is Better	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 has dipped slightly to 92.0% during M12 but remains above target.

During the COVID pandemic achievement of completing appraisals has been categorised as non-critical aligned with national guidance.

12 Month Trend

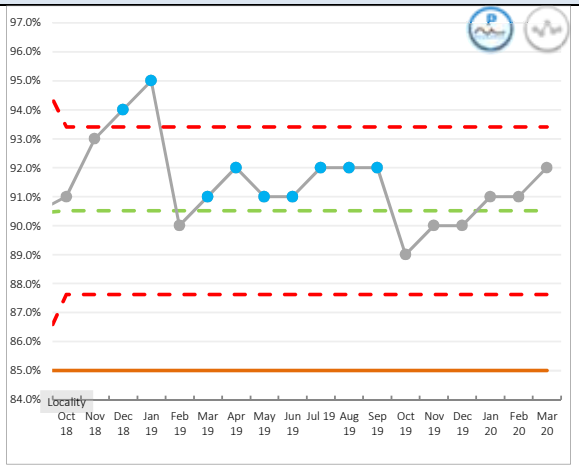
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
81.0%	84.0%	79.0%	72.0%	73.0%	82.0%	93.0%	92.0%	90.0%	93.0%	93.0%	92.0%

Trust	North Staffs Community	Stoke Community	Specialist Services	Acute and Urgent Care
✓	✓	✓	✓	✓
92.0%	90.0%	93.0%	94.0%	96.0%

22

FPE,	Board,	Board (Private)	People,	Quality,

G - Statutory & Mandatory Training ↗	Actual 92.0% M12	Executive Director of Workforce	Organisational Health
A Higher Value Is Better	Target: 85.0% Monthly	Trust Measure	



12 Month Trend

92.0%	91.0%	91.0%	92.0%	92.0%	92.0%	89.0%	90.0%	90.0%	91.0%	91.0%	92.0%
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

Trust	North Staffs Community	Stoke Community	Specialist Services	Acute and Urgent Care
✓	✓	✓	✓	✓
92.0%	94.0%	93.0%	94.0%	92.0%

-- 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 has improved during M12 to 92% and the standard has consistently been met across all directorates and throughout the year.

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FPE,	Board,	Board (Private)	People,	Quality,

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

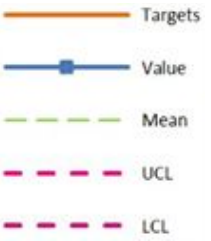
An SPC chart has a mean line and two control lines, both of which allow more statistical interpretation. These control lines are 3σ (3 Sigma) away from the Mean - with recalculation of these lines occurring when significant changes in the process occur.

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

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REPORT TO PUBLIC TRUST BOARD

Enclosure No: 10

Date of Meeting:	14th May 2020		
Title of Report:	Quality Committee Summary Report		
Presented by:	Patrick Sullivan, Non-Executive Director		
Author:	Patrick Sullivan, Non-Executive Director		
Executive Lead Name:	Dr Buki Adeyemo, Executive Medical Director	**Approved by Exec**	☒

Executive Summary:		**Purpose of report**	
The attached assurance report describes the business and outputs from the meeting of the Quality Committee on the 7th May 2020.		**Approval**	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☒ • Finance & Resource Committee ☐ • Audit Committee ☐ • People, Culture & Development Committee ☒ • Charitable Funds Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration ☒ 2. To provide the highest quality, safe and effective services ☒ 3. Inspire and implement innovation and research. ☒ 4. Embed an open and learning culture that enables continual improvement. ☒ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☐		
Risk / legal implications: Risk Register Reference	To provide assurance to the Board on quality of services, issues of concern and remedial action being taken.		
Resource Implications: Funding Source:	None highlighted		
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.		
STP Alignment / Implications:	None as part of this report		
Recommendations:	Receive for assurance purposes and ratify policies highlighted		

Version	Name/group	Date issued

North Staffordshire Combined Healthcare NHS Trust

Key points from the Quality Committee meeting held on 7 May 2020 for the Trust Board meeting on 14 May 2020

1. Introduction

This is the regular report to the Trust Board that has been produced following the last meeting of the Quality Committee with items aligned to the Trust's SPAR objectives. This report deals with the meeting that took place on 7 May 2020. This meeting was held remotely using Microsoft teams.

2. Reports received for review, information and/or approval

Reports for Assurance

- **COVID-19 Update –** This report provided assurances on the measures in place to manage the clinical problems presented by the COVID 19 outbreak. At the time of the meeting two wards were closed to admissions due to COVID19 – these are ward 5 and 6. Ward 4 is being used to cohort patients who are COVID19 positive. No current cases in the other wards although the situation is subject to change. At the moment there have been no spikes in demand, but the service is starting to see the admission of patients who have become ill or relapsed due the current situation. Liaison teams are also beginning to see increased numbers of young people presenting in crisis due to self-injury.

- **IQPR M12 2019/20 -** There are 23 RAG rated measures that have achieved target and 9 that have not achieved target and highlighted in red as exceptions. There have been two new metrics included in this report to provide additional asurance during the Covid-19 incident:
  - the number of serious incidents
  - the number of patient safety incidents

  There is 1 special cause variation agency spend. The report effectively provides a baseline for performance prior to the COVID 19 crisis.

  The performance team are also in the process of collating information/data relating to COVID19 in order to support planning, this relates to demand, patient flow and referral patterns.

- **Safe Staffing Report – March 2020** - During March 2020 an overall fill rate of 91.7% was achieved; this is a decrease from the February 2020 position. During the COVID19 crisis the Trust no longer has to submit figures externally, but they will continue to be monitored and reported internally.

- **Board Assurance Framework Q4 2019/20 and Q1 2020/21** -The Q4 2019/20 BAF provides oversight and update of the key controls and assurances to be introduced to ensure delivery of the seven strategic objectives. This also gives an indication for the Committee to consider of the items to take forward into 20/21 on a temporary 6 month basis due to COVID-19 challenges

- **Eliminating Mixed Sex Accommodation -** This report provided annual assurance and compliance with regard to the Trust's EMSA requirements.

- **Clinical Professional Advisory Group (CPAG)** - This summary provided assurance regarding the activities and outputs from The Clinical Professional Advisory Group (CPAG)

Reports for information

- **Quality Account –** A verbal update was provided and assurance given that the Quality Account will be published on time in accordance with the Project Plan.

Reports for scrutiny

Directorate Dashboards - Each Clinical Director (or nominated deputy) presented the report and the balanced scorecard for their area of responsibility. Areas of good practice were highlighted, challenges to services identified and areas of continued improvement noted. The board should note:

- Redeployment of staff from different community teams
- Support provided to care homes through the home liaison service
- Continuing challenges associated with the S75 partnership arrangements with Stoke on Trent City Council
- Some fall off in demand, but an increase anticipated, and this has started to be seen in other parts of the country
- Staffing difficulties in some teams (pre-dates COVID19) has some impact on performance
- Directorates maintaining a good position in terms of performance
- Excellent response from staff in working flexibly and in different ways
- Increased use of digital methods to support clinical services
- Good systems of governance and assurance in place
- Effective ways of delivering services developed in challenging circumstances
- Importance of not losing the gains associated with new methods of working and different systems of decision making when the current crisis recedes

3. Policy report

7.07 De-Commissioning Policy – Approved for three years

The following were approved by the Clinical Professional Advisory Group in response to the current COVID19 crisis

SOP1 Presentation of the Symptomatic MH and LD patient COVID-19 in the community
SOP2 Presentation of the Symptomatic patient COVID-19 in inpatient environment
SOP3 Isolation of a singular patient on an inpatient ward
SOP4 COVID-19 ward containment
SOP5 Advice for staff following patient contact positive or symptomatic
SOP6a Self isolating staff who live alone
SOP6b Self isolating staff who live with others
SOP7 Using video for remote consultations in NSCHT
SOP8 Patients own drugs for COVID patients
SOP9 Advice for HCPs supply of Clozapine for patients during COVID
SOP10 Guidance on the Management of Depots during COVID

SOP11 Remote Prescribing
SOP12 Remote Verbal Orders

Next meeting: 6 June 2020

Committee Chair, Mr Patrick Sullivan
Non-Executive Director
7 May 2020

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REPORT TO PUBLIC TRUST BOARD

Enclosure No: 11

Date of Meeting:	14th May 2020		
Title of Report:	Finance Position Month 12		
Presented by:	Lorraine Hooper – Executive Director of Finance, Performance & Estates		
Author:	Michelle Wild – Financial Controller		
Executive Lead Name:	Lorraine Hooper – Executive Director of Finance, Performance & Estates	**Approved by Exec**	☒

Executive Summary:		**Purpose of report**	
The report summarises the finance position at month 12 (March 2020)		**Approval**	☐
		Information	☐
		Discussion	☐
		Assurance	☒
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 Objectives (please indicate)	1. To enhance service user and carer collaboration. ☐ 2. To provide the highest quality, safe and effective services ☐ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☐ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☐		
Risk / legal implications: Risk Register Reference	Links to Trust risks around delivery of recurrent cost improvement target and delivery of trust financial position.		
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;		
STP Alignment / Implications:	Part of the aggregate STP reported financial position		

Front Sheet Template V12 01.04.20

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Recommendations:	The Trust Board are asked to: Receive the Month 12 position noting: • The reported year surplus of £1,575k against a planned surplus of £1,038k. This is a favourable variance to plan of £537k. • The M12 internal CIP achievement of £2,391k; an adverse variance of £114k to plan • The cash position of the Trust as at 31st March 2020 with a balance of £12,060k; £3,706k higher than plan. • Total Agency expenditure of £2,426k against the agency cap of £2,187k; an adverse variance of £239k to plan. • Use of resource rating of 2 against a plan of 1. • Price cap breaches for Medics and off-framework use at M12. Approve: • M12 expenditure on Agency of £2,426k reported to NHSI, £239k over the agency cap.	
Version	Name/group	Date issued
1	N/A	23/04/2020

Front Sheet Template V12 01.04.20

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Financial Overview as at 31 March 2020

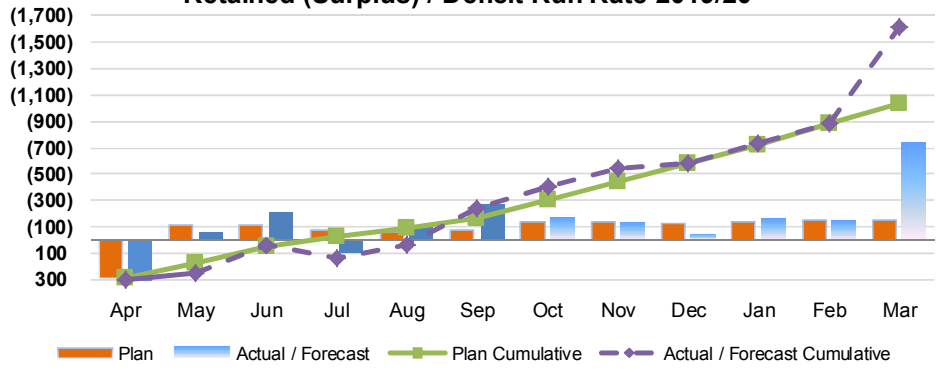
Income & Expenditure - Control Total (Surplus) / Deficit

£000	Plan	Actual	Var	%	RAG
YTD	(1,038)	(1,575)	(537)	(52)	G

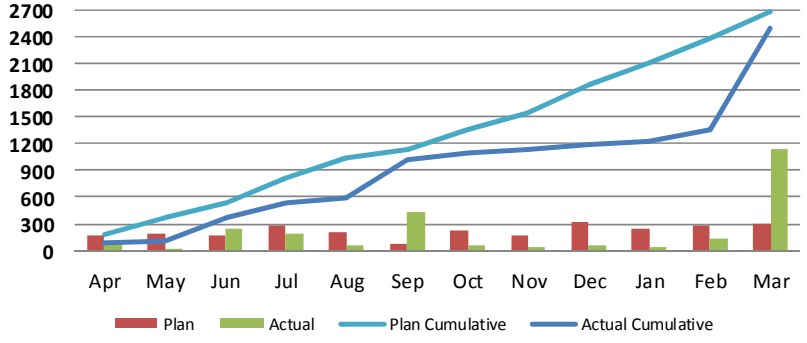
Charge to CRL

£000	Plan	Actual	Var	%	RAG
YTD	2,676	2,499	(177)	(7)	G

Retained (Surplus) / Deficit Run Rate 2019/20



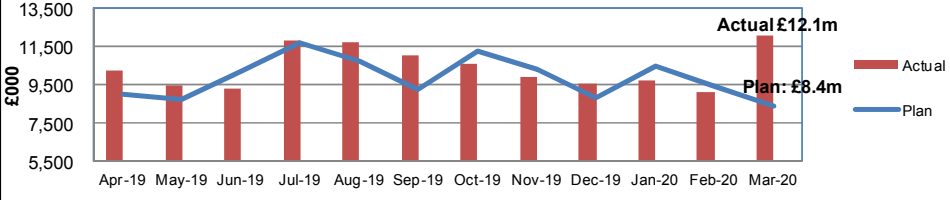
Net Capital Expenditure - Plan / Actual 2019/20



Cash Balances

£000	Plan	Actual	Var	%	RAG
YTD	8,354	12,060	3,706	44	G

Cash Balances - Actual/Forecast against Plan 2019/20



Cost Improvement

£000	Plan	Actual	Var	%	Rec Var	RAG
Clinical	1,987	1,690	(297)	(15)	(1,041)	R
Corporate	518	701	183	35	(243)	G
Total	2,505	2,391	(114)	(5)	(1,284)	R

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

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Introduction:

The Trust's 2019/20 financial plan is to deliver a trading position of £338k surplus. The trust has accepted the Control Total from NHS Improvement (NHSI) of £1,038k surplus which includes £700k from the Provider Sustainability Funding (PSF).

1. Income & Expenditure (I&E) Performance

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

- During month 12, the trust had an in month trading position of £346k surplus against a plan of £84k surplus; **giving a favourable variance of £262k**. Provider sustainability funding (PSF) has been assumed at £81k in line with plan giving an in month surplus of £695k against a plan of £165k surplus, **a favourable variance in month of £530k.**

- The Trust has a year-end trading position of £42k deficit against a planned surplus of £338k, **giving an adverse variance of £380k** including impairments of £955k. Impairments and LGPS do not form part of the control total, therefore when added back give a surplus of £875k against a planned surplus of £338k. PSF is £700k against a plan of £700k, giving a year-end surplus of £1,575k against a planned surplus of £1,038k, **a favourable variance of £537k.**

		Month 12			Final Outturn		
Table 1: Summary Performance	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
Income	(95,014)	(7,995)	(9,388)	(1,392)	(95,014)	(95,515)	(501)
Pay	69,249	5,820	5,922	102	69,249	66,874	(2,375)
Non Pay	21,000	1,723	2,532	809	21,000	23,272	2,272
EBITDA	**(4,764)**	**(453)**	**(934)**	**(481)**	**(4,764)**	**(5,368)**	**(604)**
Other Non-Op Costs	4,426	369	588	219	4,426	5,410	984
Trading (Surplus) / Deficit	**(338)**	**(84)**	**(346)**	**(262)**	**(338)**	**42**	**380**
Add Back Non Current Asset Impairments	0	0	(306)	(306)	0	(955)	(955)
Remove LGPS Benefit	0	0	38	38	0	38	38
Control Total pre Provider Sustainability Funding	**(338)**	**(84)**	**(614)**	**(530)**	**(338)**	**(875)**	**(537)**
Provider Sustainability Funding	(700)	(81)	(81)	0	(700)	(700)	0
Performance against Control Total for the Year	**(1,038)**	**(165)**	**(695)**	**(530)**	**(1,038)**	**(1,575)**	**(537)**

2. Risks

2.1 Delivery of 2019/20 Control Total

The Trust has delivered its 2019/20 Control Total therefore this is no longer a relevant risk.

2.2 Long Term Sustainability

a. **Recurrent Cost Improvement –** Risk = £1,284k recurrently against internal trust target for 2019/20 based on identified schemes. There is a risk that CIP and run rate reductions do not happen as planned in 2020/21 resulting in inability to deliver the planned surplus in future years. The pausing of CIP for months 1 – 4 due to COVID19 has increased this risk.

Mitigations

- Recruitment to transformation team underway
- Establishment of a 2 year CIP development programme including Exec led CIP Gateway review meetings
- Ongoing development of transformational schemes with divisional and corporate teams
- Monthly review of CIP progress through Finance and Resource Committee.

b. **Loss of business –** Risk of major tender losses and an inability to divest

Mitigations

- Strategic and Business Development team continue to review and learn from unsuccessful tenders submitted to increase our ability to win in the future.
- Intra-STP tender provider collaborative tender bids to continue to build on the partnership working to ensure services are retained with the NHS
- Diversification into Primary Care

c. **2020/21 Contract Risk -** There is a risk that the CCG contract value is insufficient and / or the CCG seek to rebase the IFP leading to redistribution of the deficit causing an inability to deliver financial balance

Mitigations

- Trust and STP DoF discussions during March concluded with a mutually agreeable position on the IFP value for 20/21 prior to the postponement of operational planning due to COVID19.

2.3 Regulator Risk
There is risk that by exceeding the agreed agency ceiling with NHSI the Trusts Use of Resources metric will be affected leading to potential increased spend, lower quality & additional scrutiny from regulators.

Mitigations
- Monthly review of agency spend through Finance and Resource Committee
- Executive level agency authorisation

2.4 Cash
The risk is that if cash is not managed efficiently then the trust would be unable to pay off debts as they fall due and capital plan requirements are in excess of the revenue available to support it.

Mitigations
- Monthly review of Better Payment Practice Code by the Finance and Resource Committee.
- Monthly review of Statement of Financial Position by the Finance and Resource Committee.

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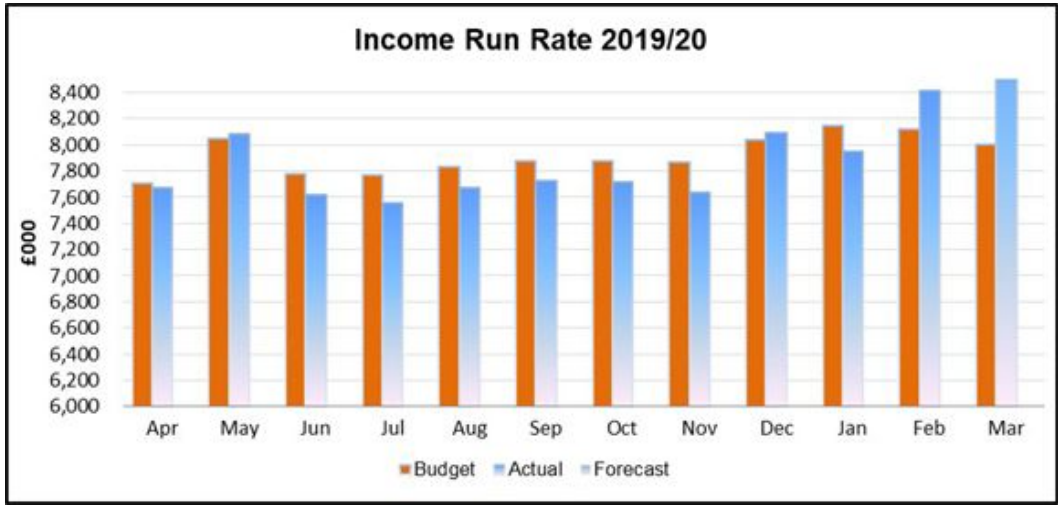
3. Run Rates

3.1 Income Run Rates

Actual and Budget income run rates are shown.

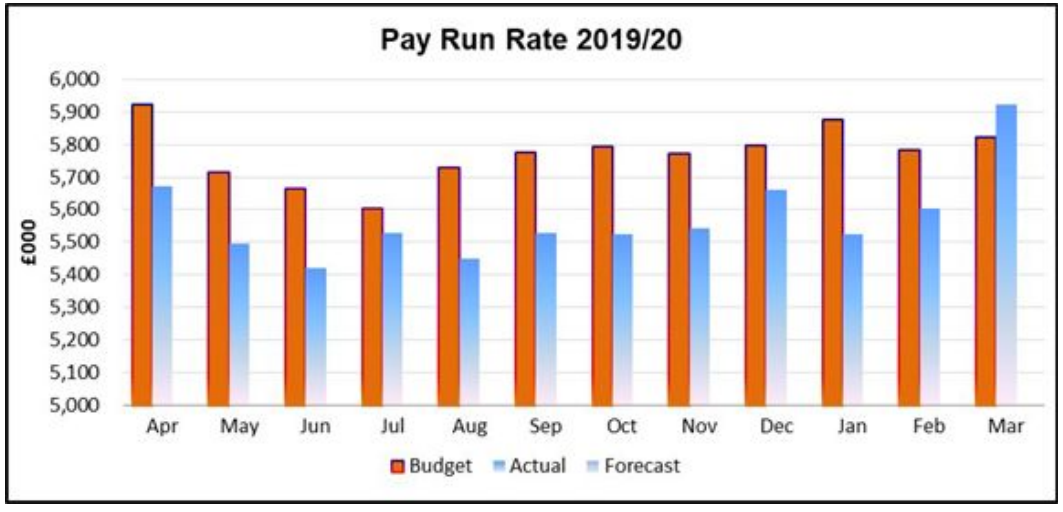
- Income in May is higher due to £347k received for section 75 Transformational Funds
- During February a non-nhs credit note provision was dropped as we received confirmation that payment will be made.
- Income in March 2020 is higher due to COVID-19 funding, Specialised Services and Mental Health Investment Income at £463k.



3.2 Pay Run Rates

Actual and Budget run rates for pay are shown.

- Additional redundancy provisions for anticipated service changes and winter pressures schemes included in latter months
- Variance to budget due to level of vacancies in early part of the year
- In March pay is higher than budget due to agency and additional hours due to COVID-19.



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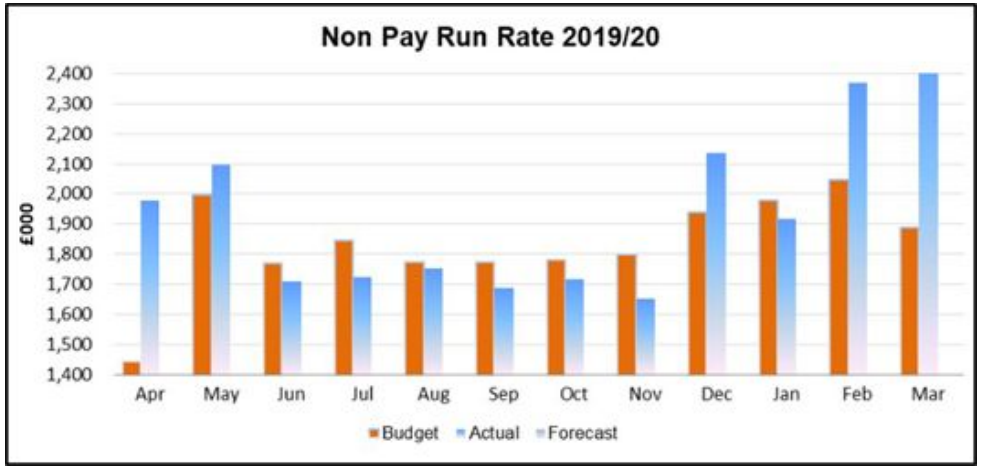
3.3 Non Pay Run Rates

Actual and Budget run rates for non-pay are shown.

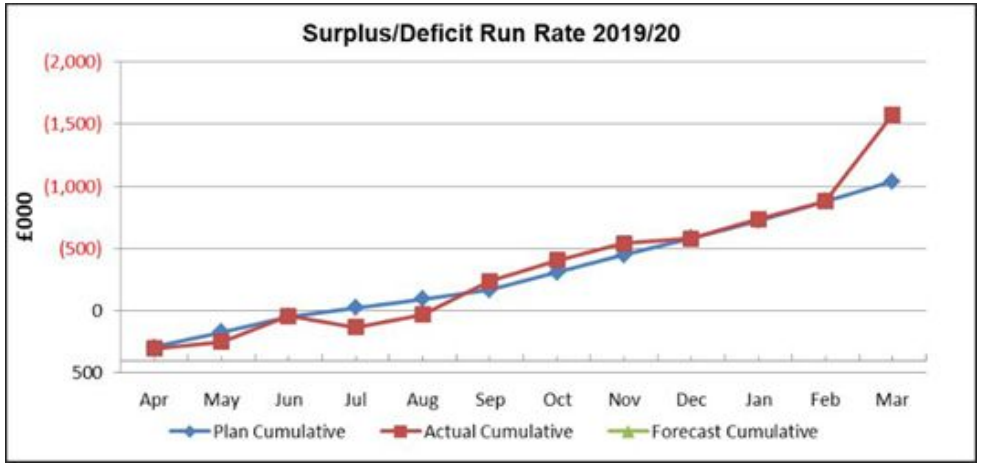
- Non Pay in December and March is higher due to total fixed asset impairment of £955k for the year.
- Non Pay Actuals are higher in later months due to part year effects of new schemes. The spike in February and March relates to the recognition of non pay provisions.



3.4 Surplus/Deficit Run Rates

Plan and Actual run rates for 2019/20 surplus/deficit are shown.

- At month 12 there is a favourable variance of £530k compared to plan mainly due to income as explained above.



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4. Income

Table 2 below shows the Trust income position.

- The NHS Stoke-on-Trent CCG and NHS North Staffordshire CCG contracts are set on a block basis. The figures currently assume:
  - £2,545k of the CCG underwriting agreement is paid through income (see appendix B).
  - £507k of the £1,000k STP efficiency savings are currently assumed to be delivered following a system stock take in September.
  - The year to date variances relate to 2018/19 under achievement of CQUIN and STP Sprint investment CVs.
- Associates over-performance relates entirely to 2018/19 over-performance, raised in month 1.
- OATs have underperformed by £290k year to date mainly due to lower activity in substance misuse.
- Other income includes Primary Care which has a full year position of £2,304k and an additional £463k additional Mental Health Cash Support notified in late March.
- The trust incurred £80k of revenue expenditure due to COVID-19 during the financial year 2019/20; this has been fully reimbursed by NHS England.

		Month 12			Final Outturn		
Table 2: Income	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
NHS Stoke-on-Trent CCG	(40,340)	(3,473)	(3,945)	(472)	(40,340)	(40,754)	(414)
NHS North Staffordshire CCG	(27,106)	(2,283)	(2,235)	48	(27,106)	(26,427)	679
Staffordshire Associates	(980)	(113)	(72)	41	(980)	(949)	31
Other Associates	(289)	(24)	(32)	(8)	(289)	(363)	(73)
University Hospital of North Staffordshire (IFP)	0	0	(51)	(51)	0	(614)	(614)
Midlands Partnership NHS Foundation Trust (IFP)	0	0	(24)	(24)	0	(283)	(283)
Specialised Services	(3,510)	(267)	(763)	(496)	(3,510)	(3,362)	148
COVID-19 Funding	0	0	(80)	(80)	0	(80)	(80)
Stoke-on-Trent CC s75	(4,347)	(333)	(333)	(0)	(4,347)	(4,347)	(0)
Stoke-on-Trent Public Health	(4,041)	(337)	(337)	0	(4,041)	(4,041)	(0)
Staffordshire Public Health	(450)	(38)	(38)	0	(450)	(450)	0
ADS/One Recovery	(1,475)	(122)	(122)	0	(1,475)	(1,475)	0
OATS	(1,006)	(84)	(65)	19	(1,006)	(715)	290
Private Patients	0	0	(8)	(8)	0	(51)	(51)
System Led CIP	(1,000)	(111)	(140)	(29)	(1,000)	(507)	493
Total Clinical Income	**(84,544)**	**(7,186)**	**(8,245)**	**(1,059)**	**(84,544)**	**(84,418)**	**126**
Other Income	(10,470)	(810)	(1,143)	(333)	(10,470)	(11,097)	(627)
NHSE 6.3% Pension contribution (notional income)	0	0	(2,825)	(2,825)	0	(2,825)	(2,825)
Total Income	**(95,014)**	**(7,995)**	**(12,213)**	**(4,217)**	**(95,014)**	**(98,340)**	**(3,326)**
Provider Sustainability Funding	(700)	(81)	(81)	0	(700)	(700)	0
Total Income Incl. PSF	**(95,714)**	**(8,076)**	**(12,294)**	**(4,217)**	**(95,714)**	**(99,040)**	**(3,326)**

North Staffordshire Combined Healthcare NHS Trust

5. Expenditure

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

- An underspend of £2,375k on pay (net of the NHSE pension contribution) is due to vacancies across the trust, partially covered by temporary staffing.
- Non-Pay over spend of £2,272k is mainly due to drugs, residential payments, IT, consultancy and premises costs which includes the Stoke CDAS service move from the Woodhouse building during August with additional car parking provision, training room re-location and the re-provision of network and IT equipment.
- COVID-19 expenditure totalling £80k is split between pay of £10k and non-pay of £70k, appendix F provides the detail regarding these costs incurred.

		Month 12			Final Outturn		
Table 3: Expenditure	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
Medical	8,667	721	718	(3)	8,667	7,079	(1,588)
Nursing	33,315	2,774	2,779	4	33,315	31,861	(1,454)
Other Clinical	14,777	1,270	1,158	(112)	14,777	13,349	(1,429)
Non-Clinical	12,251	1,030	1,049	20	12,251	11,908	(343)
Apprenticeship Lew	223	19	21	2	223	243	20
Agency	17	6	187	181	17	2,426	2,408
NHSE 6.3% Pension contribution (notional cost)	0	0	2,825	2,825	0	2,825	2,825
COVID-19 Pay Costs	0	0	10	10	0	10	10
Total Pay	**69,249**	**5,820**	**8,747**	**2,927**	**69,249**	**69,699**	**450**
Drugs & Clinical Supplies	2,915	242	488	246	2,915	3,613	698
Establishment Costs	1,842	143	151	8	1,842	1,644	(198)
Information Technology	819	57	359	302	819	1,192	373
Premises Costs	2,570	225	445	220	2,570	3,490	920
Private Finance Initiative	2,848	236	243	7	2,848	2,988	140
Services Received	5,596	466	470	3	5,596	5,435	(162)
Residential Payments	1,760	147	265	118	1,760	2,377	617
Consultancy & Prof Fees	57	3	59	56	57	369	312
External Audit Fees	65	5	(7)	(12)	65	50	(15)
Unacheived CIP	(114)	212	0	(212)	(114)	0	114
COVID-19 Non Pay Costs	0	0	71	71	0	71	71
Other	2,643	(13)	(12)	1	2,643	2,044	(599)
Total Non-Pay	**21,000**	**1,723**	**2,532**	**809**	**21,000**	**23,272**	**2,272**
Finance Costs	2,722	227	227	(0)	2,722	2,722	(0)
Local Government Pension Scheme	0	0	(38)	(38)	0	(38)	(38)
Unwinding of Discount Rate	0	0	(2)	(2)	0	(2)	(2)
Change in Discount Rate	0	0	1	1	0	62	62
Dividends Payable on PDC	635	53	(2)	(55)	635	578	(57)
Investment Revenue	(54)	(5)	(6)	(1)	(54)	(73)	(19)
Fixed Asset Impairment	0	0	306	306	0	955	955
Depreciation (excludes IFRIC 12)	1,124	94	102	8	1,124	1,206	83
Total Non-op. Costs	**4,426**	**369**	**588**	**219**	**4,426**	**5,410**	**984**
Total Expenditure	**94,676**	**7,911**	**11,867**	**3,955**	**94,676**	**98,382**	**3,706**

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5.1. Agency Utilisation

5.1a. Headlines - Trust Agency Use

The full year expenditure on agency is £2,426k; **which is over the agency ceiling by £239k.**

- This is a level 2 in the Use of Resources year to date.
- In month, Nurse Agency as a proportion of total expenditure on Nurses is **1.0%.**

	Actual												
Total Agency	Apr-19 (£'000)	May-19 (£'000)	Jun-19 (£'000)	Jul-19 (£'000)	Aug-19 (£'000)	Sep-19 (£'000)	Oct-19 (£'000)	Nov-19 (£'000)	Dec-19 (£'000)	Jan-20 (£'000)	Feb-20 (£'000)	Mar-20 (£'000)	Total (£'000)
Medical	127	141	115	151	145	160	164	152	202	113	168	144	1,783
Nursing	41	45	16	24	7	14	11	14	28	30	24	28	282
Other Clinical	(4)	0	1	(1)	0	0	6	17	3	(8)	0	0	14
Non Clinical	3	7	(0)	2	3	7	4	6	(1)	4	2	3	40
Sub Total	**167**	**193**	**132**	**176**	**155**	**180**	**184**	**188**	**233**	**140**	**195**	**175**	**2,119**
Primary Care	52	54	37	28	21	10	8	23	21	25	16	12	307
Total Agency	**219**	**247**	**169**	**203**	**176**	**191**	**193**	**211**	**254**	**165**	**211**	**187**	**2,426**
Agency Ceiling	205	205	205	188	186	186	176	176	165	165	165	165	2,187
(Surplus) / Deficit	**14**	**42**	**(36)**	**15**	**(10)**	**5**	**17**	**35**	**89**	**(0)**	**46**	**22**	**239**
Use of Resources	**2**	**2**	**1**	**2**	**1**	**2**	**2**	**2**	**4**	**1**	**3**	**2**	**2**

The YTD spend against YTD ceiling by category is summarised in the table below:

	Month 12			Final Outturn		
Agency	In Month Ceiling (£'000)	In Month Actual (£'000)	In Month Variance (£,000)	YTD Ceiling (£'000)	YTD Actual (£'000)	YTD Variance (£'000)
Medical	97	144	47	1,287	1,783	496
Nursing	40	28	(12)	540	282	(258)
Other Clinical	0	0	0	0	14	14
Non Clinical	5	3	(2)	60	40	(20)
Sub Total	**142**	**175**	**33**	**1,887**	**2,119**	**232**
Primary Care	23	12	(11)	300	307	7
Total Agency	**165**	**187**	**22**	**2,187**	**2,426**	**239**

- Nursing is £258k below the agency ceiling year to date.
- Medical is £496k above the agency ceiling year to date.
- Primary Care is £7k above the agency ceiling year to date.

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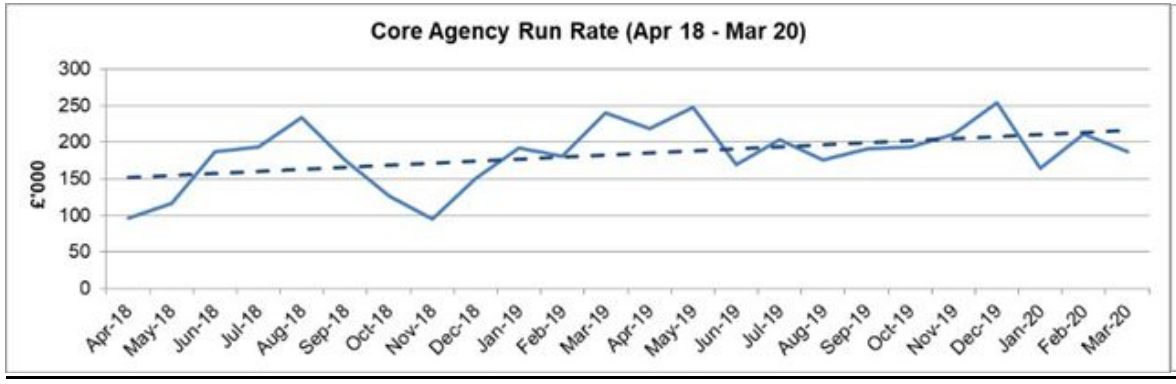
5.1b. Agency Use of Resource

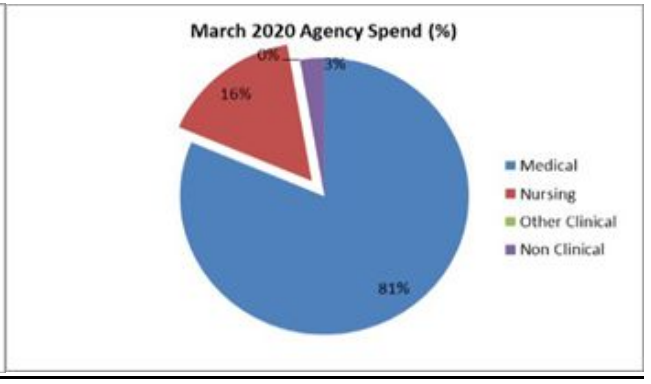
At M12, the year to date agency expenditure is £2,426k. When comparing to the phased agency ceiling agreed with NHSI, the trust was over the agency ceiling at M12; equating to a cumulative use of resources rating of 2. The in-month Use of Resources rating for agency in M12 **is level 2**.

The forecast below shows the agency forecast per quarter.

Cumulative Agency Spend				
2019/20 Agency	**Q1 £000**	**Q2 £000**	**Q3 £000**	**Q4 £000**
Core Agency	635	1,205	1,863	2,426
2019/20 Actual	**635**	**1,205**	**1,863**	**2,426**
Agency Plan	**615**	**1,175**	**1,692**	**2,187**
Over / (Under) Plan	**20**	**30**	**171**	**239**
% Over / (Under) Plan	**3%**	**3%**	**10%**	**11%**
Use of Resources FW	**2**	**2**	**2**	**2**

Use of Resources	
>50%	4
25% to 50%	3
0% to 25%	2
<0%	1





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6. Cost Improvement Programme

The Trust target for the year is £3,505k, made up of £2,505k Internal and £1,000k system efficiency requirement. This takes into account the requirement to deliver a £338k trading control surplus for 2019/20:

- For the Trust Internal Target (£2,505k)
  - The trust has identified schemes to be worked up to deliver £2,391k against the target; a £114k under-achievement for the year
  - On a recurrent basis, the trust has identified schemes to deliver £1,221k against the target, which represents a £1,284k shortfall.

➢ The Trust share of the mental health system savings is £1,000k. The savings forecast is currently based on the outcome of the system stocktake exercise carried out by Deloitte on behalf of the STP. The STP agreed that £507k was delivered against the £1,000k target in 19/20 with a full year effect of £1m.

		YTD 2019/20			Forecast 2019/20			Recurrent Forecast			
Cost Improvement Programme	**Target (£000)**	**Plan (£000)**	**Actual (£000)**	**Under / (Over) Delivery (£000)**	**Plan (£000)**	**Forecast (£000)**	**Under / (Over) Delivery (£000)**	**Plan (£000)**	**Forecast (£000)**	**Under / (Over) Delivery (£000)**	**Recurrent Transacted as at Month 12**
Clinical	1,987	1,987	1,690	297	1,987	1,690	297	1,987	946	1,041	946
Corporate	518	518	701	(183)	518	701	(183)	518	275	243	275
Internal CIP	**2,505**	**2,505**	**2,391**	**114**	**2,505**	**2,391**	**114**	**2,505**	**1,221**	**1,284**	**1,221**
System CIP	1,000	1,000	507	493	1,000	507	493	1,000	1,000	0	0
Total Trust Cost Improvement	**3,505**	**3,505**	**2,898**	**607**	**3,505**	**2,898**	**607**	**3,505**	**2,221**	**1,284**	**1,221**

➢ During March STP DOF's worked collectively to agree the level of investment to be recurrently released for each savings scheme and the level of recurrent savings to be reflected in the 2020/21 contract. The outcome of this for 2019/20 resulted in the final transactions in month 12.

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7. Statement of Financial Position

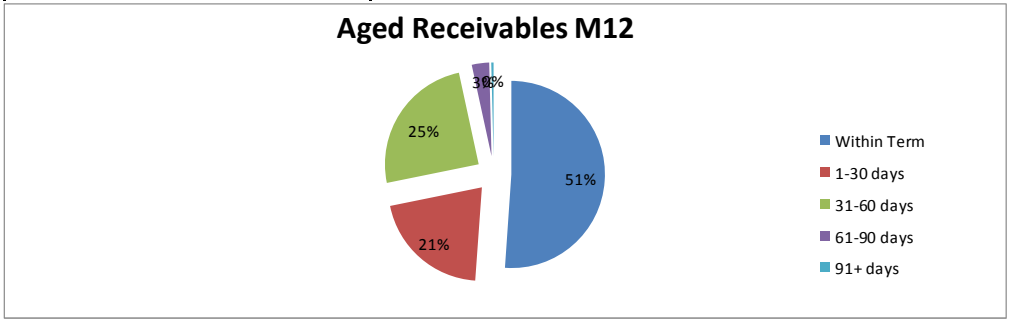
Table 6 below shows the Statement Financial Position of the Trust.

Table 6: SOFP	31/03/2019 £'000	31/01/2020 £'000	29/02/2020 £'000	31/03/2020 £'000
Non-Current Assets				
Property, Plant and Equipment - PFI	16,736	14,095	14,084	13,897
Property, Plant and Equipment	15,142	14,686	14,735	15,371
Intangible Assets	255	200	192	184
NCA Trade and Other Receivables	0	0	0	0
Other Financial Assets	321	321	321	657
Total Non-Current Assets	**32,454**	**29,302**	**29,332**	**30,109**
Current Assets				
Inventories	89	94	88	106
Trade and Other Receivables	8,787	8,579	10,050	7,270
Cash and Cash Equivalents	9,132	9,653	9,048	12,059
Non-Current Assets Held For Sale	0	0	0	0
Total Current Assets	**18,008**	**18,327**	**19,185**	**19,434**
Current Liabilities				
Trade and Other Payables	(8,294)	(8,391)	(9,195)	(9,246)
Provisions	(386)	(252)	(243)	(539)
Borrowings	(635)	(628)	(628)	(628)
Total Current Liabilities	**(9,316)**	**(9,271)**	**(10,066)**	**(10,413)**
Net Current Assets / (Liabilities)	**8,693**	**9,056**	**9,120**	**9,021**
Total Assets less Current Liabilities	**41,146**	**38,358**	**38,452**	**39,129**
Non Current Liabilities				
Provisions	(555)	(926)	(926)	(730)
Borrowings	(10,921)	(10,399)	(10,346)	(10,293)
Total Non-Current Liabilities	**(11,476)**	**(11,325)**	**(11,272)**	**(11,023)**
Total Assets Employed	**29,670**	**27,033**	**27,180**	**28,106**
Financed by Taxpayers' Equity				
Public Dividend Capital	7,787	7,787	7,787	8,287
Retained Earnings reserve	11,440	11,525	11,672	12,155
Other Reserves (LGPS)	321	321	321	657
Revaluation Reserve	10,122	7,400	7,400	7,008
Total Taxpayers' Equity	**29,670**	**27,033**	**27,180**	**28,106**

Current receivables are £7,270k, of which:

- £2,883k is based on accruals (not yet invoiced) relating to income accruals for services invoiced retrospectively at the end of every quarter.
- £4,387k is trade receivables; based on invoices raised and awaiting payment of invoice. (£2,242k within terms).
- Invoices overdue by more than 31 days are subject to routine credit control processes.

		Days Overdue				
Table 6.1 Aged Receivables/Payables	Within Term £'000	1-30 Days £'000	31-60 Days £'000	61-90 Days £'000	91+ Days £'000	Total £'000
Receivables Non NHS	343	680	7	2	(6)	**1,026**
Receivables NHS	1,899	227	1,083	129	23	**3,361**
Payables Non NHS	1,094	36	8	0	23	**1,161**
Payables NHS	696	5	13	0	25	**739**



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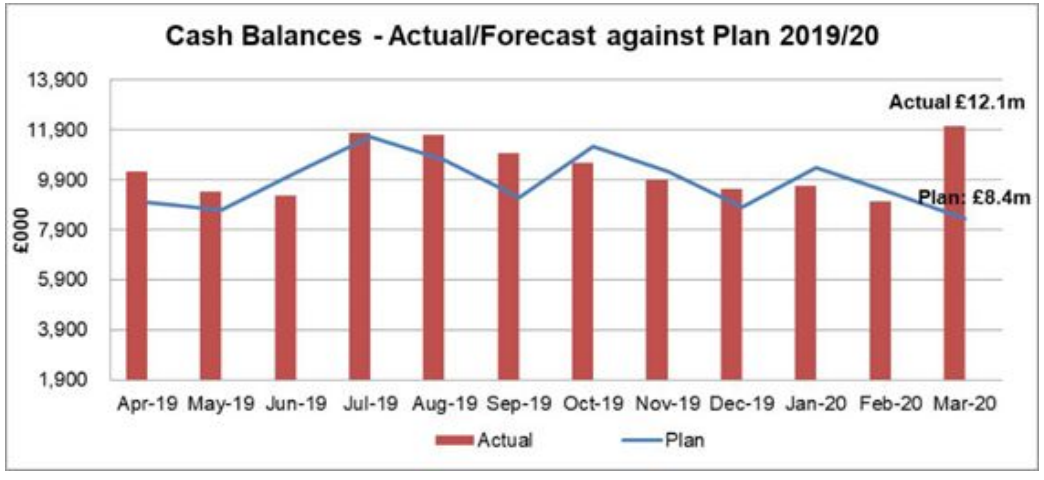
8. Cash Flow Statement

The Trust cash position at 31st March 2020 is £12,060k, **£3,706k higher than planned.** This is due to an increase in income from Health Education England, early settlement of CDAS Qtr 4 and £500k PDC funding for the Digital Aspiration Programme as well as slippage on the capital programme.

Table 7: Statement of Cash Flows	Apr-19 £'000	May-19 £'000	Jun-19 £'000	Jul-19 £'000	Aug-19 £'000	Sep-19 £'000	Oct-19 £'000	Nov-19 £'000	Dec-19 £'000	Jan-20 £'000	Feb-20 £'000	Mar-20 £'000	Annual £'000
Net Inflows/(Outflow) from Operating Activities	722	(648)	254	2,851	103	867	(32)	(384)	(18)	427	(196)	4,187	**8,133**
Net Inflows/(Outflow) from Investing Activities	522	(11)	(243)	(177)	(48)	(418)	(57)	(37)	(46)	(33)	(130)	(1,102)	**(1,780)**
Net Inflows/(Outflow) from Financing Activities	(151)	(151)	(151)	(151)	(151)	(1,192)	(280)	(280)	(280)	(280)	(280)	(73)	**(3,417)**
Net Increase/(Decrease)	**1,093**	**(810)**	**(139)**	**2,524**	**(95)**	**(744)**	**(369)**	**(701)**	**(344)**	**114**	**(605)**	**3,012**	**2,937**
Opening Cash & Cash Equivalents	**9,123**	**10,216**	**9,406**	**9,267**	**11,791**	**11,696**	**10,952**	**10,584**	**9,883**	**9,539**	**9,653**	**9,048**	**9,123**
Closing Cash & Cash Equivalents	**10,216**	**9,406**	**9,267**	**11,791**	**11,696**	**10,952**	**10,584**	**9,883**	**9,539**	**9,653**	**9,048**	**12,060**	**12,060**
Plan	8,992	8,705	10,209	11,641	10,704	9,202	11,248	10,235	8,811	10,401	9,398	8,354	8,354
Variance	**(1,224)**	**(701)**	**942**	**(150)**	**(992)**	**(1,750)**	**664**	**352**	**(728)**	**748**	**350**	**(3,706)**	**(3,706)**

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



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9. Capital Expenditure

The Trust's gross capital expenditure agreed within the 2019/20 plan is £2,676k. The Trust's plan included the sale of the Ashcombe Centre at £500k, resulting in a total capital plan of £2,176k. Additional PDC funding has been drawn down by the Trust to fund the Digital Aspiration Programme and so reinstating the full capital plan to £2.676m. Table 7 below shows the original and revised planned capital expenditure for 2019/20 as submitted to NHSI.

Capital Expenditure	Annual Plan £000	Outturn Revised Plan £000	Outturn Actual £000	Outturn Variance £000
Strategic Schemes				
Learning Disability Facilities	400	400	1	(399)
Mental Health Crisis Care Centre	766	766	799	33
Detoxification Suites and Crisis Café	200	200	0	(200)
Operational Schemes				
Environmental Improvements (Backlog Maintainen	120	120	105	(15)
Environmental Improvements (Reduced Ligature)	400	400	319	(82)
Energy Efficiency Programme	90	90	2	(88)
Equipment	200	200	180	(20)
Digital				
IT Replacement	200	200	339	139
Digital Innovations	50	35	0	(35)
Business Intelligence	150	150	0	(150)
Contingency / Reactive				
Childrens Unit Roof	0	17	12	(5)
Dragon Square Security Fencing	0	0	46	46
Dragon Square Garden	0	0	0	0
Urgent Works to A&T Unit	0	33	32	(1)
Hope Centre Works	0	10	7	(3)
Woodhouse Relocation	0	55	144	89
Ward 7 Garden Improvement Works	0	0	0	0
Sutherland Centre Air Conditioning	0	0	0	0
Generators - Harplands	0	0	0	0
Capital Projects Manager	0	0	15	15
Moorcroft Refurbishment	0	0	0	0
Smoke extract ventilation system - Seclusion Roo	0	0	0	0
PFI Capital lifecycle maintenance	0	0	0	0
Digital Aspiration Programme (£500k PDC Funded	0	500	500	0
Contingency	100	0	(0)	(0)
Sub Total Gross Capital Expenditure	**2,676**	**3,176**	**2,500**	**(676)**
Sale of Ashcombe Centre	(500)	(500)	0	500
Sub Total Gross Capital Expenditure	**2,176**	**2,676**	**2,500**	**(176)**

- Actual Capital Expenditure for 2019-20 is £2,500k, against the plan of £2,676k, **£176k lower than plan.** This relates to slippage across a number of schemes as shown in the table above, partly offset by new schemes introduced during the year.

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10. Use of Resource Metrics

The Framework covers 5 themes, quality of care, finance and use of resource, operational performance, strategic change, leadership and improvement capability. The metrics below are used to assess the Trust's financial performance. The final outcome for 2019/20 is a rating of 2 against a plan of 1. This is as a consequence of agency spend exceeding the agency ceiling. All other metrics are as per plan.

Table 9: Use of Resource	Year to Date Plan	Year to Date Actual	Year to Date RAG Rating	Forecast	Forecast RAG Rating
Liquidity Ratio (days)					
Working Capital Balance (£000)		8,915		8,769	
Annual Operating Expenses (£000)		93,032		92,972	
Liquidity Ratio days		35		34	
Liquidity Ratio Metric	1	1		1	
Capital Servicing Capacity (times)					
Revenue Available for Debt Service (£000)		6,119		6,119	
Annual Debt Service (£000)		3,935		3,935	
Capital Servicing Capacity (times)		1.56		1.56	
Capital Servicing Capacity Metric	3	3		3	
I&E Margin					
Normalised Surplus/(Deficit) (£000)		1,575		1,575	
Total Income (£000)		99,040		99,040	
I&E Margin		1.6%		1.6%	
I&E Margin Rating	1	1		1	
I&E Margin Variance from Plan					
I&E Margin Variance		0.5%		0.0%	
I&E Margin Variance From Plan	1	1		1	
Agency Spend					
Providers Cap (£000)		2,187		2,187	
Agency Spend (£000)		2,426		2,426	
Agency %		11%		11%	
Agency Spend Metric	1	2		2	
Use of Resource	1	2		2	

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11. Better Payment Practice Code

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

During month 12, the Trust has over-achieved the 95% target in terms of the total value of invoices paid, and has achieved the 95% target for the total number of invoices paid. Table 10 below shows the Trust's BPPC performance split between NHS and non-NHS suppliers.

	2018/19			2019/20 Month 12			2019/20 Total		
Table 10: Better Payment Practice Code	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**
Number of Invoices									
Total Paid	625	10,935	11,560	72	975	1,047	603	9,820	10,423
Total Paid within Target	581	9,914	10,495	71	925	996	567	9,193	9,760
% Number of Invoices Paid	93%	91%	91%	99%	95%	95%	94%	94%	94%
% Target	95%	95%	95%	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**-2%**	**-4%**	**-4%**	**4%**	**0%**	**0%**	**-1%**	**-1%**	**-1%**
Value of Invoices									
Total Value Paid (£000s)	6,449	35,113	41,562	948	4,142	5,090	7,481	39,301	46,782
Total Value Paid within Target (£000s)	6,100	33,819	39,919	947	4,066	5,013	7,201	38,394	45,595
% Value of Invoices Paid	95%	96%	96%	100%	98%	98%	96%	98%	97%
% Target	95%	95%	95%	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**0%**	**1%**	**1%**	**5%**	**3%**	**3%**	**1%**	**3%**	**2%**

The finance team will continue to review performance and take action where necessary to improve timely authorisation of invoices and avoid retrospective raising of purchase orders.

12. Recommendations

The Finance and Resource Committee are asked to:

Receive the Month 12 position noting:

- The reported year to date surplus of £1,575k against a planned surplus of £1,038k. **This is a favourable variance to plan of £537k.**
- The M12 internal CIP achievement of £2,391k; **an adverse variance of £114k to plan.**
- The cash position of the Trust as at 31st March with a balance of £12,060k; **£3,706k higher than plan.**
- Total Agency expenditure of £2,426k against the agency cap of £2,187k; **an adverse variance of £239k to plan.**
- Use of resource rating of **2** against a plan of 1.
- Price cap breaches for Medics and off-framework use at M12.

Approve:

- M12 expenditure on Agency of £2,426k reported to NHSI.

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REPORT TO PUBLIC TRUST BOARD

Enclosure No: 12

Date of Meeting:	14th May 2020		
Title of Report:	Finance & Resource Committee Assurance Report		
Presented by:	Russell Andrews Chair/Non-Executive Director		
Author:	Kimberli McKinlay –Deputy Director of Finance		
Executive Lead Name:	Lorraine Hooper – Executive Director of Finance, Performance and Estates	**Approved by Exec**	☒

Executive Summary:		**Purpose of report**	
This paper details the items discussed at the Finance, Performance and Estates Committee meeting on the 30th April 2020		**Approval**	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Resource Committee X • Audit Committee ☐ • People, Culture & Development Committee ☒ • Charitable Funds Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration.☐ 2. To provide the highest quality, safe and effective services X 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☐ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. X 7. Take a lead role in partnership working and integration. ☐		
Risk / legal implications: Risk Register Reference	Oversees the risk relevant to the Finance, Performance and Estates Committee		
Resource Implications: Funding Source:	None applicable directly from this report		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	There are no direct impact of this report on the 10 protected characteristic of the Equality Act		
STP Alignment / Implications:	The Trust Financial performance feed into the overall STP Financial Position.		
Recommendations:	The Trust Board is asked to note the contents of this report and take assurance from the review and challenge evidenced in the Committee.		

Version	Name/group	Date issued

North Staffordshire Combined Healthcare NHS Trust

Finance and Resource Committee
Assurance Report to the Trust Board
30th April 2020

Finance and Resource Committee Report to the Trust Board – 14th May 2020.

This paper details the items discussed at the Finance and Resource Committee meeting on the 30th April 2020. The meeting was held as a MS Teams conference meeting and was quorate with minutes reviewed and approved from the previous meeting on the 26th March. Progress was reviewed and actions confirmed from previous meetings.

Due to the temporary arrangements put in place for all Trust Committees during the period of national emergency relating to Coronavirus presenters took papers as read and asked for any clarifications or questions on the conference call.

Transfers of Risk

The Assistant Chief Executive presented a paper detailing proposals for the transfer or closure of all risks, workplans and actions from the recently removed Primary Care Committee and Business Development Committee. The Committee agreed to the proposed transfers and requested a review of the Primary Care Directorate is presented in six months time.

Finance

- **Financial Planning**

The Director of Finance presented the committee with a paper providing an update on the latest planning position for 2020/21 following the implementation of a new finance regime for due to the COVID19 national emergency. The committee were provided with a summary of guidance detailing how funding will transfer to ensure all organisations break even over the period 1st April to 31st July which included a planned I&E and cashflow position for the Trust covering the same period. The committee were assured following detailed analysis carried out by the team that the Trust will receive sufficient funding to breakeven and given the strong cash position is able to tolerate any retrospective top up to funding.

The Director of Finance advised the committee that budgets had been set using the same "status quo" principle at Directorate level and further planning guidance is expected in the coming weeks with regards to planning post 1st August. The Director of Finance and the Director of Operations detailed the work beginning on service recovery and expected demand both within the Trust and the system.

New guidance has also been released regarding STP wide capital limits which the committee were advised would lead to system wide prioritisation of capital and less flexibility at Trust level. The system limit is expected imminently and in the interim period the committee endorsed the Director of Finance to allocate emergency capital spend prior to the system wide agreement of capital prioritisation.

The committee noted the uncertainty and lack of clarity relating to the new capital regime.

- **Finance Update**

The Committee received an update on the financial position for the year which saw the trust over deliver against the 2019/20 planned control total. All key metrics, with the exception of recurrent CIP and achievement of the Agency cap were achieved. Due to agency expenditure being over the NHSI agreed ceiling as at M12 the Trust ended the year with a use of resources score of 2.

The committee noted the achievement of the control total and position on other key metrics for 2019/20.

- **Cost Improvement Programme (CIP)**

The Cost Improvement position for 2019/20 has delivered £2.9m against the £3.5m target for 2019/20. The recurrent value of these schemes is £2.2m, representing a £1.3m shortfall including system savings.

The Committee noted that the CIP programme had been put on hold for months 1 – 4 of 2020/21 due to national guidance in response to the COVID19 national emergency.

- **Performance**

The committee received the IQPR and recognised the adaptation of reporting to encompass the key areas of focus during the Covid19 response. Discussion was had on reporting of the IQPR from month 1 and at the request of the Director of Finance agreed that all measures should be reported in public Board session with appropriate narrative and reporting to highlight national and contractual requirements as distinct from those measures where the Trust has stretched itself to provide higher levels of performance.

- **Digital Update**

The committee received an update on the broad range of digital projects designed to optimise the use of clinical systems and drive innovation. In particular, discussion centred on the planned use of the Digital Aspirant funding and how this can continue to accelerate digital transformation across the Trust. The committee also received an update on the work of the Digital Team during the COVID-19 pandemic. This included a rapid expansion of the number of laptops and mobile phones as well as extensions to Trust infrastructure to enable reliable and resilient connectivity to support people working from home. The committee also heard how the Team has supported the roll-out of MS Teams and the Attend Anywhere software which enable virtual meetings and video-consultations.

It was agreed that a separate briefing session would be arranged for Non-Executive Directors to allow a further opportunity to hear in more detail on the key projects within the Digital Strategy.

Other:

- **Capital and Estates Update:**

The Committee received a report detailing the final capital spend position for the year which represented 93% of the Trust CRL total and an update regarding ongoing estates projects was given which are part of the capital plan. The committee noted the report and were assured by the progress to date. The committee also noted that the position regarding capital funding for 2020-21 is not yet clear as this will be subject to discussions held at system level which have been on hold due to Covid-19.

- **Risk Register**

The committee reviewed the risk register where all changes to risk were accepted based on the current situation and guidance in place. A discussion was had regarding the covid19 continuity risk and the need to review this as we move to recovery.

- **Terms of Reference**

The Associate Director of Governance presented the terms of reference for the newly formed Finance and Resources committee. It was agreed to review these in 6 months to see how the new committee is progressing.

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, Performance and Estates Committee

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REPORT TO PUBLIC TRUST BOARD

Enclosure No: 13

Date of Meeting:	14th May 2020		
Title of Report:	Extraordinary Audit Committee Assurance Report		
Presented by:	Philip Jones, Chair/Non-Executive Director		
Author:	Laurie Wrench, Associate Director of Governance		
Executive Lead Name:	Lorraine Hooper – Executive Director of Finance, Performance and Estates	**Approved by Exec**	☒

Executive Summary:		**Purpose of report**	
An extraordinary Audit Committee was held on the 27th April to approve submission of the draft accounts, following delegated authority from Trust Board.		**Approval**	☐
		Information	☐
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Resource Committee • Audit Committee X • People and Culture Development Committee ☐ • Charitable Funds Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration.☐ 2. To provide the highest quality, safe and effective services X 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☐ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. X 7. Take a lead role in partnership working and integration. ☐		
Risk / legal implications: Risk Register Reference	Oversees the risk relevant to the Audit Committee		
Resource Implications: Funding Source:	None applicable directly from this report		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	There are no direct impact of this report on the 10 protected characteristic of the Equality Act		
STP Alignment / Implications:	The Trust Financial performance feed into the overall STP Financial Position. The Digital priorities include support in delivery of STP Digital Programme; Integrated Care Record.		
Recommendations:	The Trust Board is asked to note the contents of this report and take assurance from the review and challenge evidenced in the Committee.		

Version	Name/group	Date issued
1	Laurie Wrench	1st May 2020

North Staffordshire Combined Healthcare NHS Trust

Assurance Report to the Trust Board
14th May 2020

Extraordinary Audit Committee Report to the Trust Board – held 27th April 2020.

An extraordinary Audit Committee was held on the 27th April to approve submission of the draft accounts, following delegated authority from Trust Board.

Annual Accounts 2019/2020

The draft annual accounts were presented to the Committee who noted a number of key financial successes

- Met Control Total - surplus of £1,575k against a plan of £1,038k; a £537k over performance against control
- Met Cash Requirement - Cash balance ↑ £2,927k (32%) to £12,059k
- Utilised 93% of Capital Resource Limit in year
- Met External Financing Limit (EFL)
- A Draft Accounts surplus position of £658k.
- Finance Income up by £23k (26%) to £111k
- A Consistently higher bank account balance in 2019/20

The Finance team were congratulated on producing the draft accounts in such challenging circumstances

The Committee approved submission of the draft accounts.

Going Concern

The Committee considered the Going Concern paper and assessed that it was appropriate to prepare the financial statements on a going concern basis for at least 12 months from the date the accounts are signed. The committee commented that the narrative within the statement may change over coming weeks as the national financial framework develops for 20/21. Particular consideration was given to the impact of the COVID-19 national emergency along with a number of technical matters, including the valuation of the LG pension fund and the potential delay this could have on the issuing the auditor's opinion.

The Committee approved that the 2019/20 Financial Accounts are submitted on a going concern basis.

Head of Internal Audit Opinion

KPMG, Internal Auditors presented the positive news that the internal audit opinion was that of Significant Assurance with Minor Areas for Improvement.

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 Philip Jones
Chair of Audit Committee

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North Staffordshire Combined Healthcare NHS Trust

REPORT TO PUBLIC TRUST BOARD

Enclosure No: 14

Date of Meeting:	14th May 2020		
Title of Report:	Register of Board Members – Declarations of Interest		
Presented by:	Tosca Fairchild, Assistant Chief Executive		
Author:	Lisa Wilkinson, Corporate Governance Manager		
Executive Lead Name:	Tosca Fairchild, Assistant Chief Executive	**Approved by Exec**	☒

Executive Summary:		**Purpose of report**	
The report provides an update as at 30th April 2020 of current member's interests. It is the Trust Board's responsibility to ensure the Trust operates its services in an open and transparent way. In line with the Code of Conduct and Accountability for NHS Board members and the Trust's Standards of Business Conduct Policy this information is published on the website and available for public view.		**Approval**	☒
		Information	☐
		Discussion	☒
		Assurance	☐
Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☒ • People, Culture & Development Committee ☐ • Charitable Funds Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration.☒ 2. To provide the highest quality, safe and effective services ☐ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☐ 5. Attract, develop and retain the best people. ☒ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☐		
Risk / legal implications: Risk Register Reference	The register enclosed is in line with current legislation.		
Resource Implications: Funding Source:	N/A		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	There is no direct impact of this report on the 10 protected characteristics of the Equality Act		
STP Alignment / Implications:	N/A		
Recommendations:	To accept the register as a true and accurate record. This will be uploaded to our external Trust website.		

Version	Name/group	Date issued

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NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST

REGISTER OF DIRECTORS' DECLARED PRIVATE INTERESTS

30th April 2020

NAME OF DIRECTOR	INTEREST DECLARED
D Rogers Chairman	**Crystal Care Solutions Ltd** Chairman and 33% shareholder **Staffordshire Wildlife Trust** Chair **CQC** Executive Reviewer **Positive Practice (Healthcare Collaborative)** Advisory Board **GGI (Good Governance Institution)** Non-Executive Director **Stoke-on-Trent College** Governor and Chair of Audit Committee
Peter Axon Chief Executive	**No interests declared**
P Sullivan Non-Executive Director	**Health Education and Social Care Chamber (Mental Health)** Specialist Lay Member First Tier Tribunal **(Local Prison)** Chair Independent Monitoring Board
J Walley Non-Executive Director	**Burslem Regeneration Trust** Trustee **Carrick Court Freehold Company** Director **Electoral Commission** Nominated Commissioner
Janet Dawson Non-Executive Director	**Manchester Metropolitan University** Independent Governor **Manchester Metropolitan University** Member of the Remuneration Committee and the Finance and Resources Committee **Frederic Robinson Limited** Independent member of the remuneration Committee
Russell Andrews Non-Executive Director	**Enable2 Interpretation Services (providing Services to NHS Trusts in West Yorkshire)** Non-Executive

	Diocese of Leicester Educational Trust Director **Leicester Diocesan Board of Education** Director **Diocese of Leicester Academies Trust** Director **Embrace Multi-Academy Trust** Director
Phil Jones Non-Executive Director	**No interests declared**
K Tattum GP Associate Director	**BGS Medical Ltd** Owner **Baddeley Green Surgery** Senior Partner **General Medical Council** Ad hoc Medical Case Reports **Cancer Research UK** Member of Advisory Board
A Gadsby Associate Director	**CQC** Executive Reviewer
Dr O Adeyemo Executive Medical Director	**Staff University** Honorary Lecturer **WRES – Strategic Advisory Group** Member University of Wolverhampton **Board of Governors** **CQC** Executive Reviewer
Jonathan O'Brien Executive Director of Operations	**Intec Business Solutions Ltd** Partner employed by the company that provided training for staff on the use of MS Teams at no cost to the Trust. There is no financial relationship between the Trust and the company.
Tosca Fairchild Assistant Chief Executive	**Show Racism the Red Card** Chair **Bale Crocker Associates** Client Executive
Kenny Laing Executive Director of Nursing and Quality	**No interests declared**

Chris Bird Director of Partnerships and Strategy	**No interests declared**
Lorraine Hooper Director of Finance, Performance and Estates	**No interests declared**
Shajeda Ahmed Director of Workforce, Organisational Development and Inclusion	**No interests declared**
L Wrench (In attendance) Associate Director of Governance	**Wrench Fine Jewellery (t/a Timecraft Staffs Ltd.)** Family Business
J McCrea (In attendance) Associate Director of Communications	**J B McCrea Ltd** Director **East Leicestershire and Rutland GP Federation** Head of Communications Non-Voting Member of the Board
Fung-Mai Billie Lam Next Director Placement	**Healthwatch Staffordshire** Volunteer of office support for 2-3 hours per week **Healthcare Organisations** Interim service offered – no current contract
J Harvey (In attendance) Staff Side Representative	**No interests declared**

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

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

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

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

a) any directorship of a company;

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

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

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

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

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

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

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REPORT TO PUBLIC TRUST BOARD

Enclosure No: 15

Date of Meeting:	14th May 2020		
Title of Report:	Board Assurance Framework 2019/20 – Q4 and Q1 202/21		
Presented by:	Laurie Wrench, Associate Director of Governance		
Author:	Laurie Wrench, Associate Director of Governance		
Executive Lead Name:	Tosca Fairchild, Assistant Chief Executive Officer	**Approved by Exec**	☒

Executive Summary:		**Purpose of report**	
The Board Assurance Framework (BAF) for 2019/20 aligns the Trusts strategic objectives to our quality priorities and key risks. The 2019/20 BAF provides oversight of the key control and assurances to be introduced to ensure delivery of the seven strategic objectives. This provides the update for Q4 and also gives an indication for the Committee to consider of the items to take forward into 20/21 on a temporary 6 month basis due to COVID-19 challenges		**Approval**	☒
		Information	☐
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☒ Execs ☐ Date: 5th May 2020	Document Version No.	1
Committee Approval / Review	• Quality Committee ☐ • Finance and Resources Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration.☒ 2. To provide the highest quality, safe and effective services ☒ 3. Inspire and implement innovation and research. ☒ 4. Embed an open and learning culture that enables continual improvement. ☒ 5. Attract, develop and retain the best people. ☒ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☒		
Risk / legal implications: Risk Register Ref	The paper describes the Trust's strategic risks and associated trust wide 12+ risks		
Resource Implications: Funding Source:	N/A		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	The BAF describes the ongoing work regarding diversity and inclusion		
STP Alignment	N/A		
Recommendations:	Trust Board is asked to receive the Q4 2019/20 BAF for information and assurance purposes and approve the items to carry forward into Q1 20/21 in the light of COVID-19 challenges		

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Board Assurance Framework (BAF) 2019/2020 – Quarter 4 Update and 2020/2021 Outline Plan

Welcome to the Board Assurance Framework for North Staffordshire Combined Healthcare NHS Trust.

The Trust Board is responsible for ensuring that North Staffordshire Combined Healthcare NHS Trust consistently follows the principles of good governance applicable to NHS organisations. The Board does this through the development of systems and processes for financial and organisational control, clinical and information governance and risk management.

Our Board Assurance Framework identifies the procedures for risk management against our key strategic objectives, encompassing the management of all types of risk to which the Trust may be exposed, our controls and the assurances we have in place. This includes the effective integration and management of clinical and non-clinical risk.

Those key risks, mapped against our seven strategic goals are set out in the following pages. We have also categorised each objective against our quality priorities – SPAR.

BAF 2019/2020 Q4 – 16th April 2020

Executive Team Objectives:

- A CQC rating of 'outstanding' is maintained and an increase in the number of core services rated as 'outstanding'
- Commitment to the Staffordshire & Stoke-on-Trent Sustainability Transformation Partnership (the STP) as a willing partner in deploying the skills and expertise of our workforce outside of our immediate organisational boundaries
- Delivery of CIP targets, the control total and remaining within the agency cap
- Delivery of transformed clinical pathways, zero tolerance for failure to comply with the Mental Health Act and delivery of the Trust's Suicide Prevention Strategy
- Take a lead role in the design, development and delivery of the emergent Integrated Care Partnership model across North Staffordshire in collaboration with the Northern Alliance Board

Objective 1:	**To enhance service user and carer collaboration**									
SPAR PRIORITY										
Exec owner:	Director of Nursing and Quality									
Assurance Committee:	Quality Committee									
Risk appetite	Financial		Quality (Innovation)		Regulation		Reputation			
RISK: *The Trust fails to collaborate with service user and carer involvement resulting in an inability to deliver responsive services.* *Risk Trend Arrow*	**Gross Risk (no mitigation)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/20)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	4	3	12	3	3	9	2	3	6
COVID-19 Risk - There is a risk to the quality of the Trust's services due to the COVID-19 pandemic which will impact on the safety, wellbeing and capacity of staff and patients	4	5	20	3	5	15	2	5	10
Links to 12+ Trust Risks	**Description of linked 12+ Trust Risks** • 900 – Diverse and Inclusive services									
Internal Assurance Examples							**External Assurance Examples**			
Level 1	**Level 2**						**Level 3**			

BAF 2019/2020 Q4 – 16th April 2020

• **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**
Number of Controls		

SPAR Reference	CONTROLS to Mitigate Strategic Risk	Level of Assurance	Description of Assurance	Exec Owner	Year Start RAG	Qtr Due	Forward Plan/Progress	Q4 RAG	On Target RAG	Year End RAG
R	Enhance Service User & Carer Collaboration - Focus on Service Users Recovery. **CARRY OVER TO 20/21**	2	Embed the Wellbeing Academy to support recovery with greater participation of peers. Aim to have SU attend at least one of the Well Being Academy's. Measure SU experience of the Academy and report to QC.	DON		Q4	Q4: WB Academy has continued to run sessions and evaluate positively, however increased accessibility and sustainability needs to be addressed in 2020-21 Evaluation report has not been sent to QC due to COVID-19 pandemic			
AR	**CARRY OVER TO 20/21**	2	Further embed Peer Support Workers and Peer Support Mentor roles, as a key component of our	DON		Q4	Q4: actions for the year complete but a risk in 20/21 due to Section 75 changes			

			workforce having lived experience. This will be evidenced by increased numbers of service users and carers in our workforce on either a voluntary or paid basis year on year.							
SPAR	**CARRY OVER TO 20/21**	3	The Trust will achieve a year on year improvement for the overall indicator of "better" in the Community Mental Health Survey. 2018 score = 6.7	DO		Q4	2018 score = 6.7 2019 score = 6.8, key areas for learning and improvement will be delivered to QC in February 2020.			
ARP	Ensure we are constantly pushing channel development to ensure the Trust is at the forefront of digitalisation that will enhance service user engagement. **CARRY OVER TO 20/21**	2	Embed digital channels across all service areas including the use of Combined Podcast. Create subtitled versions on Youtube to ensure inclusive as possible. Implement Social Media Optimisation Plan.	DWODI		Q3	Combined Podcast established, now has 26 episodes with over 3164 listeners since launch. Subtitled versions and Social Media Optimisation Plan will follow in Q2/Q3.			

PR	Embed Person Centredness Framework **COMPLETE – REMOVE FROM 20/21**	2	Implement the framework and produce tools to support service users and staff.	DON		Q3	Trust website has Person Centeredness framework and associated resources within it.			

Objective 2:	**To provide the highest quality, safe and effective services**								
SPAR PRIORITY									
Exec owner:	Director of Nursing and Quality and Medical Director								
Assurance Committee:	Quality Committee								
Risk appetite	Financial	3	Quality (Innovation)	3	Regulation	2	Reputation	3	

RISK: *The Trust fails to deliver safe and effective services, resulting poor care, reputational harm and regulatory restrictions* *Risk Trend Arrow* 	**Gross Risk (no mitigation)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/20)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	4	4	16	3	4	12	2	4	8
COVID-19 Risk - There is a risk to the quality of the Trust's services due to the COVID-19 pandemic which will impact on the safety, wellbeing and capacity of staff and patients	4	5	20	3	5	15	2	5	10

Links to 12+ Trust Risks	**Description of linked 12+ Trust Risks** • 12 – Staffing • 440 – Place of Safety • 441 – PICU • 423 – Compliance with MHA/MCA • 725 – Medicines Management • 900 – Diverse and Inclusive services

BAF 2019/2020 Q4 – 16th April 2020

	• 901 – Diverse and inclusive workforce • 907 – Delayed transfers of care • 1009 – Pharmacy provision • 1111 – Locality restructure • 1112 – Ligature points • 1113 – Community pathway • 1019 – ROSE and quality • 1028 – Winter planning • 1034 – Staff engagement/PDR • 1135 – Quality and safety as part of a reorganization of services • 1136 – CQUIN targets

Internal Assurance Examples		External Assurance Examples
Level 1	**Level 2**	**Level 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**

Number of Controls

SPAR Reference	CONTROLS to Mitigate Strategic Risk	Level of Assurance	Description of Assurance	Exec Owner	Year Start RAG	Qtr Due	Forward Plan/Progress	Q4 RAG	On Target RAG	Year End RAG
SPAR	CQC Rating of 'Outstanding' is maintained. **CARRY OVER TO 20/21**	3	A rating of 'good' for all core services in the	CEO		Q4	Bespoke approach to CQC inspection preparation	No RAG as CQC inspection		

BAF 2019/2020 Q4 – 16th April 2020

			Safe domain (Adult Inpatient Wards).				developed. Core service action plans in place for improvement and also 'Towards Outstanding'. Request made to CQC to return to OP wards.	cancelled due to COVID-19 – roll over into 2020/2021 BAF
SPAR	**CARRY OVER TO 20/21**	3	An increase in the number of core services rated as 'outstanding' currently 3/11).	CEO		Q4	Bespoke approach to CQC inspection preparation developed. Core service action plans in place for improvement and also 'Towards Outstanding'. Self-assessment for Darwin & LD Community is `outstanding`.	No RAG as CQC inspection cancelled due to COVID-19 – roll over into 2020/2021 BAF
SPAR	**COMPLETE - REMOVE FROM 20/21**	3	Continue partnership arrangements with Northumberland, Tyne and Wear with a focus on: • Mental Health Act Compliance • Clinical Pathways • Quality Improvement	CEO		Ongoing	Partnerships on-going. LiA in place for MHA compliance. Pathway transformation on-going. Deputy Director of Operations now in post. QI programme on-going.	

BAF 2019/2020 Q4 – 16th April 2020

SPAR	Continue work to strengthen approach to risk management including: **CARRY OVER TO 20/21**	1	Risk appetite analysis is undertaken for strategic risks.	ACEO		Q3	Risk appetite matrix developed. To include as Board Development topic.			
	CARRY OVER TO 20/21	2	Undertake residual and target score gap analysis 6 monthly.	ACEO		Q4	On target.			
	WORK ONGOING TO CARRY OVER TO 20/21	2	Undertake deep dive for long standing risks 6 monthly.	ACEO		Q2	Deep dive completed for Finance, Performance and Estates, PCDC and Quality Committee.			
SPAR	Develop a Trust wide systematic approach to quality improvement. **WORK ONGOING TO CARRY OVER TO 20/21**	1	Continue to strengthen relationship with the CQC via regular engagement meetings and new inspection team	DON		Q1	Work completed but to extend into next year. Schedule of meetings in place – continue to meet with CQC monthly and wider engagement as required.			
		2	Develop and implement Combined Quality Improvement (QI) strategy	DON		Q4	Completed but needs a new section next year			
		3	Embed SPAR accreditation across all inpatient wards (pilot completed 18/19).	DON		Q2	Completed but needs a new section next year			
R	Develop our social work partnership with Stoke on Trent City Council to ensure professional support for social workers in the	2	Social work Network took place 27.3.19. Tasked with completed	DON		Q3	Q4: Due to section 75 arrangements with SOT city council, we have taken the			

	Trust **WORK ONGOING TO CARRY OVER TO 20/21**		Strategy May 2019.				decision to defer the work on social work strategy.			
S	Improved physical health monitoring for service users. **COMPLETE REMOVE FROM 20/21**	1	Introduce NEWS2 early warning tool to support the SEPSIS programme.	DON		Q2	NEWS2 introduced across in-patient wards.			
S	People with complex needs are supported. **COMPLETE REMOVE FROM 20/21**	2	Embed trauma informed care across all wards (QI). 85% of acute in-patient staff to receive training in Trauma Informed Care and SU to report satisfaction with Care Plan.	DON		Q2	Q4: The anticipated compliance for Trauma Informed Care Training has dropped to 70% in Q4. In part this is due to a number of new starters as well as the current COVID-19 situation. An e-learning package is being developed by the A&UC Directorate for use on LMS. In the meantime Sue has offered to review a number of external e-learning packages to plug the gap. If we can do this quickly we should be able to meet our 85% in Q1 20/21.			
SPAR	**WORK ONGOING TO CARRY OVER TO 20/21**	2	Updated narrative - Implement new PD service to enable pathway for service users with EUPD	DO		Q2	Business Case & Pathways approved at SLT in Q2 but to operationalise needs to carry forward.			

AR	**COMPLETE REMOVE FROM 20/21**	2	Develop autism strategy and inform commissioning.	DON		Q1	Completed and approved by Trust Board.			
S	Zero Suicide Ambition – 2019/20 is the third year of this collaborative journey with partners to reduce deaths by suicide as part of the county wide strategy. **COMPLETE REMOVE FROM 20/21**	2	Deliver the Trust Suicide Prevention Strategy:	MD		Q4	Links with Trust GP surgeries and Brighter Futures self-harm services have been developed. These partners have been invited to Trust Suicide Prevention steering group			
	WORK ONGOING TO CARRY OVER TO 20/21	1	• Provide 8 NSCHT staff members with 'Train the Trainer suicide response training' NEW for 20/21 - Change objective to - Cascade 'Connecting with People' training approach	MD		Q2	Once trained in the Connecting with People approach – staff will be eligible to use the risk assessments developed by this recognised training approach. Lorenzo/Halo/Laptus will require some adjustment to facilitate this. The Trust's IT has agreed to support development of existing software – suicide response interventions to be added to clinical records. Action to be completed by mid- May			
S	**COMPLETE REMOVE FROM 20/21**	1	Work with partners to deliver Suicide Charter: • Deliver Annual STP	MD		Q4	We linked with partners to deliver suicide prevention conference. Event held 11.10.2019			

			Zero Suicide Conference				MPFT to lead on 2020 conference- supported by NSCHT. Next event planned for 01.10.2020			
PA	**COMPLETE REMOVE FROM 20/21**	2	• Ensure standardised bereavement support is offered to the family and carers each time (monitor through review of SI report).	MD		Qtly	Process audited. Bereavement leaflet and external Trust website developed			
S	**WORK ONGOING TO CARRY OVER TO 20/21**	2	Investment in environmental ligature improvements as per the capital plan.	DOF		Q4	Ward 3 has 6 doors replaced, Darwin 5 doors in process of being replaced. Ward 3 remaining doors agreed via reduced ligature OPO, however order time means won't be in place for year end, but early April. Monies reserved in 2020 capital plan to carry out works.			
S	**WORK ONGOING TO CARRY OVER TO 20/21**	2	Complete PDSA cycle into panel review methodology to improve learning from serious incidents. Findings of review to inform the Trust's approach to	MD		Q2	Further work is being undertaken with Clinical Risk Workshop to support improvement in our Serious Incident Policy.			

			structuring 'Panel Reviews' throughout the Trust.							
SPAR	Every patient can expect Mental Health Law compliance.		Zero tolerance for failure to comply with the MHA:	MD						
	WORK ONGOING TO CARRY OVER TO 20/21	1	• Two LiA workshops (informed by QI methodology) to be held for section 17 leave and consent.	MD		Q1	Pass it on event for Consent held in November 2019. A LIA conversation for Section 17 was held in November 2019, following which a steering group was formed and have reviewed all actions and Quick Wins. The Steering group has two work streams Digital Group and Practice/Process Group with meetings set for end of May 2020..			
	WORK ONGOING TO CARRY OVER TO 20/21	1	• 100% compliance with requirements for Section 17 leave.	MD		Qtly from Q2	In light of current circumstances Q4 audit has not yet taken place. Results of Q3 MHL audit indicate 98% compliance with Section 17 leave. Further work is underway with Directorate leads and through LIA process to improve			

							performance. Pass it on event scheduled to take place in June 2020.			
	WORK ONGOING TO CARRY OVER TO 20/21	1	• 100% compliance with requirements for consent.	MD		Qtly from Q2	In light of current circumstances Q4 audit has not yet taken place. Results of Q3 MHL audit indicate 95% compliance with consent. Embedding the work from the Consent LIA continues with Directorate leads to improve performance.			
AR	Dual Diagnosis – 2019/20 is the second year for this programme of work. Delivery of the Trust wide Strategy for service users with Dual Diagnosis. **CONSIDER CLOSING**	2	• Integrate DD strategy by disseminating and publicising.	MD		Q3	The publicising and dissemination continues, it has been presented in Directorate meetings, and personally to quality leads and key lead clinicians within teams. The NICE quality standards for co-existing need (August 2018) have been emphasised in these discussions to provide further focus to the strategy and action planning for teams.			
AR	**WORK ONGOING TO CARRY OVER TO 20/21**	1	• Establish joint case review processes in all Directorates for all service users with DD.	MD		Q2	Care planning meetings and multi-professional meetings occur across all directorates; including the involvement of both substance misuse and			

							mental health practitioners. Learning from incidents has been incorporated into training to strengthen the importance of inter-agency communication and working. Monthly case review meetings are now established at Greenfield, Sutherland, Ashcombe and Lymebrook . These meetings currently operate with Substance Misuse representation from both County and Stoke services. (These structures were a focus of a practice innovation reported in the Nurse Directors Leading Minds journal)			
AR	**CONSIDER CLOSING**	2	• Embed Dual Diagnosis Training across the Trust through e-learning (monitoring from Q2).	MD		Q3	E-learning in place and is embedded as core training within LMS (this focuses on AUDIT assessment and brief intervention). Training leaflets have been produced to support this. There is a monthly face to face dual diagnosis training session available for all staff booked and recorded			

							through LMS. In addition whole team training has become popular and is seen as a viable alternative to individuals attending centralised sessions.			
S	100% achievement of CQUIN scheme **WORK ONGOING TO CARRY OVER TO 20/21**	2	Flu Vaccination Achievement target 90%.	DON		Qtly	Q4: Flu campaign has achieved 80% target at end of Jan 2020. New target for 20/21			
S	**COMPLETE REMOVE FROM 20/21**	2	Data Quality • DQMI 95% • Interventions 70%	DOF		Qtly	DQMI at 97.2% in November (most recent data). Some areas of challenge which are part of DQ improvement plan.			
R	**COMPLETE REMOVE FROM 20/21**	2	IAPT Anxiety Outcome Measures 65%.	DO		Qtly	An action plan has been developed and compliance is being monitored on an ongoing basis by the Healthy Minds team.			
SPAR	**COMPLETE REMOVE FROM 20/21**	2	Tobacco and Alcohol Achievement targets: • Screening 80% • Tobacco intervention 90%	MD		Qtly	End of year audit demonstrates that top targets for full achievement have not been achieved for these metrics. However, we are reporting compliance			

			• Alcohol intervention 90%				significantly above baseline requirements for partial achievement, as follows: Tobacco and alcohol screening – 76% compliance (90% achievement) Tobacco brief interventions – 87% compliance (92.5% achievement) Alcohol brief interventions / referral offer – 82% compliance (80% achievement) An annual audit will be prioritised as part of the 2020/21 Clinical Audit Programme in accordance with contractual requirements.			
A	**WORK ONGOING TO CARRY OVER TO 20/21**	2	72 hour follow-up: • Achievement target 95% (48 hour)	DO		Qtly	Q1 total = 91.6% (CPA = 88.7%) Q2 total = 90% (CPA = 83.9%) Q3 total = 89.2% Q4 total = 91.4% (CPA 92.1%) Trust figures are against 48 hour follow up, in line with national pilot.			
S	Revise Pharmacy strategy to ensure delivery of integrated working within the community teams.	1	Align a Pharmacist with each Directorate.	MD		Q2	Pharmacist assigned to Directorates and reviewing opportunities with Quality			

	COMPLETE REMOVE FROM 20/21						Leads.			
-	**WORK ONGOING TO CARRY OVER TO 20/21**	1	Each Pharmacist to complete an innovation project within their Directorate.	MD		Q4	The Ward 4 Stop/start with frailty project has been completed and a paper is being prepared for publication. In collaboration with the regional ASHN and Staffordshire LPC 'Transfer of CARE Around Medicines' (TCAM) was launched at Harplands on the 1st March – this platform allows patients who are being discharged to be referred in to the local community pharmacy for further support with the management of their medication. The project planned for substance misuse has had to be postponed at this time.			
S	**COMPLETE REMOVE FROM 20/21**	2	Pharmacists to deliver four training sessions within their Directorate in collaboration with Clinical Leads.	MD		Q4	Training packages have been developed and sessions have been delivered across Directorates with support from Clinical Leads.			
A	Services are responsive to the needs of service users.	1	92% compliance for referral to treatment	DO		Qtly	Q1 = 93.3% Q2 = 91.9%			

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	WORK ONGOING TO CARRY OVER TO 20/21		(2nd contact) in 18 weeks.				Q3 = 97.2% Q4 = 97.3%			
SA	**WORK ONGOING TO CARRY OVER TO 20/21**	1	100% compliance with 3 hour assessment target for service users entering the Place of Safety (where clinically appropriate).	DO		Qtly	Q3 = 65.4% Q4 – 79.5%			
A	**WORK ONGOING TO CARRY OVER TO 20/21**	1	90% compliance referral to assessment within 4 weeks (CAMHS).	DO		Qtly	Q1 = 34.1% Q2 = 32.7% Q3 = 69.5% Q4 = 54.2%			
S	**WORK ONGOING TO CARRY OVER TO 20/21**	1	Deliver substantial compliance against EPRR core standards in annual declaration.	DO		Q3	Full / Substantial compliance confirmed at end of Q2. Declaration taken to Board in Q3.			
A	**WORK ONGOING TO CARRY OVER TO 20/21**	1	There are zero acute adult mental health out of area placements.	DO		Qtly	No out of area placements at M12.			
A	**COMPLETE REMOVE FROM 20/21**	1	PICU is fully open and operational with six beds from May 2019.	DO		Q1	Six beds are now fully commissioned and operational from 1st October 2019.			
SPAR	**COMPLETE REMOVE FROM 20/21**	1	Improve the responsiveness and quality of mental	DO		Q4	Crisis Care Centre build complete and opened on 23rd October 2019.			

			health urgent care services through delivery of the Mental Health Crisis Care Centre and Alcohol Detox Pathway.							
SPAR	**ON HOLD**	2	Drive CIP and productivity through the Directorates utilising Model Hospital, NHS Benchmarking Network and other national productivity benchmarks.	DO		Qtly	On-going			
A	Provision of more accessible services through the Trust wide use of video conferencing services to make life more convenient for service users, carers and staff. **WORK ONGOING TO CARRY OVER TO 20/21**	1	Pilot video conferencing across inpatient and community site to assess compatibility with services design.	MD		Q3	Pre COVID-19 the video-conferencing facility Visiba was piloted with Home Treatment, Learning Disability, CAMHS IP, and Darwin Centre Services. This was demonstrated			
	COMPLETE REMOVE FROM 20/21		Implement and embed the use of video consultation services across the Trust to facilitate agile working.	MD		Q4	Microsoft Teams is now fully operational across the Trust to support interorganisational communications. Attend Anywhere has been deployed to enable video consultations (Update DH			

							28/04/2020)			
S	Protect the Trust from Cyber Threats. **WORK ONGOING TO CARRY OVER TO 20/21**	1	Work in partnership with UHNM & MPFT to deliver Cyber Security project. • Project plan Q1.	DPS		Q1	NHS E Digital Lead confirmed arrangements for draw down of funds and delivered.			
S	**WORK ONGOING TO CARRY OVER TO 20/21**	1	• Project mobilisation from Q2.	DPS		Q2	Co-ordinated through STP Digital Programme Board and working with NHS Digital Cyber team the organisations are aligning their cyber responses and these will be reported to the STP Digital Programme Board via the KPI assessments. (Updated DH 28/04/2020)			
SPAR	Improve the accessibility of data across multiple providers - ICR Procurement. **WORK ONGOING TO CARRY OVER TO 20/21**	1	Undertake assessment of 'readiness' to align internal systems with the new ICR to FPD.	DPS		Q1	Complete			
		1	Preferred bidder identified.	DPS		Q1	Supplier evaluation process has been completed and Graphnet identified as preferred bidder. (Updated DH 28/04/2020)			
		1	Contract sign-off.	DPS		Q1	Contract signed			

		2	Mobilisation from Q2 onwards.	DPS		Q4	Implementation plan from Q2 (Updated DH 28/04/2020)			
-	Become a more digitally mature organisation - Align with action to review Digital Governance architecture. **COMPLETE REMOVE FROM 20/21**	1	Develop action plan to support improvement in Digital Maturity following completion of DMI 18/19.	DPS		Q1	Action plan to improve digital maturity incorporated into the Lorenzo Digital Exemplar programme. These improvements have been identified in a gap analysis and will be reported in the next DMI submission. (Updated DH 28/04/2020)			
-	**COMPLETE REMOVE FROM 20/21**	1	• Bring forward proposals to NSCHT Exec and F&r Q1.	DPS		Q3	Completed via Board Development session September 2019.			
-	**WORK ONGOING TO CARRY OVER TO 20/21**	2	• Implementation Q2 20/21.	DPS		Q2 20/21	Implementation Q2 20/21 following the Digital Strategy being approved at July Board.			

Objective 3:	Inspire and implement innovation and research								
SPAR PRIORITY									
Exec owner:	Medical Director								
Assurance Committee:	Quality Committee								
Risk appetite	Financial		Quality (Innovation)		Regulation		Reputation		
RISK: *The Trust fails to exploit its potential in research and innovation, resulting in a loss of credibility and a failure to improve services.* *Risk Trend Arrow*	**Gross Risk (no mitigation)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/20)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	4	3	12	3	3	9	2	3	6
COVID-19 Risk - There is a risk to the quality of the Trust's services due to the COVID-19 pandemic which will impact on the safety, wellbeing and capacity of staff and patients	4	5	20	3	5	15	2	5	10
Links to 12+ Trust Risks	**Description of linked 12+ Trust Risks** • 440 – Place of Safety • 441 – PICU • 933 – Rose								

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Internal Assurance Examples		External Assurance Examples
Level 1	**Level 2**	**Level 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

Number of Controls

SPAR Reference	CONTROLS to Mitigate Strategic Risk	Level of Assurance	Description of Assurance	Exec Owner	Year Start RAG	Qtr Due	Forward Plan / Progress	Q4 RAG	On Target RAG	Year End RAG
A	Ensure delivery of the Research Strategy. **WORK ONGOING TO CARRY OVER TO 20/21**	2	Optimise use of 'Consent to research initiative' – 20% increase on consenting to research against 2018/19 figure of 702 (13%).	MD		Q3	Q4: Over 8000 service users have been asked if they would like to take part in research with 990 (12%) consenting to be contacted for research. This has translated into 45 service users, 14% of overall recruitment consenting to take part in research from Lorenzo.			
A	**WORK ONGOING TO CARRY OVER TO 20/21**	1	Launch mandatory GCP training for clinical	MD		Q4	• 2018/19 Baseline by Professional GCP Trained			

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			professionals – 85% medics achieving compliance.				○ Doctors = 15 ○ AHP's = 2 ○ Nursing = 7 ○ Psychology = 5 ○ HCSW – 3 **Progress to date** • AHP, Psychology, Medic and Nursing professional groups all given access to GCP and information, how to book on and guidance. • Doctors' GCP Compliance - 74 Doctors identified 15 completed (19%) **Forward Plan:** • GCP monitored by R&D and fed back to Senior Medical Team; • GCP report available on EDGE to monitor compliance; • Performance reporting updated to CEG, MACE,R&D steering group and Senior Medical Team Meetings			
A	**COMPLETE REMOVE FROM 20/21**	2	Ensure alignment with Directorates. Develop capacity and capability to deliver R&D within Directorates in line	MD		Q3	• Directorates now receive tailored R&D bi-monthly performance reports for their performance meetings. These are			

			with Directorate plans, working in collaboration with Quality Improvement Leads.				reviewed and adapted based on the needs of the Directorates. • Objectives linked into GCP Training, PI Development and Early Career researchers to further support capacity and capability within Directorates			
SPAR	**WORK ONGOING TO CARRY OVER TO 20/21**	2	Continue to strengthen Keele & Staffordshire University Partnership. • Formalise Honorary lecture roles in: Nursing, Psychology, AHP and Social Work. • Meet criteria to become a University Trust. • Appoint a NED from academia.	MD		Q4	Work is on-going to strengthen relationships to build on the 4 medical Honorary Lecturer roles in place. Workshop undertaken with Keele to explore University opportunities and enhance partnership with Keele University.			
SPAR	**WORK ONGOING TO CARRY OVER TO 20/21**	1	Support and develop roles within the Trust structure. Identify one Primary Investigator (PI) within	MD		Q4	Six research specialties identified for research; Five PI's identified to date in five specialties; Dementia, Substance Misuse, Adult and			

			each specialty to ensure research delivery.				Older Peoples Mental Health, Learning Disability and Neurodegenerative. • To date no PI identified within Children and Young Peoples Services - no open studies **Forward Plan** • All staff completing GCP training and asked if they would like to become an early career researcher and/or Principal Investigator • PI Essential and Masterclass open to all staff			
SPAR	Implement a Trust wide innovation Strategy to support widespread engagement and to celebrate the successes achieved. **WORK ONGOING TO CARRY OVER TO 20/21**	1	Establish an Innovation Group incorporating expertise from across the Trust • 10% increase of ideas presented at Innovation Nation	MD		Q1	Innovation Collaborative Group established and first meeting held on the 24.09.2019. • ToR reviewed and approved at CEG, awaiting for discussion and review at SLT in January.			

SPAR	**WORK ONGOING TO CARRY OVER TO 20/21**	2	Develop and implement an 'Innovation Strategy' with support from MIDTECH and AHSN – to be approved by QC.	MD		Q3	**During Q3** • First meeting held September 2019; • Terms of Reference developed and currently under review; • Innovation page live on CAT **Forward Plan:** • MIDTECH to review of the R&D strategy and Intellectual Property Policy.			
SPAR	**WORK ONGOING TO CARRY OVER TO 20/21**	2	Establish Innovation Nation as the springboard for Dragon's Den to inspire and engage staff as part of an annual cycle to embed a culture of innovation (50% Conversion rate of ideas presented at Dragon's Den presented at Innovation Nation).	MD		Q4	• First meeting held September 2019; • Terms of Reference developed and reviewed by CEG; will be reviewed again alongside Trust Long Term Plan and Strategy – completion October 2020. • Innovation page live on CAT **Forward Plan:** • MIDTECH to undertake review of the R&D strategy and Intellectual Property Policy to align with innovation updates – completion October 2020.			

A	Increase Digital profile as national exemplar improving access to services within CYP through the use of digital technology. **WORK ONGOING TO CARRY OVER TO 20/21**	2	Delivery of the Lorenzo digital exemplar pilot within the CYP Directorate.	DPS		Q1	DXE have produced Project Initiation Document which has been approved by DoPS.			
A	**COMPLETE REMOVE FROM 20/21**	2	Complete LDE stocktake.	DPS		Q1	Presented at SLT – agreed.			
A	**COMPLETE REMOVE FROM 20/21**	2	Work with Director of Ops to ensure CYP & CAMHS clinical requirement is accurately articulated and technical solution is aligned.	DPS		Q1	Delivered through PID referenced above.			
-	Increased business acumen - Aligned to ICP masterclass, publication of Directorate Plan, Digital Maturity and Lorenzo GDE. **COMPLETE REMOVE FROM 20/21**	1	Development and delivery of masterclass material for business acumen & digital.	DPS		Q1	Digital schedule for November Board Development.			
-	**COMPLETE REMOVE FROM 20/21**	2	Expand Masterclass to include Integrated Care Partnership models and opportunities through ICP contract.	DPS		Q1	Board Development session held Q1 – complete.			

Objective 4:	**Embed an open and learning culture that enables continual improvement**									
SPAR PRIORITY										
Exec owner:	Director of Workforce, Organisational Development and Inclusion									
Assurance Committee:	People and Culture Development Committee									
Risk appetite	Financial		Quality (Innovation)		Regulation		Reputation			
RISK: *The Trust fails to continually learn and improve resulting in poor staff and service user experience.* *Risk Trend Arrow* ⟷	**Gross Risk (no mitigation)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/20)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	3	4	12	2	4	8	2	4	8
COVID-19 Risk - There is a risk to the quality of the Trust's services due to the COVID-19 pandemic which will impact on the safety, wellbeing and capacity of staff and patients	4	5	20	3	5	15	2	5	10
Links to 12+ Trust Risks	**Description of linked 12+ Trust Risks** • 901 – Diverse and inclusive workforce • 1034 –Staff engagement/PDR • 1072 – Clinical supervision									
Internal Assurance Examples				**External Assurance Examples**						

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Level 1	Level 2	Level 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

Number of Controls

SPAR Reference	CONTROLS to Mitigate Strategic Risk	Level of Assurance	Description of Assurance	Exec Owner	Year Start RAG	Qtr Due	Forward Plan/Progress	Q4 RAG	On Target RAG	Year End RAG
SPAR	Retain the best and develop new roles. **CARRY OVER TO 20/21 – NEW NARRARIVE ADDED**	1	New CPD resource for nurses and AHP's needs to be fully implemented to ensure that practice is supported	DON		Q4	Programme established and delivered by Consultant Nurses.			
A	**COMPLETE – REMOVE FOR 20/21**	2	Work with HEIs and partners in developing new roles for HCSW.	DON		Q3	Second cohort of Nursing Associates commenced.			
A	**CARRY OVER TO 20/21**	2	Develop leadership roles for non-medical staff with a BAME background.	DON		Q2	Practice Education Facilitator for BAME staff appointed.			

SPAR	Develop and deliver a strategy for the Psychology workforce with the key objectives of research, recruitment and retention. **COMPLETE – REMOVE FOR 20/21**	2	Deliver Psychology Strategy including clear career development pathway.	MD		Q3	During Q4 All strategy workstreams have been operationalised with accountable leads.			
SPAR	**CARRY OVER TO 20/21**	1	Develop a programme of 'Inspiring Clinical Psychologist' events for undergraduates.	MD		Q4	In line with the NHS workforce plan, future events will broaden out this offer by focusing on 'Aspiring Psychological Professionals'.			
SPAR	**CARRY OVER TO 20/21**	1	Deliver psychology led conference in partnership with Staffordshire University to Launch new Psychology Strategy.	MD		Q4	Psychological Professions Conference had been planned to take place on 20/05/20 at Stoke City FC. This conference has been cancelled due to the coronavirus pandemic and will be rescheduled at the earliest opportunity.			
SPAR	Embed and deliver Medical Transformation Programme. **CARRY OVER TO 20/21**	2	Deliver Medical Strategy through Medical Transformation Programme: • MDT care co-ordination	MD		Q3	Standard care plan format agreed. Added onto Lorenzo/			

SPAR	**CARRY OVER TO 20/21**	2	Deliver Medical Leadership programme with Keele.	MD		Q4	On-going and planning on track for another cohort to be delivered by end of the year.			
Delivering the right learning and development options through collaboration, partnering and best practice										
SPAR	Upskilling our workforce (new, existing and those returning). **CARRY OVER TO 20/21**	2	Maximise the apprenticeship levy to meet the future needs of the workforce based on the care pathways and business plan. Meet and exceed our public sector target for use of apprenticeship levy.	DWODI		Q4	Public Sector Target of 37 but a self-imposed Trust Target of 47 to address deficits 2017 - 2019 There were 5 new sign ups in Quarter 4 bringing the year end total to 24 new Apprenticeships Some starts planned for Q4 have been postponed by training providers due to the impact of Covid 19. This is also impacting on sign ups and recruitment for Quarter 1 for 2020/21 due to the focus being shifted to dealing with issues associated with the pandemic. The enhanced apprentice pay package is impacting with a marked increase in			

							applicants for recent positions. Two Levy transfers agreed Public sector target for 2020/21 is 37 new apprentice starts, however 70 new apprentice starts will be needed in year to account for shortfall in numbers 2017 - 2020			
SPAR	Maximise collaborative working across the STP to build skills and capacity in the local health economy. **CARRY OVER TO 20/21**	1	Continue to develop programmes in collaboration with delivery partners and other NHS Trusts and stakeholders. Cohorts of staff from local health economy learning together.	DWODI		Q4	Development of STP wide Train the Trainer courses for a number of specialist subject areas: 1. Suicide Awareness, Suicide Response 1 & 2. This course has been procured and funded to provide 20 Train the Trainer places across the STP. Appropriate organisations in the STP have been approached: D&B, UHNM, MPFT, Stoke Council, Staffs Council and NSCHT to nominate persons for their allocated places. Any shortfall leaving available places are to be given to Staffordshire and Keele			

							University with the agreement that all Student Clinician will receive the training during their education. Venues have been sourced and original dates amended with both venues and provider due to Covid-19 – provisional dates have been identified. Project plan for HEEWM amended and returned to reflect changes due to Covid-19. All monies secured for delivery in 20/21: venues, resources, organisational registrations etc Prospective trainers from across the Stoke and Staffs STP have been identified, HRD's across the STP have agreed to support the cascaded delivery throughout system over at least the next 2 years. Dementia Tier 2 Train the Trainers Courses (2) and Dementia Tier 2 courses (2). Dementia courses have successfully been developed and run in			

							Sept/Nov/Dec/Feb 20/21. Providing each organisation with Cascade Dementia Trainers able to deliver both Tier 1 & 2 Dementia Training within their organisations.. Project plan completed and returned to HEEWM. Remaining funds will be utilised to develop online learning resources to share with Primary Care Service 20/21			
SPAR	Continue to lead and influence the Leadership and OD programme to ensure the leaders in the STP are equipped with the behaviours to support integrated care models, and there is a pipeline of diverse aspirant leaders to progress into senior roles. **COMPLETE – REMOVE FROM 20/21**	1	Deliver 1st national pilot of the national Leadership Academy High Potential Scheme (HPS) across the STP.	DWODI		Q3	Applications opened in July and closed end of August. Assessment process, psychometric testing and interviews were completed in October. 16 Participants were identified in November 2019. Launch event complete 28th January 2020.			
SPAR	Learning and development options reflect the demands of our sector and the investment in Mental Health through the 10 year Plan. **WORK ONGOING – CARRY OVER TO 20/21**	1	Develop a suite of learning and development options that reflect the demands of our sector.	DWODI		Q4	Development of organisation and personal development: including clinical, service improvement and leadership skills.			

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							Train the Trainer courses for a number of specialist subject areas (suicide/self-harm domestic abuse /mental health awareness/dementia/frailty, stress in the workplace etc) and Stat/Mand education (SaferPeople Handling/Resus/Fire)			
SPAR	Leadership development activity aligns with the changing health economy landscape. **WORK ONGOING – CARRY OVER TO 20/21**	1	Delivery of In Place Leadership Programme with delivery partners AQuA.	DWODI		Q3	This 12 month development programme of 2 cohorts was completed in March 2020. Post programme (3 month) evaluation put on hold due to operational pressures (Covid-19)			
SPAR	**COMPLETE – REMOVE FROM 20/21**	1	Annual 2/3 week induction for newly registered professionals to include 1 week mandatory, 1 week preceptorship, 1 week MAPA (in-patient).	DWODI		Q1	All induction weeks planned, booked into the LMS and new starter places allocated ready for delivery upon commencement of employment Fully developed and delivered to coincide with the academic year – new professional – next cohort planned for October 2020.			

	COMPLETE – REMOVE FROM 20/21									
SPAR		1	Develop internal coaching and mentoring capacity to support leadership development activities.	DWODI		Q2	A coaching lead (0.1 WTE at Band 7) has been identified. Our internal coaching/mentoring pool has been established with membership of 16 qualified internal coaches. Coaching CPD and supervision commenced in September 2019 and takes place on a quarterly basis. Our internal coaching/mentoring pool are supporting delegates through the BAME Stepping Up programme, In Place Leadership Programme, Reverse Mentoring programme.			
SPAR	**Equality Delivery System (EDS2)** The care that services users and carers receive respects the diverse requirements of our local population **CARRY OVER TO 20/21**	2	The workforce more accurately represents the community it serves through themes identified within the: • Staff Survey • WRES	DWODI		Q4	Significant progress made towards being more representative of our local population. As at the end of March 2020, the Trust has achieved the following:-			

			• WDES • Annual D&I report • Deliver 1st cohort of Reverse Mentoring • Inclusion Council embedded and mainstreamed into normal business				• Workforce Representation: ACHIEVED Whilst there is more to achieve, good progress has been made on workforce representation in relation to ethnicity, LGB and Disability as follows:- • Ethnicity (BAME v white: as at 31st March 2020 8.05% of the Trust workforce are BAME (when not known excluded). Local population is 7.6% according to 2011 census. • LGB status 3.00% of those who stated sexual orientation stated they were LGorB (compared to national rate of approx. 6% and rate of 2.7% in 2019 ie minor improvement). 415 staff chose not to disclose (24%) which			

							remains the same as the 2019 figure. • Disability 7.7% (96 people) of the Trust workforce have declared a disability (after not known excluded; 5.5% of whole workforce which is an improvement on the rate reported in our 2019 WDES of 2.4% (34 people)). We have reduced the not know gap from 33% in 2019 to 28% in 2020, so heading in the right direction, but still a large gap. • Deliver 1st cohort of Reverse Mentoring: ACHIEVED: we are additionally planning further cohorts of Reverse Mentoring following the commencement of usual business following the end of COVID-19, including opportunity to work across			

							STP organisations • Inclusion Council embedded and mainstreamed into normal business: ACHIEVED: Bi-monthly meetings, chaired by CEO /Director of Workforce, widened remit to cover broader diversity characteristics (not just BAME).			

Objective 5:	Attract, develop and retain the best people									
SPAR PRIORITY										
Exec owner:	Director of Workforce, Organisational Development and Inclusion									
Assurance Committee:	People and Culture Development Committee									
Risk appetite	Financial		Quality (Innovation)		Regulation		Reputation			
RISK: *The Trust fails to attract, develop and retain talented people resulting in reduced quality and increased cost of services* *Risk Trend Arrow* ↑	**Gross Risk (no mitigation)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/20)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	4	4	16	4	4	16	3	4	12
COVID-19 Risk - There is a risk to the quality of the Trust's services due to the COVID-19 pandemic which will impact on the safety, wellbeing and capacity of staff and patients	4	5	20	3	5	15	2	5	10
Links to 12+ Trust Risks	**Description of linked 12+ Trust Risks** • 12 – Staffing • 901 – Diverse and inclusive workforce • 1011 – Exec capacity and STP • 1034 – Staff engagement/PDR									

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	• 1072 – Clinical supervision • 1111 – Locality Restructure and staff engagement

Internal Assurance Examples		External Assurance Examples
Level 1	**Level 2**	**Level 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**

Number of Controls

SPAR Reference	CONTROLS to Mitigate Strategic Risk	Level of Assurance	Description of Assurance	Exec Owner	Year Start RAG	Qtr Due	Forward Plan/Progress	Q4 RAG	On Target RAG	Year End RAG
SPAR	Deliver Talent Management Strategy linking Trust People & OD strategy and the Regional Talent Review Board. **WORK ONGOING – CARRY OVER TO 20/21**	1	Gather talent management ratings electronically.	DWODI		Q3	Appraisal module is live on LMS. All new appraisals include talent rating which can be reported on for the Trust, this element of LMS will be live by 31st March 2020. LMS Module complete. Work completed to address the Talent element of the Appraisal.			

							Appraisals all on hold due to Covid-1			
	WORK ONGOING – CARRY OVER TO 20/21	1	Hold staff engagement sessions.	DWODI		Q3	RISK – Capacity issues - Mitigation of risk capacity temporarily increased until. 30.06.2020 Engagement has now concluded and a talent management strategy is being drafted, ready to launch post-Covid-19, alongside the launch of our newly updated talent section of appraisal, and after the launch of the new national People Plan.			
	WORK ONGOING – CARRY OVER TO 20/21	1	Launch Talent Management Steering Group.	DWODI		Q4	RISK – Capacity issues - Mitigation of risk capacity temporarily increased until 30.06.20 On hold - Steering Group was originally to be set up once national People Plan launched, but this has been suspended due to Covid-19 New NHS People Plan to contain framework for Talent Management and Succession planning			

							linked to Regional Talent Boards.			
	WORK ONGOING – CARRY OVER TO 20/21	1	Approve Talent Management Strategy.	DWODI		Q2	See above note. RISK – Capacity issues - Mitigation of risk capacity temporarily increased until 30.06.20 See above note. Staff engagement underway and drafting basic draft strategy. This will be shaped and amended following further staff engagement and launch of national People Plan, before going out to consultation			
	WORK ONGOING – CARRY OVER TO 20/21	1	Form Talent Management Steering Group project teams.	DWODI		Q3	RISK – Capacity issues - Mitigation of risk capacity temporarily increased until 30.06.20 Due to dependency on above 2 actions, this action is likely to be carried over into Q1 of 2020/21 BAF.			
Building our capacity - Recruiting and retaining – Making Combined Healthcare a workplace destination										
SPAR	Establish the Trusts employment offer. **WORK ONGOING – CARRY OVER TO 20/21**	1	Develop comprehensive and competitive attraction	DWODI		Q1	Q4: Both the Trust's Vacancy and Turnover position have significantly			

			and retention offer				improved in year. Vacancy rate – from 14.5% in April 2019 to 12.5% in March 2020 Turnover position - from 14.4% April 19 to 11.8% March 2020.			
	COMPLETE – REMOVE FROM 20/21	1	Maximise reach through social media and traditional recruitment channels.	DWODI		Q2	The Trust has received 155 submissions through recruitment sign up form. Word of mouth has proven to be very effective in promoting the recruitment event, opportunity to maximise on this. We are also continuing to develop a virtual recruitment fair intending to reach potential applicants outside of the local area with a focus on Consultant, Band 5 Nursing and Psychology Roles.			
SPAR	Enhance our staff and wellbeing activities and initiatives to ensure that our working environment is supportive and encourages self-care. **WORK ONGOING – CARRY OVER TO 20/21**	1	Refresh workforce Health and Wellbeing Strategy – focused work streams regarding:	DWODI		Q2	H & W group now has local representatives from directorate teams to enhance engagement. Strategy and action plan in development. H&W is			

			• Musculoskeletal • Stress, Anxiety and Depression				currently being supported by the OD & Education Team due to the Covid-19 crisis: thus the focus is on addressing issues relating to COVID-19 as a priority over and above all previous strategy documentation.			
	WORK ONGOING – CARRY OVER TO 20/21	1	Enhanced presence of H&W via CAT and supporting communications	DWODI		Q3	Business case presented to Exec Team and SLT with aim to roll out Wellbeing and benefits platform in November 2019. In response to the COVID-19 major incident dedicated H&W pages have been developed which encompass both a comprehensive national and local offer.			
SPAR	Establish the Trusts employment offer. **COMPLETE – REMOVE FROM 20/21**	1	Comprehensive plans at Trust and Directorate level – to be reviewed on a quarterly basis.	DWODI		Q1	Initial Workforce plan completed and submitted based on financial forecast. Directorate plans remain ongoing and under review in accordance with identified transformation schemes and the Trust's			

							Business Cycle. As a result of COVID-19 all national and STP workforce plan submissions are currently suspended until further notice.			
SPAR	Deliver OD interventions to support staff engagement aligned to staff survey trends **WORK ONGOING – CARRY OVER TO 20/21**	2	Facilitate the development of staff survey action plans through staff engagement. Ensuring they reflect the Directorates ownership of their action plan.	DWODI		Q2	Each Directorate have developed their own action plans. OD Engagement Lead identified for Staff Survey, to support directorate action planning and developments in line with the Staff Survey – work on-going The Workforce Business Partner Team will also be providing Directorate support, advice and guidance with regards to this matter.			
Valuing and recognising individual contributions										
SPAR	Improve workforce engagement and recognition. **COMPLETE – REMOVE FROM 20/21**	1	Review, revamp and relaunch corporate induction.	DWODI		Q2	Corporate induction has been reviewed and revamped – we are continuing to develop the day: reviewing each day, amending and reflecting.			

							Induction e Magazine has been completed and now corporate induction is to be reviewed - to utilise released time to develop sessions within the day related to Trust values and behaviours. The e magazine includes information from the CEO presentation (facts, figures, directorates etc) Enabling the CEO slot into the Corporate Induction to be a 'welcome' and opening of good communication. Currently options paper being written for the Exec team to determine best way forward.			
	COMPLETE – REMOVE FROM 20/21	2	Appropriate development programmes to support staff as they embed locality based working and prepare for next phase. (Resource dependent).	DWODI		Q3	In Place Leadership programme now successfully completed.			

	COMPLETE – REMOVE FROM 20/21	1	Review the Trust's recognition and reward approach and streamline into an annual plan.	DWODI		Q2	Compassion card scheme continues: Q1 = 81 nominations. Q2 nominations =149 Q3 nominations = 236 Q4 nominations = 98 REACH – Monthly team and individual awards REACH Annual Awards.			
	COMPLETE – REMOVE FROM 20/21	2	Review impact and outcomes of Towards Outstanding Engagement initiative.	DWODI		Q3	No longer applicable as initiative not currently adopted.	**NO RAG**		
	Ensure our internal communication channels are accessible to all staff in all locations, are relevant and timely. **COMPLETE – REMOVE FROM 20/21**	2	Conduct and implement Strategic Review of integrated Comms & Engagement channels and products, maximising efficacy and reducing duplication.	DWODI		Q2	Communications plan updated and will be revised as part of the refreshed strategic plans.			
SPAR	Encouraging an open, fair, inclusive, transparent and just culture. **COMPLETE – REMOVE FROM 20/21**	1	Development of FTSU champions and being open approach.	DWODI		Q4	Champions in place and have received appropriate training and continue to receive support via FTSUG.			

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	WORK ONGOING – CARRY OVER TO 20/21	1	Widen the focus of the Inclusion Council to include other protected characteristics.	DWODI		Q3	We have discussed widening the remit of the Inclusion Council and agreed that positions be opened out widely to increase the representation of protected different characteristics. (This has successfully been achieved to include 3 new members).			
	WORK ONGOING – CARRY OVER TO 20/21		Explore Merseycare approach to Just Culture and how it can be applied here.	MD		Q3	MD and DOWODI to collaborate on how to embed a Just and Restorative Culture across the Trust. Restorative Workshop attended by Trust members. Presentation entitled "Just and Learning Culture" presented by Dr Adeyemo to November 2019 Board.			
	Co-create with staff and service users relevant and appropriate communication and engagement opportunities. **WORK ONGOING – CARRY OVER TO 20/21**	2	Build and extend Awareness Days calendar by liaison with staff groups and service users.	DWODI		Q3	Awareness Days Calendar now operational via MOOD and Comms Outlook account, cross-checking with national Awareness Days resource.			

							Specific social media and Podcast activities timetabled to coincide with Ramadan, national Apprenticeship Week, world Autism Week, Parkinson UK Day, LD Awareness Week, Mental Health Awareness Week, Volunteers Week, Stress Awareness Month, Cares Week and national `Share a Story` Month, National Smile Month.			
	Raise the profile of the Trust through enhanced reputation, brand and innovation. **WORK ONGOING – CARRY OVER TO 20/21**	2	Develop plan to increase external awareness of the corporate brand and straplines including profile in conferences, awards, thought leadership articles.	DWODI		Q3	In development. LEAP Active Partnerships Programme launched and initial sign-ups secured.			
SPAR	Embed Values and Behaviour framework. **WORK ONGOING – CARRY OVER TO 20/21**	2	Evidenced in all development programmes e.g. In Place Systems Leadership Programme	DWODI		Q1	RISK – Capacity issues - Mitigation of risk capacity temporarily increased			
	COMPLETE – REMOVE FROM 20/21	1	Co-produce and deliver Leadership Academy calendar activity for	DWODI		Q2	Leadership Academy is running bi-monthly. These strategic sessions			

			senior cadre of leaders in the Trust.				have successfully been run in April, June September November and February. These sessions deliver high level strategic sessions with our senior leaders. Sessions planned for 2020/21 Engagement has now concluded and a talent management strategy is being drafted, ready to launch post-Covid-19, alongside the launch of our newly updated talent section of appraisal, and after the launch of the new national People Plan.			
	WORK ONGOING – CARRY OVER TO 20/21	2	Develop a Values recognition scheme in addition to the current compassion scheme. Refresh staff REACH Awards criteria to embed values and behaviours in time for 2020 awards.	DWODI		Q3	This approach has been placed on hold in light of Covid-19, with the compassion recognition scheme continuing to be a vehicle for staff to recognise and value each others compassionate acts.			

SPAR	Leadership framework is visible throughout our documentation **WORK ONGOING – CARRY OVER TO 20/21**	2	Leadership framework evidenced in all development programmes.	DWODI		Q1	All current leadership development opportunities mapped against our talent pipeline. Once our new People Plan has been written (following engagement), all current leadership offers will be reviewed.			
	WORK ONGOING – CARRY OVER TO 20/21	2	Leadership development available at all stages of the talent pipeline in preparation for the link to the Regional Talent Board.	DWODI		Q4	All current leadership development opportunities mapped against our talent pipeline. Collaborative work is taking place with system NHS provider organisations to develop a new leadership offer that will strengthen our development throughout our leadership pipeline			
SPAR	Promote and extend our reach into all communities within our localities. **WORK ONGOING – CARRY OVER TO 20/21**	1	Stakeholder Engagement Map and Listening Landscape in MOOD. Develop Stakeholder Engagement Programme.	DWODI		Q3	LEAP programme launched and initial sign-ups secured. Stakeholder Map and Listening Landscape under construction.			

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			Find SomeOne in Health and Windows on the World to identify and engage key targets. Build LEAPS (Listening and Engagement Activity Partnerships). Increase number of engaged groups, with emphasis on Seldom Heard Groups.							

Objective 6:	Maximise and use our resources effectively and sustainably									
SPAR PRIORITY										
Exec owner:	Director of Finance, Performance and Digital									
Assurance Committee:	Finance, Performance and Estates									
Risk appetite	Financial		Quality (Innovation)		Regulation		Reputation			
RISK: *The Trust fails to optimise its resources resulting in an inability to be sustainable.* *Risk Trend Arrow*	**Gross Risk (no mitigation)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/20)**			
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	
	4	5	20	4	4	16	3	4	12	
COVID-19 Risk - There is a risk that as a result of COVID-19 business as usual and financial arrangements are not in place for 20/21 and there is insufficient monies to ensure continued abilities to pay staff and suppliers and so ensure business continuity	4	5	20	3	5	15	2	5	10	
Links to 12+ Trust Risks	**Description of linked 12+ Trust Risks** • 12 –Staffing • 843 – ROSE system change restrictions • 868 – Agency spend • 1010 – New models of care									

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	• 1111 – Locality restructure • 1071 – Contract for Estates services • 1019 – ROSE and quality • 1035 – CIP • 1037 – Substance misuse contract • 1069 – Carillion • 1124 – Financial risk re PICU beds

Internal Assurance Examples		External Assurance Examples
Level 1	**Level 2**	**Level 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**

Number of Controls

SPAR Reference	CONTROLS to Mitigate Strategic Risk	Level of Assurance	Description of Assurance	Exec Owner	Year Start RAG	Qtr Due	Forward Plan/Progress	Q4 RAG	On Target RAG	Year End RAG
-	Delivery of CIP targets. **ON HOLD PENDING NATIONAL GUIDANCE**	1	CIP target of £2.5m for 19/20 is achieved recurrently.	DO		Q4	Shortfall of recurrent position currently £0.8m			
		1	CIP target for CEO portfolio is achieved	CEO		Q4	CIP target achieved.			

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			recurrently.							
		1	CIP target for DoN portfolio is achieved recurrently.	DON		Q4	Q4 – partial achievement of CIP at year end			
		1	CIP target for MD portfolio is achieved recurrently.	MD		Q4	CIP target achieved.			
		1	CIP target for DSDE portfolio is achieved recurrently.	DPS		Q4	CIP target achieved.			
		1	CIP target for DOF portfolio is achieved recurrently.	DOF		Q4	Plans in place for whole target remains an amount to be transacted.			
		1	CIP target for DWODI portfolio is achieved recurrently.	DWODI		Q4	Remains a challenge. Non recurrent monies identified.			
		1	CIP target for DO portfolio is achieved recurrently.	DO		Q4	CIP target achieved.			
		2	Granular CIP plans are developed for 20/21.	DO		Q4	On hold due to pending national guidance	No RAG as on hold nationally		

		2	All CIP proposals are assessed for the impact on quality of services (QIA).	DON/MD		Ongoing	QIA refreshed for Q4 and 20/21.			
		1	Undertake a review of CIP QIA documentation and process.	DO		Q2	New PID and QIA documentation developed and in place from M1.			
SPAR	Medical job plans reflect efficient use of resources. **WORK ONGOING – CARRY OVER TO 20/21**	2	Each session in the job plan is identified and in line with contracted activities and is kept up to date.	MD/DO		Q3	Job planning policy has been revised on track for approval by LNC.			
SPAR	Five year financial model aligned to organisational and STP strategy (year 1 of 5). **ON HOLD PENDING NATIONAL GUIDANCE**		Five year plan is developed which describes plans for sustainability.	DOF		Q3	System plan complete along with Combined long term plan.			
			Delivery of the control total.	DOF		Q4	Achieved .			
			Use of resources level 1.	DOF		Q4	Use of resources level 2.			
			Agency spend contained within the agency cap throughout the year.	DO		Qtly	Agency spend above ceiling.			
	COMPLETE REMOVE FOR 20/21		Implementation of automatic team level financial dashboards.	DOF		Q3	Overtaken by work on EVO and service line reporting. Remove for 20/21			

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SPAR	Delivery of STP Financial Plan. **ON HOLD PENDING NATIONAL GUIDANCE**	3	Work with the STP long-term financial plan for system solutions to. resolve the deficit.	DOF		Q1	5 year plan complete but does not return the system to surplus in the period. Combined plan is to maintain surplus in the period. Work on-going re ST sprints.			
SPAR	Rationalisation of the Trust Estate ensuring value for money. **WORK ONGOING – CARRY OVER TO 20/21**	2	Development of a five year Estates Strategy aligning the estate to operational delivery, locality working and strategic direction.	DOF		Q3	Resource challenges in estates have made this difficult to deliver. Estates workstream established to drive this forward.			
SPAR	Capital Plan **WORK ONGOING – CARRY OVER TO 20/21**	2	Implement 20/21 capital plan:	DOF		Q4	Develop and implement capital plan for 20/21			
	WORK ONGOING – CARRY OVER TO 20/21	2	• Crisis Cafes	DOF		Q3	OPO established chaired by DOPS considering options. Business case being developed as part of this.			
	WORK ONGOING – CARRY OVER TO 20/21	2	• Disposal of Ashcombe Centre.	DOF		Q4	Decision taken to not proceed with this project.	**NO RAG**		
	WORK ONGOING – CARRY OVER TO 20/21	2	Develop 2-5 year capital plan.	DOF		Q2	Capital plan developed.			

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SPAR	Implementation of a Business Intelligence Strategy. **WORK ONGOING – CARRY OVER TO 20/21**		Strategy developed.	DOF		Q1	Development underway			
			Roll out of new PQMF.	DOF		Q1	New IQPR reported to September Board.			
	COMPLETE REMOVE FOR 20/21		Develop Business Case for infrastructure associated with business intelligence.	DOF		Q2	Development underway in conjunction with development of strategy.			
SPAR	Deliver Operational plan - Complete for 19/20 and await revised national guidance expected in June 2021 to create a new 20/21 Operational Plan objective alongside refresh of Strategic Plan and Enabling strategies **COMPLETE REMOVE FOR 20/21**	2	Complete publication of Directorate Plans in order to support objectives outlined in Operational Plan.	DPS		Q1	Operational Plan submitted per national timeline. Need to organise refresh of Directorate Plans to reflect final version.			
	COMPLETE REMOVE FOR 20/21	2	Directorate Plans to be approved Q1 aligned to submission of final Operational Plan.	DPS		Q1	As above.			
		1	Review of delivery on quarterly basis.	DPS		Qtly	Quarterly review in place.			
	COMPLETE REMOVE FOR 20/21	2	Development of longer term Directorate Plans to support delivery of 5 year Strategy.	DPS		Q4	Revised timeframe to Q4 as agreed by Board.			

	COMPLETE REMOVE FOR 20/21									
		2	Directorate resource and skills map to ensure corporate support function is articulated and equipped to deliver.	DPS		Q1	PMO will be established by November 2019.			
S	Enhance our recruitment service experience Streamlining our systems and processes. **COMPLETE REMOVE FOR 20/21**	1	Deliver electronic talent management system in the Trust (PDRs in LMS).	DWODI		Q1	Appraisal Module in LMS and fully functional.			
A	Enhance our HRIS effectiveness Streamlining our systems and processes. **CARRY OVER TO 20/21**	1	Develop ESR Self Service capabilities and efficiencies	DWODI		Q3	This was paused due to the appointment of a substantive DOWDI starting in post in order to determine the agreed direction for the Trust.			
SPAR	Effective implementation of the Agenda for Change contract refresh. **COMPLETE REMOVE FOR 20/21**	1	All Workforce Policies and Procedures are progressive and aligned to the amended terms and conditions by 2021.	DWODI		Q4	Action complete All policies are updated. Still to complete long term plan around roll out linked to ESR Manager Self Service.			
	COMPLETE REMOVE FOR 20/21	1	Closure of Band 1 for new entrants and process for	DWODI		Q1/ Q4	Action complete.			

			progressing current Band 1 staff.							
	COMPLETE REMOVE FOR 20/21	1	Associated Workforce Policies to be refreshed and approved. • Pay Progression • PDR • Performance Management Policy	DWODI		Q4	Complete.			

Objective 7:	Take a lead role in partnership working, integration and well-being									
SPAR PRIORITY										
Exec owner:	Director of Partnerships and Strategy									
Assurance Committee:	Business Development Committee									
Risk appetite	Financial		Quality (Innovation)		Regulation		Reputation			
RISK: *The Trust fails to lead in partnership working resulting in an absence of system and clinical integration.* *Risk Trend Arrow*	Gross Risk (no mitigation)			Residual Risk (with mitigation)			Target Risk (31/03/20)			
	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE	
	4	4	16	4	4	16	2	4	8	
COVID-19 Risk - There is a risk that the Trust cannot maintain business critical functions due to the impact of COVID-19	4	5	20	3	5	15	2	5	10	
Links to 12+ Trust Risks	**Description of linked 12+ Trust Risks** •									

Internal Assurance Examples		External Assurance Examples
Level 1	**Level 2**	**Level 3**
• Corporate Performance Report/ Dashboard • Internal Performance • Reportable Issues Alert • Quality Account	• Strategy implemented • Plan realised • Clinical Audit • Unannounced Assurance Visits	• Internal Audit (linked to annual plan) • National Patient Satisfaction Surveys (F & F Test) • Healthwatch Reports • Independent Reviews (e.g. Ombudsman Reports)

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• **Practice Improvement & Lessons Learnt Report** • **Complaints and Concerns Report** • **Incident Reports** • **SI Reports**	• **Performance Scrutiny**	• **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**

Number of Controls

SPAR Reference	CONTROLS to Mitigate Strategic Risk	Level of Assurance	Description of Assurance	Exec Owner	Year Start RAG	Qtr Due	Forward Plan / Progress	Q4 RAG	On Target RAG	Year End RAG
SPAR	Enhance approach to Sustainability Development Goals. **CARRY OVER TO 20/21**	2	DPS will bring forward an assessment of the Trust's position against the SDGs with a plan for further development	DPS		Q4	As part of Board Development and linked to the development of the 5 year strategies. SDG scheduled for January Board Development			
SPAR	Commitment to the STP as a willing partner in deploying the skills and expertise of our workforce outside of our immediate organisational boundaries. **WORK ONGOING – CARRY OVER TO 20/21**	3	CEO is the lead for the Mental Health workstream.	CEO		Ongoing	On hold			
	WORK ONGOING – CARRY OVER TO 20/21	3	Trust is the lead for the OD workstream.	CEO (DW ODI)		Ongoing	On hold			

	WORK ONGOING – CARRY OVER TO 20/21	3	Trust is Programme Director lead for the Mental Health work stream.	CEO (DO)		Ongoing	On hold			
SPAR	Alliance Board **WORK ONGOING – CARRY OVER TO 20/21**	2	The system has agreed to manage the entire Recovery agenda through ICP footprints. Which essentially means that the next stage of system change will be done through the lens of ICPs	DPS		Q3 20/21	The system has agreed to manage the entire Recovery agenda through ICP footprints. Which essentially means that the next stage of system change will be done through the lens of ICPs (which are the alliance Board footprints by a different name)			
AR	Development of Co-operative Working Group beyond March 2018 - Aligned to reset of Alliance Board. **COMPLETE REMOVE FOR 20/21**	1	CWG in current form will cease Q4 18/19.	DPS		Q4 (18/19)	CWG ceased.			
	COMPLETE REMOVE FOR 20/21	2	Re-specify Alliance Board PMO needs following Alliance Board workshop and agree recruitment process.	DPS		Q1	System agreement on system architecture. Operational in shadow form April 2020. Alliance Board workshop planned for October 2019.			
	WORK ONGOING – CARRY OVER TO 20/21	2	Collaborative Network	DPS		Q1	Collaborative Network continues to meet monthly			

							with DPS as Vice-Chair			
SPAR	Reset Alliance Board - To provide leadership to the reset of the Alliance Board in collaboration with other system partners. **COMPLETE REMOVE FOR 20/21**	2	Alliance Board workshop.	DPS		Q4 (18/19)	Alliance Board workshop held 20.03.19.			
	COMPLETE REMOVE FOR 20/21	2	Development of Alliance Board roadmap.	DPS		Q1	Alliance Board reset in progress.			
	COMPLETE REMOVE FOR 20/21	3	Influence STP Integrated Care Systems workshop.	DPS		Q1	Complete and continues with PWC facilitation events.			
	COMPLETE REMOVE FOR 20/21	1	Establish Alliance Board PMO.	DPS		Q2	Alliance Board workshop October 2019.			
AR	IAPT tender. **COMPLETE REMOVE FOR 20/21**	1	IAPT procurement process expected to go live.	DPS		Q1	Complete.			
	COMPLETE REMOVE FOR 20/21	3	Co-ordinate NSCHT response to IAPT tender.	DPS		Q2	Complete.			
SPAR	Develop Partnership Strategy. **COMPLETE REMOVE FOR 20/21**	2	Complete stakeholder analysis to identify key partners and	DPS		Q1	Complete.			

			relationship with NSCHT.							
	COMPLETE REMOVE FOR 20/21	2	Use outcome of above to inform development of NSCHT Partnership Strategy.	DPS		Q2	Complete – approved by BDC August 2019.			
	COMPLETE REMOVE FOR 20/21	2	Host series of 1-2-1 meetings with key partners to share strategic direction of travel.	DPS		Q2	Complete.			
SPAR	Complete migration of Primary Care Services into NSCHT **COMPLETE REMOVE FOR 20/21**	1	Recruit to Senior Primary Care Support Manager.	DPS		Q1	Complete – in post.			
		1	Complete residual tasks handed over through mobilisation.	DPS		Q1	Plan remains on track.			
		2	Establish Primary Care reporting lines fully via finance and performance support.	DPS		Q1	Performance & Finance through PCC.			
		2	Consider transfer to	DPS		Q3	Will be a Primary Care			

			Ops Directorate as BAU.				Directorate from 1st April 2020			
SPAR	Continue to identify and develop further primary care service offerings. **WORK ONGOING – CARRY OVER TO 20/21**	2	Continued dialogue with GP Practices who have shown an interest in NSCHT service menu.	DPS		Q1-4	In progress.			
		2	Share PCN support proposal and agree how to bring to market.	DPS		Q1	PCN support package developed. Discussions with Practices being arranged.			
		3	Propose NSCHT hosts PCN for integrated practice.	DPS		Q1	Offer has been made.			
		2	Establish PCN support programme.	DPS		Q2	Complete.			
SPAR	Publish Directorate Plan. **COMPLETE REMOVE FOR 20/21**	3	To work with Partnerships and Strategy colleagues to develop a granular level Directorate plan to include key objectives, individual actions and CIP	DPS		Q1	Complete and CIP plan developed.			

			delivery.							

Board Assurance Framework (BAF) 2019/2020 – Quarter 4 Update and 2020/2021 Outline Plan

Summary Report in Response to COVID-19 – May 2020

Key

Carry over to 20/21
Work ongoing to carry over to 20/21
Complete – remove from 20/21
On hold
Consider Closing

Objective 1:		**To enhance service user and carer collaboration**		
Exec owner:		Director of Nursing and Quality		
Assurance Committee:		Quality Committee		
SPAR Reference	**CONTROLS to Mitigate Strategic Risk**	**Status**	**Description of Assurance**	**Exec Owner**
R	Enhance Service User & Carer Collaboration - Focus on Service Users Recovery.	Carry over to 20/21	Embed the Wellbeing Academy to support recovery with greater participation of peers. Aim to have SU attend at least one of the Well Being Academy's. Measure SU experience of the Academy and report to QC.	DON
AR		Carry over to 20/21	Further embed Peer Support Workers and Peer Support Mentor roles, as a key component of our workforce having lived experience. This will be evidenced by increased numbers of service users and carers in our workforce on either a voluntary or paid basis year on year.	DON
SPAR		Carry over to 20/21	The Trust will achieve a year on year improvement for the overall indicator of "better" in the Community Mental Health Survey. 2018 score = 6.7	DO
ARP	Ensure we are constantly pushing channel development to ensure the Trust is at the forefront of digitalisation that will enhance service user engagement.	Carry over to 20/21	Embed digital channels across all service areas including the use of Combined Podcast. Create subtitled versions on YouTube to ensure inclusive as possible. Implement Social Media Optimisation Plan.	DWODI
PR	Embed Person Centredness Framework	Complete – remove from 20/21	Implement the framework and produce tools to support service users and staff.	DON

BAF 2019/20 Q4 Update and Summary of Actions to Carry Forward to 20/21

Objective 2:		**To provide the highest quality, safe and effective services**		
Exec owner:		Director of Nursing and Quality and Medical Director		
Assurance Committee:		Quality Committee		
SPAR Reference	**CONTROLS to Mitigate Strategic Risk**	**Status**	**Description of Assurance**	**Exec Owner**
SPAR	CQC Rating of 'Outstanding' is maintained.	Carry over to 20/21	A rating of 'good' for all core services in the Safe domain (Adult Inpatient Wards).	CEO
			An increase in the number of core services rated as 'outstanding' currently 3/11).	CEO
SPAR		Complete - remove from 20/21	Continue partnership arrangements with Northumberland, Tyne and Wear with a focus on: • Mental Health Act Compliance • Clinical Pathways • Quality Improvement	CEO
SPAR	Continue work to strengthen approach to risk management including:	Work ongoing to carry over to 20/21	Risk appetite analysis is undertaken for strategic risks.	ACEO
			Undertake residual and target score gap analysis 6 monthly and undertake deep dive for long standing risks 6 monthly.	ACEO
SPAR	Develop a Trust wide systematic approach to quality improvement.	Work ongoing to carry over to 20/21	Continue to strengthen relationship with the CQC via regular engagement meetings and new inspection team	DON
			Develop and implement Combined Quality Improvement (QI) strategy	DON
			Embed SPAR accreditation across all inpatient wards (pilot completed 18/19).	DON
R	Develop our social work partnership with Stoke on Trent City Council to ensure professional support for social workers in the Trust	Work ongoing to carry over to 20/21	Social work Network took place 27.3.19. Tasked with completed Strategy May 2019.	DON
S	Improved physical health monitoring for service users.	Complete remove from 20/21	Introduce NEWS2 early warning tool to support the SEPSIS programme.	DON

BAF 2019/20 Q4 Update and Summary of Actions to Carry Forward to 20/21

S	People with complex needs are supported.	Complete remove from 20/21	Embed trauma informed care across all wards (QI). 85% of acute in-patient staff to receive training in Trauma Informed Care and SU to report satisfaction with Care Plan.	DON
SPAR		Work ongoing to carry over to 20/21	Updated narrative - Implement new PD service to enable pathway for service users with EUPD	DO
AR		Complete remove from 20/21	Develop autism strategy and inform commissioning.	DON
S	Zero Suicide Ambition – 2019/20 is the third year of this collaborative journey with partners to reduce deaths by suicide as part of the county wide strategy.	Complete remove from 20/21	Deliver the Trust Suicide Prevention Strategy:	MD
		Work ongoing to carry over to 20/21	• Provide 8 NSCHT staff members with 'Train the Trainer suicide response training' • NEW for 20/21 - Change objective to - Cascade 'Connecting with People' training approach	MD
S		Complete remove from 20/21	Work with partners to deliver Suicide Charter: • Deliver Annual STP Zero Suicide Conference	MD
PA		Complete remove from 20/21	• Ensure standardised bereavement support is offered to the family and carers each time (monitor through review of SI report).	MD
S		Work ongoing to carry over to 20/21	Investment in environmental ligature improvements as per the capital plan.	DOF
S		Work ongoing to carry over to 20/21	Complete PDSA cycle into panel review methodology to improve learning from serious incidents. Findings of review to inform the Trust's approach to structuring 'Panel Reviews' throughout the Trust.	MD
SPAR	Every patient can expect Mental Health Law compliance.	Zero tolerance for failure to comply with the MHA:		MD
		Work ongoing to carry over to 20/21	• Two LiA workshops (informed by QI methodology) to be held for section 17 leave and consent.	MD
		Work ongoing to carry over to 20/21	• 100% compliance with requirements for Section 17 leave.	MD

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		Work ongoing to carry over to 20/21	• 100% compliance with requirements for consent.	MD
AR	Dual Diagnosis – 2019/20 is the second year for this programme of work. Delivery of the Trust wide Strategy for service users with Dual Diagnosis.	Consider closing	• Integrate DD strategy by disseminating and publicising.	MD
AR		Work ongoing to carry over to 20/21	• Establish joint case review processes in all Directorates for all service users with DD.	MD
AR		Consider closing	• Embed Dual Diagnosis Training across the Trust through e-learning (monitoring from Q2).	MD
S	100% achievement of CQUIN scheme	Work ongoing to carry over to 20/21	Flu Vaccination Achievement target 90%.	DON
S		Complete remove from 20/21	Data Quality • DQMI 95% • Interventions 70%	DOF
R		Complete remove from 20/21	IAPT Anxiety Outcome Measures 65%.	DO
SPAR		Complete remove from 20/21	Tobacco and Alcohol Achievement targets: • Screening 80% • Tobacco intervention 90% • Alcohol intervention 90%	MD
A		Work ongoing to carry over to 20/21	72 hour follow-up: • Achievement target 95% (48 hour)	DO
S	Revise Pharmacy strategy to ensure delivery of integrated working within the community teams.	Complete remove from 20/21	Align a Pharmacist with each Directorate.	MD
-		Work ongoing to carry over to 20/21	Each Pharmacist to complete an innovation project within their Directorate.	MD
S		Complete remove from 20/21	Pharmacists to deliver four training sessions within their Directorate in collaboration with Clinical Leads.	MD
A	Services are responsive to the	Work ongoing to carry over	92% compliance for referral to treatment (2nd contact) in 18 weeks.	DO

BAF 2019/20 Q4 Update and Summary of Actions to Carry Forward to 20/21

	needs of service users.	to 20/21		
SA		Work ongoing to carry over to 20/21	100% compliance with 3 hour assessment target for service users entering the Place of Safety (where clinically appropriate).	DO
A		Work ongoing to carry over to 20/21	90% compliance referral to assessment within 4 weeks (CAMHS).	DO
S		Work ongoing to carry over to 20/21	Deliver substantial compliance against EPRR core standards in annual declaration.	DO
A		Work ongoing to carry over to 20/21	There are zero acute adult mental health out of area placements.	DO
A		Complete remove from 20/21	PICU is fully open and operational with six beds from May 2019.	DO
SPAR		Complete remove from 20/21	Improve the responsiveness and quality of mental health urgent care services through delivery of the Mental Health Crisis Care Centre and Alcohol Detox Pathway.	DO
SPAR		On hold	Drive CIP and productivity through the Directorates utilising Model Hospital, NHS Benchmarking Network and other national productivity benchmarks.	DO
A	Provision of more accessible services through the Trust wide use of video conferencing services to make life more convenient for service users, carers and staff.	Work ongoing to carry over to 20/21	Pilot video conferencing across inpatient and community site to assess compatibility with services design.	MD
		Complete remove from 20/21	Implement and embed the use of video consultation services across the Trust to facilitate agile working.	MD
S	Protect the Trust from Cyber Threats.	Work ongoing to carry over to 20/21	Work in partnership with UHNM & MPFT to deliver Cyber Security project. • Project plan Q1.	DPS
S		Work ongoing to carry over to 20/21	• Project mobilisation from Q2.	DPS
SPAR	Improve the accessibility of data across multiple providers - ICR Procurement.	Work ongoing to carry over to 20/21	Undertake assessment of 'readiness' to align internal systems with the new ICR to FPD.	DPS
			Preferred bidder identified.	DPS

BAF 2019/20 Q4 Update and Summary of Actions to Carry Forward to 20/21

			Contract sign-off.	DPS
			Mobilisation from Q2 onwards.	DPS
-	Become a more digitally mature organisation - Align with action to review Digital Governance architecture.	Complete remove from 20/21	Develop action plan to support improvement in Digital Maturity following completion of DMI 18/19.	DPS
-		Complete remove from 20/21	• Bring forward proposals to NSCHT Exec and F&r Q1.	DPS
-		Work ongoing to carry over to 20/21	• Implementation Q2 20/21 following the Digital Strategy being approved at July Board.	DPS

BAF 2019/20 Q4 Update and Summary of Actions to Carry Forward to 20/21

Objective 3:		**Inspire and implement innovation and research**		
Exec owner:		Medical Director		
Assurance Committee:		Quality Committee		
SPAR Reference	**CONTROLS to Mitigate Strategic Risk**	**Status**	**Description of Assurance**	**Exec Owner**
A	Ensure delivery of the Research Strategy.	Work ongoing to carry over to 20/21	Optimise use of 'Consent to research initiative' – 20% increase on consenting to research against 2018/19 figure of 702 (13%).	MD
A		Work ongoing to carry over to 20/21	Launch mandatory GCP training for clinical professionals – 85% medics achieving compliance.	MD
A		Complete remove from 20/21	Ensure alignment with Directorates. Develop capacity and capability to deliver R&D within Directorates in line with Directorate plans, working in collaboration with Quality Improvement Leads.	MD
SPAR		Work ongoing to carry over to 20/21	Continue to strengthen Keele & Staffordshire University Partnership. • Formalise Honorary Lecture roles in: Nursing, Psychology, AHP and Social Work. • Meet criteria to become a University Trust. • Appoint a NED from academia.	MD
SPAR		Work ongoing to carry over to 20/21	Support and develop roles within the Trust structure. Identify one Primary Investigator (PI) within each specialty to ensure research delivery.	MD
SPAR	Implement a Trust wide innovation Strategy to support widespread engagement and to celebrate the successes achieved.	Work ongoing to carry over to 20/21	Establish an Innovation Group incorporating expertise from across the Trust • 10% increase of ideas presented at Innovation Nation	MD
SPAR		Work ongoing to carry over to 20/21	Develop and implement an 'Innovation Strategy' with support from MIDTECH and AHSN – to be approved by QC.	MD
SPAR		Work ongoing to carry over to 20/21	Establish Innovation Nation as the springboard for Dragon's Den to inspire and engage staff as part of an annual cycle to embed a culture of innovation (50% Conversion rate of ideas presented at Dragon's Den presented at Innovation Nation).	MD

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A	Increase Digital profile as national exemplar improving access to services within CYP through the use of digital technology.	Work ongoing to carry over to 20/21	Delivery of the Lorenzo digital exemplar pilot within the CYP Directorate.	DPS
A		Complete remove from 20/21	Complete LDE stocktake.	DPS
A		Complete remove from 20/21	Work with Director of Ops to ensure CYP & CAMHS clinical requirement is accurately articulated and technical solution is aligned.	DPS
-	Increased business acumen - Aligned to ICP masterclass, publication of Directorate Plan, Digital Maturity and Lorenzo GDE.	Complete remove from 20/21	Development and delivery of masterclass material for business acumen & digital.	DPS
-		Complete remove from 20/21	Expand Masterclass to include Integrated Care Partnership models and opportunities through ICP contract.	DPS

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Objective 4:		**Embed an open and learning culture that enables continual improvement**		
Exec owner:		Director of Workforce, Organisational Development and Inclusion		
Assurance Committee:		People and Culture Development Committee		
SPAR Reference	**CONTROLS to Mitigate Strategic Risk**	**Status**	**Description of Assurance**	**Exec Owner**
SPAR	Retain the best and develop new roles.	Carry over to 20/21	New CPD resource for nurses and AHP's needs to be fully implemented to ensure that practice is supported	DON
A		Complete – remove for 20/21	Work with HEIs and partners in developing new roles for HCSW.	DON
A		Carry over to 20/21	Develop leadership roles for non-medical staff with a BAME background.	DON
SPAR	Develop and deliver a strategy for the Psychology workforce with the key objectives of research, recruitment and retention.	Complete – remove for 20/21	Deliver Psychology Strategy including clear career development pathway.	MD
SPAR		Carry over to 20/21	Develop a programme of 'Inspiring Clinical Psychologist' events for undergraduates.	MD
SPAR		Carry over to 20/21	Deliver psychology led conference in partnership with Staffordshire University to Launch new Psychology Strategy.	MD
SPAR	Embed and deliver Medical Transformation Programme.	Carry over to 20/21	Deliver Medical Strategy through Medical Transformation Programme: • MDT care co-ordination	MD
SPAR		Carry over to 20/21	Deliver Medical Leadership programme with Keele.	MD
Delivering the right learning and development options through collaboration, partnering and best practice				
SPAR	Upskilling our workforce (new, existing and those returning).	Carry over to 20/21	Maximise the apprenticeship levy to meet the future needs of the workforce based on the care pathways and business plan. Meet and exceed our public sector target for use of apprenticeship levy.	DWODI
SPAR	Maximise collaborative working across the STP to build skills and capacity in the local health	Carry over to 20/21	Continue to develop programmes in collaboration with delivery partners and other NHS Trusts and stakeholders. Cohorts of staff from local health economy learning together.	DWODI

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	economy.			
SPAR	Continue to lead and influence the Leadership and OD programme to ensure the leaders in the STP are equipped with the behaviours to support integrated care models, and there is a pipeline of diverse aspirant leaders to progress into senior roles.	Complete – remove from 20/21	Deliver 1st national pilot of the national Leadership Academy High Potential Scheme (HPS) across the STP.	DWODI
SPAR	Learning and development options reflect the demands of our sector and the investment in Mental Health through the 10 year Plan.	Work ongoing – carry over to 20/21	Develop a suite of learning and development options that reflect the demands of our sector.	DWODI
SPAR	Leadership development activity aligns with the changing health economy landscape.	Work ongoing – carry over to 20/21	Delivery of In Place Leadership Programme with delivery partners AQuA.	DWODI
SPAR		Complete – remove from 20/21	Annual 2/3 week induction for newly registered professionals to include 1 week mandatory, 1 week preceptorship, 1 week MAPA (in-patient).	DWODI
SPAR		Complete – remove from 20/21	Develop internal coaching and mentoring capacity to support leadership development activities.	DWODI
SPAR	**Equality Delivery System (EDS2)** The care that services users and carers receive respects the diverse requirements of our local population	Carry over to 20/21	The workforce more accurately represents the community it serves through themes identified within the: • Staff Survey • WRES • WDES • Annual D&I report • Deliver 1st cohort of Reverse Mentoring • Inclusion Council embedded and mainstreamed into normal business	DWODI

Objective 5:		**Attract, develop and retain the best people**		
Exec owner:		Director of Workforce, Organisational Development and Inclusion		
Assurance Committee:		People and Culture Development Committee		
SPAR Reference	**CONTROLS to Mitigate Strategic Risk**	**Status**	**Description of Assurance**	**Exec Owner**
SPAR	Deliver Talent Management Strategy linking Trust People & OD strategy and the Regional Talent Review Board.	Work ongoing – carry over to 20/21	Gather talent management ratings electronically.	DWODI
		Work ongoing – carry over to 20/21	Hold staff engagement sessions.	DWODI
		Work ongoing – carry over to 20/21	Launch Talent Management Steering Group.	DWODI
		Work ongoing – carry over to 20/21	Approve Talent Management Strategy.	DWODI
		Work ongoing – carry over to 20/21	Form Talent Management Steering Group project teams.	DWODI
Building our capacity - Recruiting and retaining – Making Combined Healthcare a workplace destination				
SPAR	Establish the Trusts employment offer.	Work ongoing – carry over to 20/21	Develop comprehensive and competitive attraction and retention offer	DWODI
		Complete – remove from 20/21	Maximise reach through social media and traditional recruitment channels.	DWODI
SPAR	Enhance our staff and wellbeing activities and initiatives to ensure that our working environment is supportive and encourages self-care.	Work ongoing – carry over to 20/21	Refresh workforce Health and Wellbeing Strategy – focused work streams regarding: • Musculoskeletal • Stress, Anxiety and Depression	DWODI
		Work ongoing – carry over to 20/21	Enhanced presence of H&W via CAT and supporting communications	DWODI
SPAR	Establish the Trusts employment offer.	Complete – remove from 20/21	Comprehensive plans at Trust and Directorate level – to be reviewed on a quarterly basis.	DWODI

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SPAR	Deliver OD interventions to support staff engagement aligned to staff survey trends	Work ongoing – carry over to 20/21	Facilitate the development of staff survey action plans through staff engagement. Ensuring they reflect the Directorates ownership of their action plan.	DWODI
Valuing and recognising individual contributions				
SPAR	Improve workforce engagement and recognition.	Complete – remove from 20/21	Review, revamp and relaunch corporate induction.	DWODI
		Complete – remove from 20/21	Appropriate development programmes to support staff as they embed locality based working and prepare for next phase. (Resource dependent).	DWODI
		Complete – remove from 20/21	Review the Trust's recognition and reward approach and streamline into an annual plan.	DWODI
		Complete – remove from 20/21	Review impact and outcomes of Towards Outstanding Engagement initiative.	DWODI
	Ensure our internal communication channels are accessible to all staff in all locations, are relevant and timely.	Complete – remove from 20/21	Conduct and implement Strategic Review of integrated Comms & Engagement channels and products, maximising efficacy and reducing duplication.	DWODI
SPAR	Encouraging an open, fair, inclusive, transparent and just culture.	Complete – remove from 20/21	Development of FTSU champions and being open approach.	DWODI
		Work ongoing – carry over to 20/21	Widen the focus of the Inclusion Council to include other protected characteristics.	DWODI
		Work ongoing – carry over to 20/21	Explore Merseycare approach to Just Culture and how it can be applied here.	MD
	Co-create with staff and service users relevant and appropriate communication and engagement opportunities.	Work ongoing – carry over to 20/21	Build and extend Awareness Days calendar by liaison with staff groups and service users.	DWODI
	Raise the profile of the Trust through enhanced reputation, brand and innovation	Work ongoing – carry over to 20/21	Develop plan to increase external awareness of the corporate brand and straplines including profile in conferences, awards, thought leadership articles.	DWODI
SPAR	Embed Values and Behaviour framework.	Work ongoing – carry over to 20/21	Evidenced in all development programmes e.g. In Place Systems Leadership Programme	DWODI

BAF 2019/20 Q4 Update and Summary of Actions to Carry Forward to 20/21

		Complete – remove from 20/21	Co-produce and deliver Leadership Academy calendar activity for senior cadre of leaders in the Trust.	DWODI
		Work ongoing – carry over to 20/21	Develop a Values recognition scheme in addition to the current compassion scheme. Refresh staff REACH Awards criteria to embed values and behaviours in time for 2020 awards.	DWODI
SPAR	Leadership framework is visible throughout our documentation	Work ongoing – carry over to 20/21	Leadership framework evidenced in all development programmes.	DWODI
		Work ongoing – carry over to 20/21	Leadership development available at all stages of the talent pipeline in preparation for the link to the Regional Talent Board.	DWODI
SPAR	Promote and extend our reach into all communities within our localities.	Work ongoing – carry over to 20/21	• Stakeholder Engagement Map and Listening Landscape in MOOD. • Develop Stakeholder Engagement Programme. • Find SomeOne in Health and Windows on the World to identify and engage key targets. • Build LEAPS (Listening and Engagement Activity Partnerships). • Increase number of engaged groups, with emphasis on Seldom Heard Groups.	DWODI

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Objective 6:		**Maximise and use our resources effectively and sustainably**		
Exec owner:		Director of Finance, Performance and Digital		
Assurance Committee:		Finance, Performance and Estates		
SPAR Reference	**CONTROLS to Mitigate Strategic Risk**	**Status**	**Description of Assurance**	**Exec Owner**
-	Delivery of CIP targets.	On hold pending national guidance	CIP target of £2.5m for 19/20 is achieved recurrently.	DO
			CIP target for CEO portfolio is achieved recurrently.	CEO
			CIP target for DoN portfolio is achieved recurrently.	DON
			CIP target for MD portfolio is achieved recurrently.	MD
			CIP target for DSDE portfolio is achieved recurrently.	DPS
			CIP target for DOF portfolio is achieved recurrently.	DOF
			CIP target for DWODI portfolio is achieved recurrently.	DWODI
			CIP target for DO portfolio is achieved recurrently.	DO
			Granular CIP plans are developed for 20/21.	DO
		Work ongoing – carry over to 20/21	All CIP proposals are assessed for the impact on quality of services (QIA).	DON/MD
		Complete remove for 20/21	Undertake a review of CIP QIA documentation and process.	DO
SPAR	Medical job plans reflect efficient use of resources.	Work ongoing – carry over to 20/21	Each session in the job plan is identified and in line with contracted activities and is kept up to date.	MD/DO
SPAR	Five year financial model aligned to organisational and STP strategy (year 1 of 5).	On hold pending national guidance	Five year plan is developed which describes plans for sustainability.	DOF
			Delivery of the control total.	DOF

BAF 2019/20 Q4 Update and Summary of Actions to Carry Forward to 20/21

			Use of resources level 1.	DOF
			Agency spend contained within the agency cap throughout the year.	DO
SPAR	Delivery of STP Financial Plan.	On hold pending national guidance	Work with the STP long-term financial plan for system solutions to. resolve the deficit.	DOF
SPAR	Rationalisation of the Trust Estate ensuring value for money.	Work ongoing – carry over to 20/21	Development of a five year Estates Strategy aligning the estate to operational delivery, locality working and strategic direction.	DOF
SPAR	Capital Plan	Complete remove for 20/21 and re-open for 20/21	Develop and implement 19/20 capital plan:	DOF
		Work ongoing – carry over to 20/21	• Crisis Cafes	DOF
		Work ongoing – carry over to 20/21	• Disposal of Ashcombe Centre.	DOF
		Work ongoing – carry over to 20/21	Develop 2-5 year capital plan.	DOF
SPAR	Implementation of a Business Intelligence Strategy.	Work ongoing – carry over to 20/21	Strategy developed.	DOF
		Complete remove for 20/21	Roll out of new PQMF.	DOF
		Complete remove for 20/21	Develop Business Case for infrastructure associated with business intelligence.	DOF
SPAR	Deliver Operational plan – Complete for 19/20 and await revised national guidance expected in June 2021 to create a new 20/21 Operational Plan objective alongside refresh of Strategic Plan and Enabling strategies	Complete remove for 20/21	Complete publication of Directorate Plans in order to support objectives outlined in Operational Plan.	DPS
		Complete remove for 20/21	Directorate Plans to be approved Q1 aligned to submission of final Operational Plan.	DPS
		Complete remove for 20/21	Review of delivery on quarterly basis.	DPS
		Complete remove	Development of longer term Directorate Plans to support delivery of 5 year Strategy.	DPS

BAF 2019/20 Q4 Update and Summary of Actions to Carry Forward to 20/21

		for 20/21		
		Complete remove for 20/21	Directorate resource and skills map to ensure corporate support function is articulated and equipped to deliver.	DPS
S	Enhance our recruitment service experience Streamlining our systems and processes.	Complete remove for 20/21	Deliver electronic talent management system in the Trust (PDRs in LMS).	DWODI
A	Enhance our HRIS effectiveness Streamlining our systems and processes.	Carry over to 20/21	Develop ESR Self Service capabilities and efficiencies	DWODI
SPAR	Effective implementation of the Agenda for Change contract refresh.	Complete remove for 20/21	All Workforce Policies and Procedures are progressive and aligned to the amended terms and conditions by 2021.	DWODI
		Complete remove for 20/21	Closure of Band 1 for new entrants and process for progressing current Band 1 staff.	DWODI
		Complete remove for 20/21	Associated Workforce Policies to be refreshed and approved. • Pay Progression • PDR • Performance Management Policy	DWODI

BAF 2019/20 Q4 Update and Summary of Actions to Carry Forward to 20/21

Objective 7:		**Take a lead role in partnership working, integration and well-being**		
Exec owner:		Director of Partnerships and Strategy		
Assurance Committee:		Business Development Committee		
SPAR Reference	**CONTROLS to Mitigate Strategic Risk**	**Status**	**Description of Assurance**	**Exec Owner**
SPAR	Enhance approach to Sustainability Development Goals.	Carry over to 20/21	DPS will bring forward an assessment of the Trust's position against the SDGs with a plan for further development	DPS
SPAR	Commitment to the STP as a willing partner in deploying the skills and expertise of our workforce outside of our immediate organisational boundaries.	Work ongoing – carry over to 20/21	CEO is the lead for the Mental Health workstream.	CEO
		Work ongoing – carry over to 20/21	Trust is the lead for the OD workstream.	CEO (DWODI)
		Work ongoing – carry over to 20/21	Trust is Programme Director lead for the Mental Health work stream.	CEO (DO)
SPAR	Alliance Board	Work ongoing – carry over to 20/21	The system has agreed to manage the entire Recovery agenda through ICP footprints. Which essentially means that the next stage of system change will be done through the lens of ICPs	DPS
AR	Development of Co-operative Working Group beyond March 2018 - Aligned to reset of Alliance Board.	Complete remove for 20/21	CWG in current form will cease Q4 18/19.	DPS
		Complete remove for 20/21	Re-specify Alliance Board PMO needs following Alliance Board workshop and agree recruitment process.	DPS
		Work ongoing – carry over to 20/21	Collaborative Network continues to meet monthly with DPS as Vice-Chair	DPS
SPAR	Reset Alliance Board - To provide leadership to the reset of the Alliance Board in collaboration with other system partners.	Complete remove for 20/21	Alliance Board workshop.	DPS

BAF 2019/20 Q4 Update and Summary of Actions to Carry Forward to 20/21

		Complete remove for 20/21	Development of Alliance Board roadmap.	DPS
		Complete remove for 20/21	Influence STP Integrated Care Systems workshop.	DPS
		Complete remove for 20/21	Establish Alliance Board PMO.	DPS
AR	IAPT tender.	Complete remove for 20/21	IAPT procurement process expected to go live.	DPS
		Complete remove for 20/21	Co-ordinate NSCHT response to IAPT tender.	DPS
SPAR	Develop Partnership Strategy.	Complete remove for 20/21	Complete stakeholder analysis to identify key partners and relationship with NSCHT.	DPS
		Complete remove for 20/21	Use outcome of above to inform development of NSCHT Partnership Strategy.	DPS
		Complete remove for 20/21	Host series of 1-2-1 meetings with key partners to share strategic direction of travel.	DPS
SPAR	Complete migration of Primary Care Services into NSCHT	Complete remove for 20/21	Recruit to Senior Primary Care Support Manager.	DPS
			Complete residual tasks handed over through mobilisation.	DPS
			Establish Primary Care reporting lines fully via finance and performance support.	DPS
			Consider transfer to Ops Directorate as BAU.	DPS
SPAR	Continue to identify and develop further primary care service offerings.	Work ongoing – carry over to 20/21	Continued dialogue with GP Practices who have shown an interest in NSCHT service menu.	DPS
			Share PCN support proposal and agree how to bring to market.	DPS
			Propose NSCHT hosts PCN for integrated practice.	DPS
			Establish PCN support programme.	DPS

BAF 2019/20 Q4 Update and Summary of Actions to Carry Forward to 20/21

SPAR	Publish Directorate Plan.	Complete remove for 20/21	To work with Partnerships and Strategy colleagues to develop a granular level Directorate plan to include key objectives, individual actions and CIP delivery.	DPS

BAF 2019/20 Q4 Update and Summary of Actions to Carry Forward to 20/21

North Staffordshire Combined Healthcare NHS Trust

REPORT TO PUBLIC TRUST BOARD

Enclosure No: 16a

Date of Meeting:	14th May 2020		
Title of Report:	Trust Self Certification – Condition G6 – The provider has taken all precautions necessary to comply with the license, NHS Acts and NHS Constitution.		
Presented by:	Tosca Fairchild, Assistant Chief Executive		
Author:	Laurie Wrench, Associate Director of Governance		
Executive Lead Name:	Tosca Fairchild, Assistant Chief Executive Officer	**Approved by Exec**	☒

Executive Summary:	**Purpose of report**	
Although NHS trusts are exempt from needing the provider licence, directions from the Secretary of State require NHSIE to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate. The Single Oversight Framework (SOF) bases its oversight on the NHS provider licence. NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions (including Condition G6 and Condition FT4) and must self-certify under these licence provisions. NHS trusts are required to self-certify that they can meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that they have complied with governance requirements. Trust Board must self-certify and confirm compliance against condition G6 by 31st May 2020	**Approval**	☒
	Information	☐
	Discussion	☐
	Assurance	☐

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	1
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration. ☐ 2. To provide the highest quality, safe and effective services ☐ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☐ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. ☐ 7. Take a lead role in partnership working and integration. ☐		

Risk / legal implications: Risk Register Ref	The Single Oversight Framework (SOF) bases its oversight on the NHS provider licence. NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions (including Condition G6 and Condition FT4) and must self-certify under these licence provisions
Resource Implications: Funding Source:	None
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	There is no direct impact on the protected characteristics as part of the completion of this report;
STP Alignment / Implications	None
Recommendations:	That the Board approve the G6 self-certification.

Worksheet "G6 & CoS7" | **Financial Year to which self-certification relates** | 2019/2020 | Please complete the explanatory information in cell

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.		Please Respond

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		Please Respond

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

[e.g. key risks to delivery of CRS, assets or subcontractors required to deliver CRS, etc.]

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	David Rogers	**Name**	Peter Axon
Capacity	Chair	**Capacity**	Chief Executive
Date	27th April 2020	**Date**	27th April 2020

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

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REPORT TO PUBLIC TRUST BOARD

Enclosure No:16b

Date of Meeting:	14th May 2020		
Title of Report:	Self-Certification – Condition FT4		
Presented by:	Tosca Fairchild, Assistant Chief Executive		
Author:	Laurie Wrench, Associate Director of Governance		
Executive Lead Name:	Tosca Fairchild, Assistant Chief Executive Officer	**Approved by Exec**	☒

Executive Summary:	**Purpose of report**	
Although NHS trusts are exempt from needing the provider licence, directions from the Secretary of State require the NHS Trust Development Authority to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate. The Single Oversight Framework (SOF) bases its oversight on the NHS provider licence. NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions (including Condition G6 and Condition FT4) and must self-certify under these licence provisions. NHS trusts are required to self-certify that they can meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that they have complied with governance requirements. Trust Board must self-certify and confirm compliance against condition FT4 by 30th June 2020	**Approval**	☒
	Information	☐
	Discussion	☐
	Assurance	☐

Seen at:	SLT ☐ Execs ☒ Date:	Document Version No.	1
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration. ☐ 2. To provide the highest quality, safe and effective services ☐ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☐ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. ☐ 7. Take a lead role in partnership working and integration. ☐		
Risk / legal implications: Risk Register Ref	The Single Oversight Framework (SOF) bases its oversight on the NHS provider licence. NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions (including Condition G6 and Condition FT4) and must self-certify under these licence provisions		

Resource Implications: Funding Source:	N/A
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	N/A
SYP Alignment / Implications	None
Recommendations:	The Board approve the self-certification for condition FT4

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1 Corporate Governance Statement	Response	Controls and Assurances
1 The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	**Confirmed**	Risk is mitigated through the following mechanisms: • Statement of Internal Audit Assurance within the Annual Governance Statement (AGS) • Regular review of the Board Assurance Framework (BAF) • Regular review of Committee and Board Effectiveness • Register of Declarations of Interest • Freedom of Information responses • Risk Management processes and reporting • Board Development • Fit and Proper Persons • CQC rating of 'good' for well led • Overall CQC rating of 'Outstanding' • Internal, external and counter fraud work programme • Affiliation with AQUA • Adherence to Standards of Business Conduct
2 The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	**Confirmed**	Mitigation of Risk: • Single Oversight Framework Category 2 • Affiliation with AQUA as recommended by NHSIE

		• Overall CQC rating of 'Outstanding'
3 The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	**Confirmed**	Risk is mitigated through: • A review of Board and Committee effectiveness undertaken including Committee Terms of Reference, frequency of meetings, membership of committees, ongoing Board development, sub group reporting arrangements • Committee structure review including sub-committees • Board Development Programme • Leadership Academy

4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	**Confirmed**	Risk is mitigated through: • Financial balance • Finance and Resource Committee reporting to Board • CQC rating of 'good' • Robust Performance Management Framework and performance improvement plans • Purchase order processes • Investment policy • Delegated authority limits • 1, 2 and 5 year business plans • CIP plans and QIA process

5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	**Confirmed**	Risk is mitigated through: • Executive Director leadership for quality by Director of Nursing and Quality and Medical Director • Board developments topics in quality • Board to team unannounced quality assurance visits • Announced quality assurance visits with CCG, service users / carers and Healthwatch • Involvement of service user and carer council • Observe and Act programme • QIA on CIP • Quality Account • Quality Committee reports to Board • Scrutiny of the Performance Management Framework at committee and Board • Performance Improvment plans for metrics where target not achieved, including actions and trajectory for improvement • New Improving for Quality Report introdcued • Quality priorities – Safe, Personalise, Accessible and Recovery Focussed (SPAR) • Strategic objectives relate to quality measured through the BAF • Overall CQC rating of 'Outstanding'

6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Confirmed**	• Declaration of good character • Fit and Proper Persons • Declarations of Interest • NHSI led process re appointment of Chair and Non-Executive Directors • DBS

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____

Name David Rogers

Signature _____

Name Peter Axon

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REPORT TO PUBLIC TRUST BOARD

Enclosure No: 17

Date of Meeting:	14th May 2020		
Title of Report:	Workforce Disability Equality Standard (WDES) update: NSCHT performance in 2019 WDES compared to national picture		
Presented by:	Shajeda Ahmed, Director of Workforce, OD and Inclusion		
Author:	Lesley Faux, Diversity & Inclusion Lead		
Executive Lead Name:	Shajeda Ahmed, Director of Workforce, OD and Inclusion	**Approved by Exec**	☒

Executive Summary:	**Purpose of report**	
The Workforce Disability Equality Standard (WDES) became a requirement under the NHS Standard Contract in 2019-20. All Trusts were required to submit their WDES data in Summer 2019, with their action plans being published by end September. The 2019 WDES national report and executive summary were published this month. This report compares the performance for North Staffordshire Combined Healthcare NHS Trust to the national average. It also provides an update on changes to the WDES process for 2020 in view of the COVID-19 pandemic and includes a short update on action taken since September 2019. Overall, the Trust has performed well in relation to the 10 WDES indicators. Our best performing area were: • **Presenteeism** – fewer staff (disabled and non-disabled) feeling pressured to come to work despite not feeling well enough to perform their duties • **Harassment, bullying and abuse by both managers and other colleagues** – much lower levels than the national average • **Workplace adjustments** – a greater proportion of staff with disabilities who are satisfied that adjustments put in place to support them are adequate The 3 areas of weakest performance for NSCHT were:- • **Recruitment –** our worst indicator - almost twice as difficult to be appointed from interview with a disability compared to those without a disability • **Disability declaration rates** - lower than the national average • **Harassment, bullying and abuse by patients** – slightly higher than the national average	**Approval**	☐
	Information	☒
	Discussion	☐
	Assurance	☒

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 Objectives (please indicate)	1. To enhance service user and carer collaboration. ☐ 2. To provide the highest quality, safe and effective services ☒ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☐ 5. Attract, develop and retain the best people. ☒ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☐		
Risk / legal implications: Risk Register Reference	• WDES is mandated under the NHS Standard Contract and assessed and monitored by the CQC and local commissioners • Disability is a protected characteristic under the Equality Act 2010 and its associated Public Sector Equality Duty		
Resource Implications: Funding Source:	Within existing resources. As part of the NHS Standard Contract, commissioners ultimately have the ability to reduce funding as a penalty for non-compliance. Not applicable.		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	The WDES is a positive action process specifically intended to reduce the inequalities experienced in the NHS workplace between those with disabilities and those without. The first year of reporting (2019) focusses on identifying the base-line position		

North Staffordshire Combined Healthcare NHS Trust

	locally and nationally and beginning to formulate action based on these findings. Future years will focus on making improvements and reducing the identified gaps.	
STP Alignment / Implications:	All NHS organisations are required to participate in the WDES.	
Recommendations:	To receive for assurance	
Version	Name/group	Date issued

North Staffordshire Combined Healthcare NHS Trust

Workforce Disability Equality Standard Update:
NSCHT compared to national rates
(national data as published April 2020)

1.0 Introduction

The Workforce Disability Equality Standard (WDES) became a requirement under the NHS Standard Contract from the financial year 2019-20. All Trusts were required to submit their WDES data in summer 2019, with their action plans being published by end September. The 2019 WDES national report and executive summary were published this month.

The WDES comprises a collection of 10 Metrics that incorporate data from three primary sources; the NHS Electronic Staff Record (ESR), NHS Staff Survey, and local HR and recruitment systems.

The Workforce Disability Equality Standard (WDES) has been introduced to make a positive impact for the benefit of Disabled people, either currently working in, or aspiring to work in, the NHS. The WDES is underpinned by the Social Model of Disability, which proposes that people are disabled because of societal barriers, rather than a long-term health condition. With the social model in mind, the WDES will help inform year-on-year improvements in reducing those barriers that impact most on the career and workplace experiences of Disabled staff; driving changes in attitudes, increasing employment and career opportunities, and implementing long-lasting change for Disabled people.

This report compares the performance for North Staffordshire Combined Healthcare NHS Trust to the national average. It also provides an update on changes to the WDES process for 2020 in view of the COVID-19 pandemic and includes a short update on action taken since September 2019.

2.0 WDES Update

2.1 WDES 2019

The recently published WDES Annual Report 2019 provides the first national review of the NHS workforce relating to workplace representation and career experiences of staff with disabilities. An easy read version of the Executive summary will shortly be shared and NHS England/Improvement will be sending 3 printed copies of the main report to each Trust in May 2020.

The detailed data analysis contained in the report clearly highlights disparities between the experiences of Disabled and non-disabled staff across the 10 WDES metrics. This evidence demonstrates the need for trusts to take robust action, with monitoring and evaluation, to ensure that progress takes place and to embed the WDES into ongoing work programmes that support positive change.

Over the coming 12 months, NHS England/Improvement will continue to support progress through a range of actions and activities including an innovation fund, webinars, best practice guides and the dissemination of information and evidence-based actions that will lead to further improvement.

2.2 WDES 2020 and the COVID-19 pandemic

Due to the deepening COVID-19 pandemic, both the WDES and the Workforce Race Equality Standard (WRES) teams have decided to suspend the data collection process for 2020. As a result, there is no longer a requirement on NHS organisations to submit their WDES data this summer. Both the WDES and WRES teams will look to produce short data reports later this year; these will be based upon already available data for NHS trusts. Momentum on both these programmes will be re-established once the COVID-19 situation has dissipated.

Details of a number of FREE webinars over the coming weeks relating to disability at work are contained at ***Appendix One***.

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3.0 Trust Results compared to National Averages for 2019

The Trust's results in the 2019 WDES, compared to the national findings are set out in the table below, and also presented in a more visually appealing format at ***Appendix Two***.

Metric 1: Workforce representation

Percentage of staff with disability compared to staff without a disability:-

- **National:** 2.9% clinical and 3.6% non-clinical
- **NSCHT:** 2.4% clinical and 2.1% non-clinical (2.4% overall) – slightly lower reporting of disability than nationally

Metric 2: Recruitment

Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.

- **National score:** 1.23
- **NSCHT score** 1.9 (almost twice as hard to be appointed if disabled – much worse than national rate)

Metric 3: Capability

Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process (formal capability procedure).

- **National score:** 1.1 (ie slightly more likely to go through formal capability process if have a disability)
- **NSCHT**: n/a - no formal capability cases where subject has a disability (only 2 capability cases in total)

Metric 4: Harassment, Bullying & Abuse

Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:

i. Patients/service users, their relatives or other members of the public
   - **National:** 33.8% v 26.8% (difference of 7.0 percentage points)
   - **NSCHT:** 35.6% v 26.5% (difference of 9.1 percentage points) – slightly higher level of HBA and a larger gap between the 2 groups

ii. Managers
   - **National:** 19.8% v 13.0% (difference of 6.8 percentage points)
   - **NSCHT:** 8.8% v 6.7% (difference of 2.1 percentage points) – much lower rates of HBA and much smaller gap between the 2 groups

iii. Other colleagues
   - **National:** 26.8% v 18.1% (difference of 8.7 percentage points
   - **NSCHT:** 14.0% v 9.4% (difference of 4.6 percentage points) – much lower rates of HBA and much smaller gap between the 2 groups

Metric 5: Career Progression

Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.

- **NSCHT:** 80.2% v 87.8% - higher rates of belief that the Trust provides equal opportunities compared to national rates (difference of 7.7 percentage points – slightly bigger gap, but in same ballpark)
- **National:** 75.3% v 82.7% (difference of 7.4 percentage points)

Metric 6: Presenteeism

Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

- **National:** 32.0% v 23.0% (difference of 9.0 percentage points)
- **NSCHT:** 15.3% v 13.1% (difference of 2.1 percentage points) – much lower rates of presenteeism for both disabled and non-disabled than nationally, and much smaller difference between the two groups

Metric 7: Feeling Valued

Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

- **National:** 37.2% v 47.9% (difference of 10.7 percentage points)
- **NSCHT:** 37.8% v 48.5% (difference of 10.7 percentage points) – very slightly lower/virtually the same as national level of satisfaction with feeling valued, with same difference between the 2 groups.

Metric 8: Workplace Adjustments

Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

- **National:** 72.4% satisfied adjustments made are adequate:
- **NSCHT:** 82.7% satisfied adjustments made are adequate – considerably higher levels of satisfaction with adjustments made than national rate

Metric 9: Disabled Staff Engagement

The staff engagement score for Disabled staff, compared to non-disabled staff.

- **National score**: 6.64 for disabled staff v 7.01 for non-disabled
- **NSCHT score**: 6.8 for disabled staff v 7.1 for non-disabled – slightly higher rates of engagement (both groups) and a similar/slightly smaller gap between the 2 groups

Metric 10: Board Representation

Percentage difference between the organisation's board voting membership and its overall workforce

- **National:** 2.1% of board members declared a disability
- **NSCHT:** No board members declared a disability – ie data suggests our Board is not representative of the reported disability levels across the workforce as a whole

3.1 Trust Strongest and Weakest Areas of Performance in the WDES

Overall, the Trust has performed quite well in relation to the 10 indicators in the first year of reporting (2019 WDES).

Our 3 **best performing** area were:

- **Presenteeism (Metric 6)** – significantly fewer staff (disabled and non-disabled) feeling pressured to come to work despite not feeling well enough to perform their duties compared to the national findings:-
  - National: 32.0% v 23.0% (difference of 9.0 percentage points)
  - **NSCHT: 15.3% v 13.1% (difference of 2.1 percentage points)**
- **Harassment, bullying and abuse by both managers and other colleagues (Metric 4ii & 4iii)** – much lower levels than the national average:-

  4ii. HBA from Managers (however, see below re 4i HBA by patients)
  - National: 19.8% v 13.0% (difference of 6.8 percentage points)
  - **NSCHT: 8.8% v 6.7% (difference of 2.1 percentage points)**

  4iii. HBA from other colleagues
  - National: 26.8% v 18.1% (difference of 8.7 percentage points
  - **NSCHT: 14.0% v 9.4% (difference of 4.6 percentage points)**
- **Workplace adjustments (Metric 8)** – a greater proportion of staff with disabilities who are satisfied that adjustments put in place to support them are adequate
  - National: 72.4% satisfied adjustments made are adequate:
  - **NSCHT: 82.7% satisfied adjustments made are adequate**

The 3 areas of **weakest performance** for NSCHT were:-

- **Recruitment (Metric 2)** – our worst indicator - almost twice as difficult to be appointed from interview if you have a disability compared to those without a disability
  - National score: 1.23
  - **NSCHT score 1.9** (almost twice as hard to be appointed if disabled – much worse than national rate)
- **Disability declaration rates (Metric 1)** – slightly lower disability reporting compared with the national average
  - National: 2.9% clinical and 3.6% non-clinical
  - **NSCHT: 2.4% clinical and 2.1% non-clinical (2.4% overall)**
- **Harassment, bullying and abuse by patients/service users and the public (Metric 4i)*** – slightly higher than the national average and a bigger difference between the 2 groups

  4i. HBA by patients/service users, their relatives or other members of the public
  - National: 33.8% v 26.8% (difference of 7.0 percentage points)
  - **NSCHT: 35.6% v 26.5% (difference of 9.1 percentage points)** – slightly higher level of HBA and a larger gap between the 2 groups

  * It is important to note on this indicator that the WDES national benchmarking is based on all Trusts. Mental health Trusts are likely to experience a higher level of harassment, bullying and abuse from patients/service users and this is indeed reflected in the data when groups of similar trusts are compared. The national average on this indicator for mental health and learning disability trusts in the 2018 staff survey (2019 WDES) was actually 36.5%, making the Trust slightly better than average (see Appendix 4 for data).

NHS North Staffordshire Combined Healthcare NHS Trust

4.0 WDES Progress Update

Our Trust performance in the NHS Staff Survey (2019) questions relevant to the WDES has been recently reported (see summary at Appendix Three). It is likely that this will form the majority of the 2020 WDES reporting in view of the changes to arrangements due to the COVID-19 crisis.

The table below provides commentary on changes in WDES indicators formed from the NHS Staff Survey over the first 2 years of the WDES (ie 2018 and 2019 NHS Staff Survey feeding 2019 and 2020 WDES).

Overall, the Trust performed well and improved performance across the WDES indicators. Frequently, the Trust's scores showed improvement on the previous year and were better than average for the benchmark group (MH & LD trusts).

Metric 4 (harassment, bullying and abuse) is the only indicator that did not show clear improvement. On this indicator, there was some improvement (4i, HBA from patients and the public) and for the areas where there was a deterioration (see red below), the change was minimal and the scores still better than average for mental health and learning disability trusts.

• **Metric 4:** a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: i. Patients/service users, their relatives or other members of the public ii. Managers iii. Other colleagues b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	**4a** i. Slight reduction in % experiencing HBA from patients & public (36% to 35%). Slightly better than benchmark average (37%). **ii.** Slight increase in HBA of staff with disabilities by managers (9% to 10%) but significantly better than benchmark rate. **iii.** Increase in bullying by others (8.8% to 10%) - but significantly better than benchmark rate (17%). **4b** – reduction (68%to 60%) in reporting of HBA by staffs with disabilities, but in line with benchmark rates
• **Metric 5:** Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	• Marginal improvement (80% to 82%) in perception of equal opportunities by staff with disabilities • Better than benchmark group (76%)
• **Metric 6:** Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	• Marginal reduction in experience pressure by staff with disabilities (15.2% to 14.8%) • Much better than benchmark group (22%)
• **Metric 7:** Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	• Slight improvement in staff satisfaction by staff with disabilities (38% to 41%) • In line with benchmark group (41.7%)
• **Metric 8:** Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	• Improvement (from 83% to 88%) in positive perceptions • Much better than benchmark group (77% on both years)
• **Metric 9:** (a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.	• Improvement in staff engagement score for staff with disabilities 6.8 to 7.0. • Better than benchmark group.

Key progress with our WDES action plan is listed below:-

- Developing membership of our Neurodiversity Staff Network
- Establishment of a Trust Autism Strategy Implementation Group
- Staff with no information recorded in ESR contacted to ask to update their record
- Various activities and communications pieces through 2019-20 to raise awareness and profile about disability at work and to encourage staff to feel more confident to be open about disability

Key action still to be progressed:-

- Establishment of a Disability Staff Network
- Embedding of our Disability Staff Network and our Neurodiversity Staff Network as key voice for people with disabilities, consulted and influential in the development of Trust policy and practice
- Task and Finish Group to be established to deliver progress against the Disability Confident Framework

5.0 Conclusion and Recommendations

In summary, the Trust has performed generally quite well in comparison to other Trusts nationally in relation to the WRES measures in 2019 and also in 2020 (based on those measures that form part of the NHS Staff Survey).

We have also delivered improvement on a significant number of the WDES measures that form part of the NHS Staff Survey, and which are likely to form the bulk of the WDES data collection for 2020.

Considerable progress has been made against our 2019-20 WDES Action Plan, but a number of key actions remain uncomplete.

It is proposed that the Trust resume action against this plan following the end of COVID-19 restrictions with outstanding deadlines extended to December 2020.

APPENDIX ONE

Disability Confident and AbilityNet (Free) Practical Webinars

Disability Confident Webinar topics and details:

Topic 1: New Ways of Working – how best to support disabled people

When: 22nd April 2020, 11.30 – 12.00

- Creating your home-work setting
- Considering your ergonomic environment
- Accessible hints and tips

Registration URL: https://attendee.gotowebinar.com/register/6029084455780210443
Webinar ID: 384-426-099

Topic 2: Managing Communications in your team and ensuring accessibility

When: 30th April 2020 11.30 - 12.00

- What does communication mean in a virtual environment?
- How do we get the setting right?
- How to avoid communication clashes in your team

Registration URL: https://attendee.gotowebinar.com/register/6515508399908415499
Webinar ID: 176-746-427

Topic 3: Looking after your health and well-being

When: 6th May 2020, 11.30 - 12.00

- Understanding anxieties at this time
- Considering ways of taking control
- Ways to help your whole-self and supporting others
- Hints and tips

Registration URL: https://attendee.gotowebinar.com/register/3746708323238313995
Webinar ID: 491-693-875

Topic 4: Recruiting and Retaining Disabled People

When: 13th May 2020 11.30 - 12.00

- Considering the challenges that COVID 19 has raised for disability employment
- Opening up new opportunities for work
- Question and answer session

Registration URL: https://attendee.gotowebinar.com/register/8430137475378197771
Webinar ID: 335-182-307

Abilitynet free webinars (Wednesdays)
AbilityNet helps people of any age and with any disability to use technology to achieve their goals at home, at work and in education. By providing specialist advice services, free information resources, e.g. webinars and by helping to build a more accessible digital world. Please listen to a recording of the 1st webinar held on 26 March 2020 and sign up for future Wednesday webinars.

NHS North Staffordshire Combined Healthcare NHS Trust

APPENDIX TWO

Workforce Disability Equality Standard (WDES)
NSCHT 2019 (baseline) data compared to national rates

Metric 1: Workforce representation

Percentage of staff with disability compared to staff without a disability:-

- **National:** 2.9% clinical and 3.6% non-clinical
- **NSCHT:** 2.4% clinical and 2.1% non-clinical (2.4% overall) – slightly lower reporting of disability than nationally

Metric 2: Recruitment

Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.

- **National score:** 1.23
- **NSCHT score** 1.9 (almost twice as hard to be appointed if disabled – much worse than national rate)

Metric 3: Capability

Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process (formal capability procedure).

- **National score:** 1.1 (ie slightly more likely to go through formal capability process if have a disability)
- **NSCHT**: n/a - no formal capability cases where subject has a disability (only 2 capability cases in total)

Metric 4: Harassment, Bullying & Abuse

Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:

iii. Patients/service users, their relatives or other members of the public

- **National:** 33.8% v 26.8% (difference of 7.0 percentage points)
- **NSCHT:** 35.6% v 26.5% (difference of 9.1 percentage points) – slightly higher level of HBA and a larger gap between the 2 groups

iv. Managers

- **National:** 19.8% v 13.0% (difference of 6.8 percentage points)
- **NSCHT:** 8.8% v 6.7% (difference of 2.1 percentage points) – much lower rates of HBA and much smaller gap between the 2 groups

iii. Other colleagues

- **National:** 26.8% v 18.1% (difference of 8.7 percentage points
- **NSCHT:** 14.0% v 9.4% (difference of 4.6 percentage points) – much lower rates of HBA and much smaller gap between the 2 groups

Metric 5: Career Progression

Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.

- **NSCHT:** 80.2% v 87.8% - higher rates of belief that the Trust provides equal opportunities compared to national rates (difference of 7.7 percentage points – slightly bigger gap, but in same ballpark)
- **National:** 75.3% v 82.7% (difference of 7.4 percentage points)

Metric 6: Presenteeism

Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

- **National:** 32.0% v 23.0% (difference of 9.0 percentage points)
- **NSCHT:** 15.3% v 13.1% (difference of 2.1 percentage points) – much lower rates of presenteeism for both disabled and non-disabled than nationally, and much smaller difference between the two groups

Metric 7: Feeling Valued

Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

- **National:** 37.2% v 47.9% (difference of 10.7 percentage points)
- **NSCHT:** 37.8% v 48.5% (difference of 10.7 percentage points) – very slightly lower/virtually the same as national level of satisfaction with feeling valued, with same difference between the 2 groups.

Metric 8: Workplace Adjustments

Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

- **National:** 72.4% satisfied adjustments made are adequate:
- **NSCHT:** 82.7% satisfied adjustments made are adequate – considerably higher levels of satisfaction with adjustments made than national rate

Metric 9: Disabled Staff Engagement

The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.

- **National score**: 6.64 for disabled staff v 7.01 for non-disabled
- **NSCHT score**: 6.8 for disabled staff v 7.1 for non-disabled – slightly higher rates of engagement (both groups) and a similar/slightly smaller gap between the 2 groups

Metric 10: Board Representation

Percentage difference between the organisation's board voting membership and its overall workforce

- **National:** 2.1% of board members declared a disability
- **NSCHT:** No board members declared a disability – ie data suggests our Board is not representative of the reported disability levels across the workforce as a whole

APPENDIX THREE

WDES Visual Representation

[To follow when Comms Team have capacity to support over next week or so..]

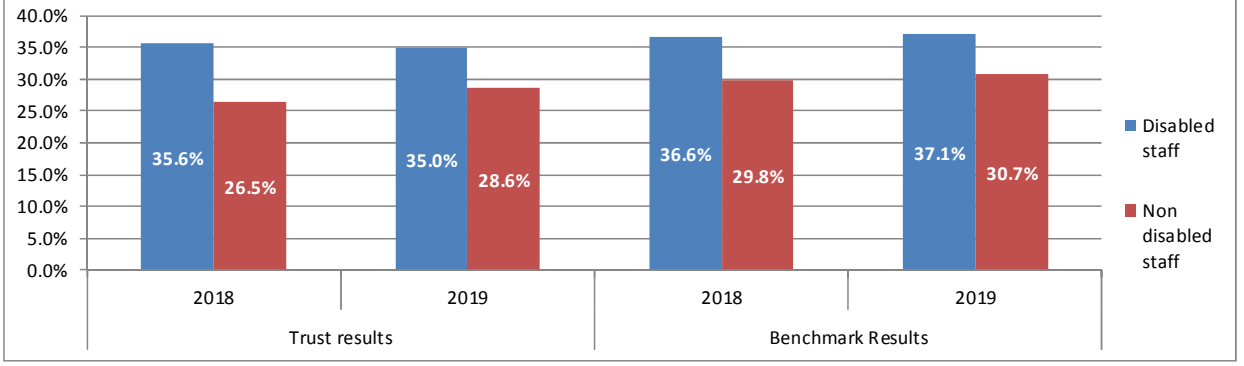
North Staffordshire Combined Healthcare NHS Trust

APPENDIX FOUR

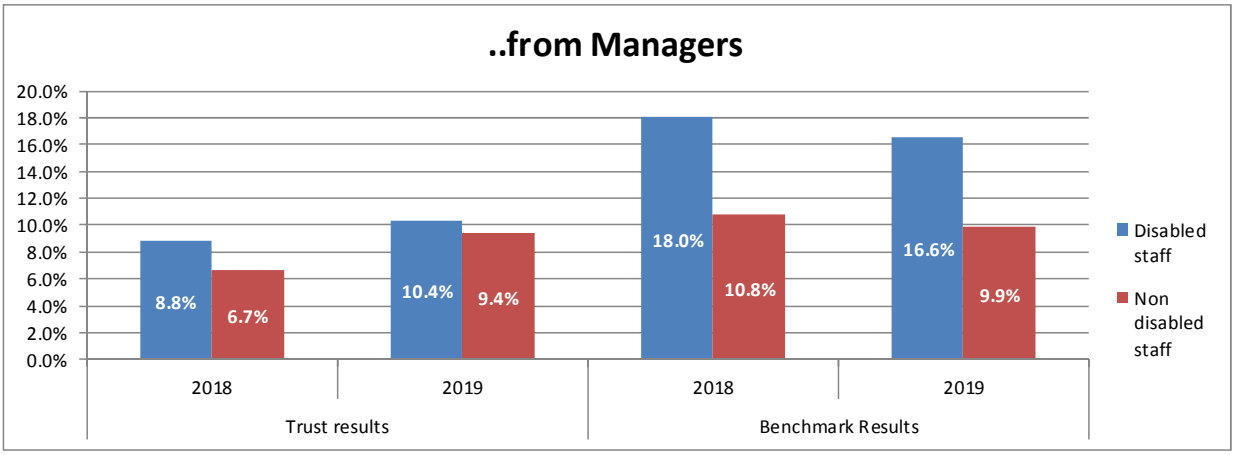
2019 STAFF SURVEY - 2020 WDES DATA

Indicator 4a: Harassment, Bullying or Abuse..

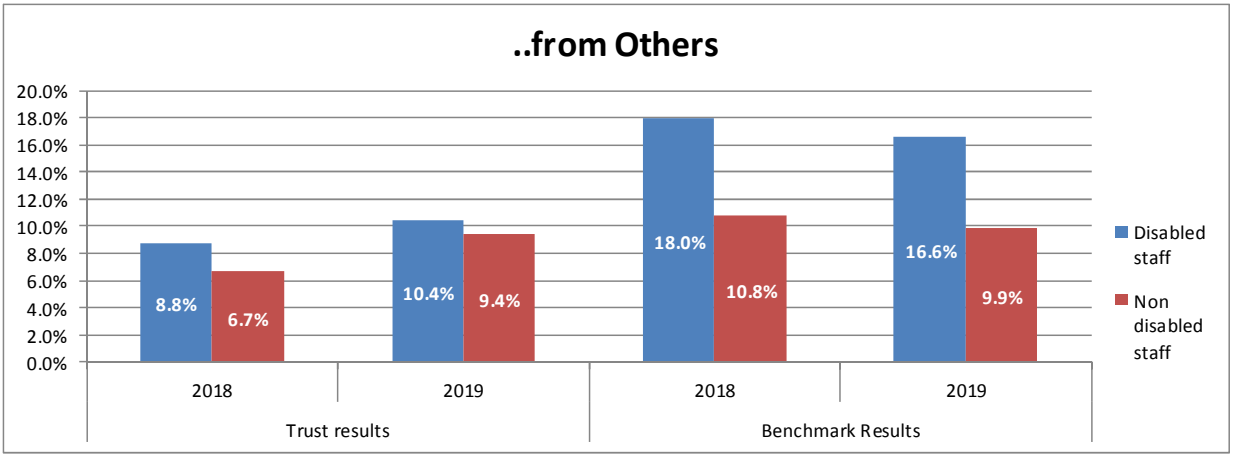
.. from Patients/Service Users/Public

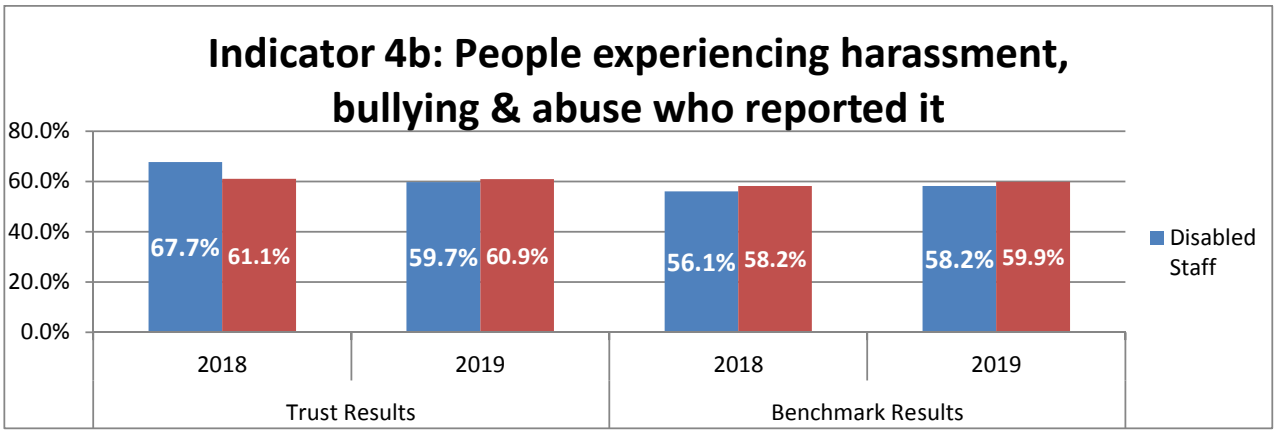


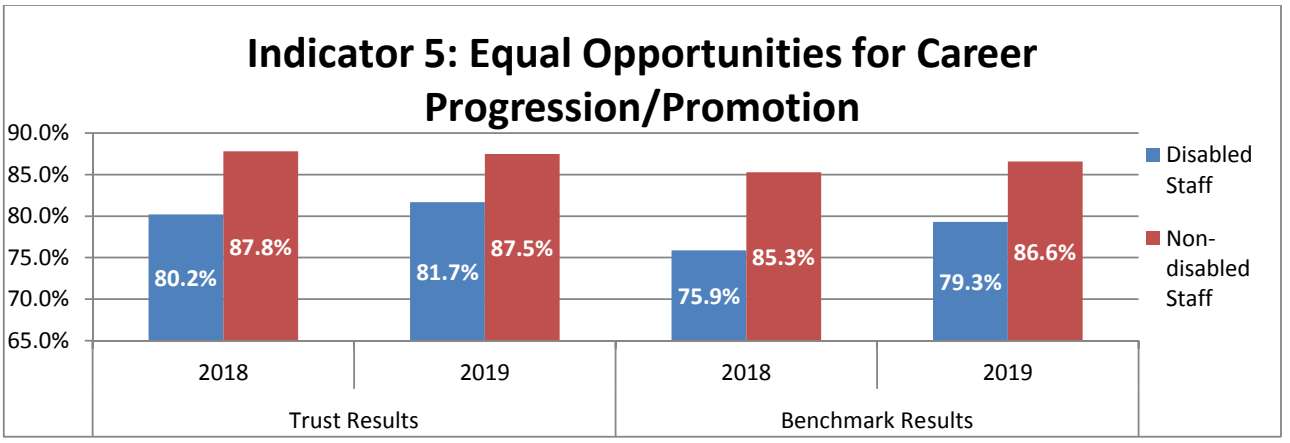
..from Managers

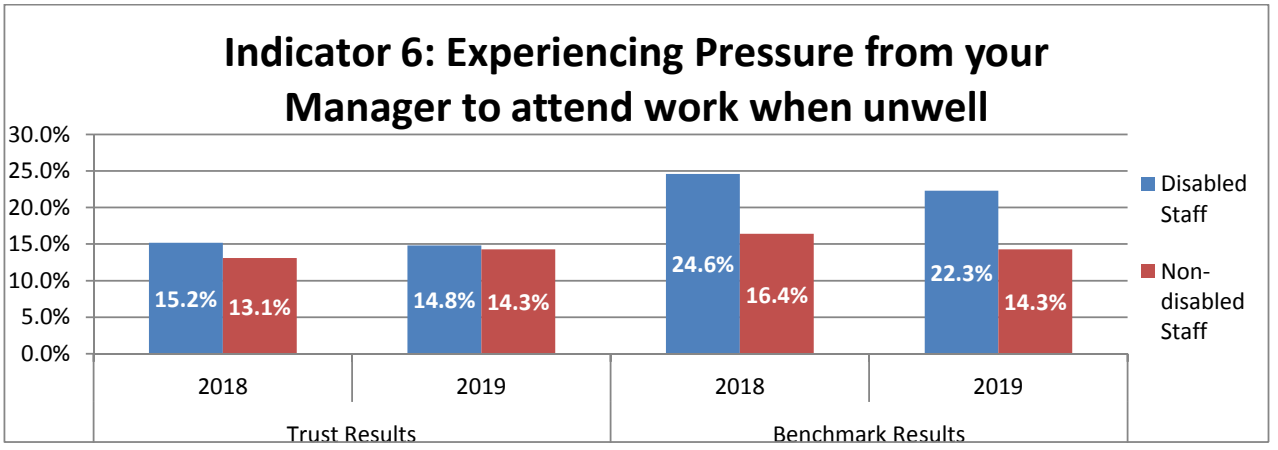


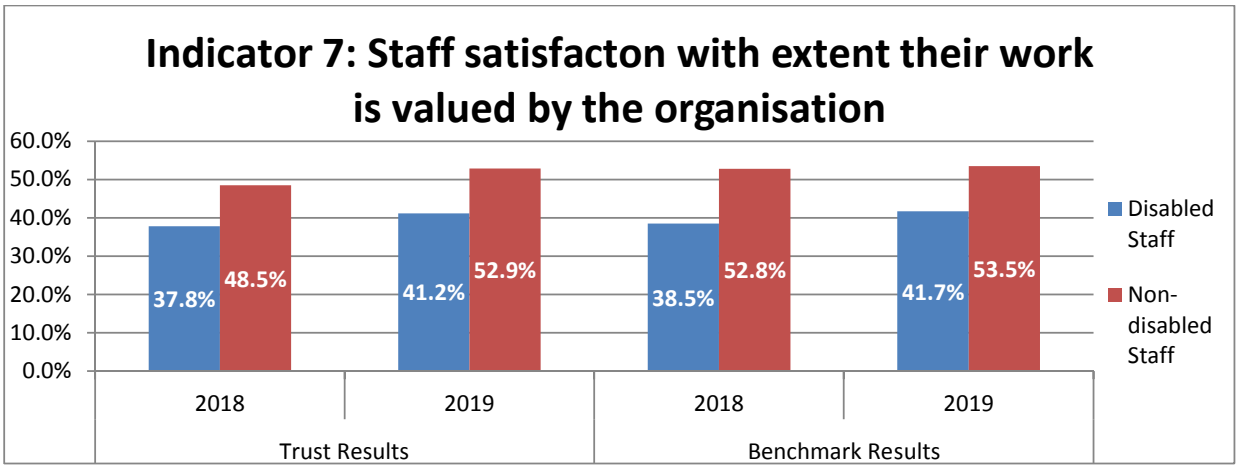
..from Others

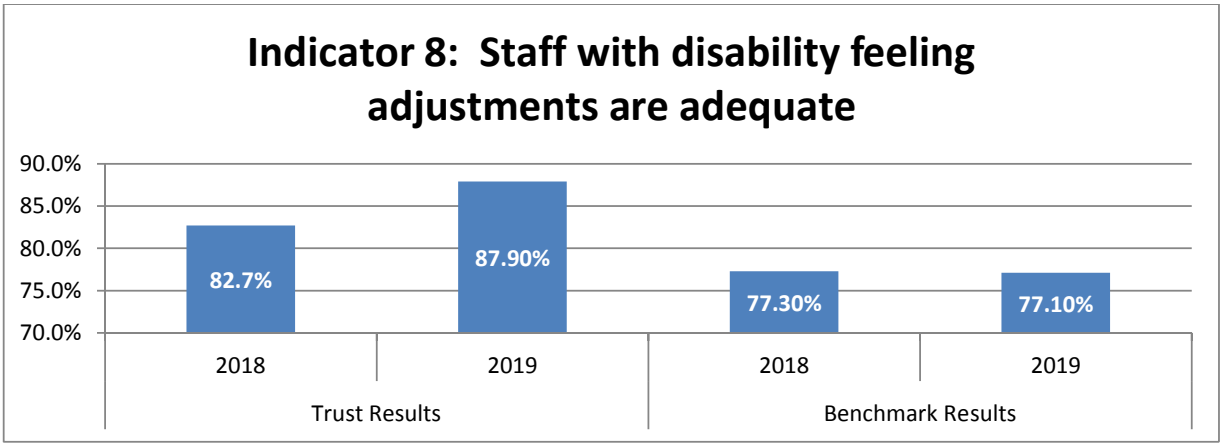


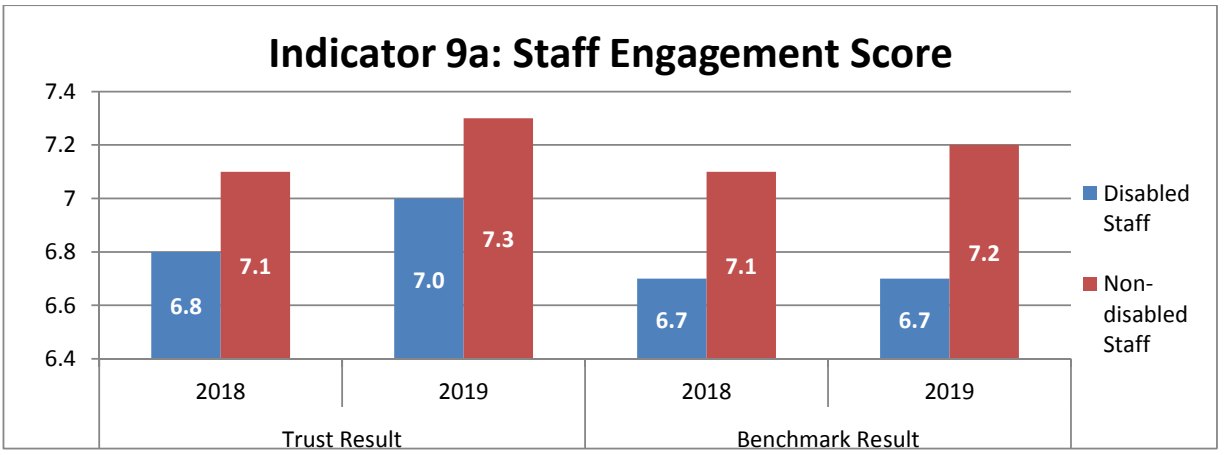

Indicator 4b: People experiencing harassment, bullying & abuse who reported it
80.0%
60.0%
40.0%
20.0%
0.0%
67.7%
61.1%
59.7%
60.9%
56.1%
58.2%
58.2%
59.9%
2018
2019
2018
2019
Trust Results
Benchmark Results
Disabled Staff


Indicator 5: Equal Opportunities for Career Progression/Promotion
90.0%
85.0%
80.0%
75.0%
70.0%
65.0%
80.2%
87.8%
81.7%
87.5%
75.9%
85.3%
79.3%
86.6%
2018
2019
2018
2019
Trust Results
Benchmark Results
Disabled Staff
Non-disabled Staff


Indicator 6: Experiencing Pressure from your Manager to attend work when unwell
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
15.2%
13.1%
14.8%
14.3%
24.6%
16.4%
22.3%
14.3%
2018
2019
2018
2019
Trust Results
Benchmark Results
Disabled Staff
Non-disabled Staff


Indicator 7: Staff satisfacton with extent their work is valued by the organisation
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
37.8%
48.5%
41.2%
52.9%
38.5%
52.8%
41.7%
53.5%
2018
2019
2018
2019
Trust Results
Benchmark Results
Disabled Staff
Non-disabled Staff


Indicator 8: Staff with disability feeling adjustments are adequate
90.0%
85.0%
80.0%
75.0%
70.0%
82.7%
87.90%
77.30%
77.10%
2018
2019
2018
2019
Trust Results
Benchmark Results


Indicator 9a: Staff Engagement Score
7.4
7.2
7
6.8
6.6
6.4
6.8
7.1
7.0
7.3
6.7
7.1
6.7
7.2
2018
2019
2018
2019
Trust Result
Benchmark Result
Disabled Staff
Non-disabled Staff

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APPENDIX FIVE **WDES ACTION PLAN PROGRESS REPORT as at 31 March 2020**

Action No	Action Detail	Action taken / Progress made	Action still to be taken
1.1	Focus on improving disability declaration rates to give greater validity and understanding of our workforce data in relation to disability through a campaign inviting all staff to review their personal equality data.	• Items to raise awareness on disability in Newsround, including item for Day for People with Disability 3 December • Disability featured in Wellbeing Wednesday event at Harplands 13 January 2020 • Promotion and growth of Neurodiversity Staff Network throughout 2019-20 • Staff with no data recorded for disability written to by email early March 2020 to ask to update their record. A number of staff came forward as a result to ask about definitions of disability and to gain support to declare their conditions. • Staff with disability 'not declared' were contacted by email to ask to consider either declaring a disability or recording no disability as may be the case.	• Updated data to be run to assess level of change • Keep raising awareness about disability and inclusion, and developing staff confidence to disclose personal disability-related issues
1.2	The Trust should monitor appointments to band 8a+ roles and raise leadership awareness about the apparent lack of opportunity for people with a disability at this level in order to instigate change. Consider positive action approaches.	• No action to date	• Monitoring not yet completed due to COVID-19 pandemic – roll action forward
1.3	To develop as an employer of choice for people with a disability through development of our performance against the Disability Confident standard, including the development of role models through our recruitment literature and social media.	• A number of Trust disability role models have come forward and created role model stories, with conditions including hearing loss, dyslexia and Asperger's.	• Disability Confident Task & Finish Group to be formed ASAP following end of COVID-19 and action prioritised to deliver improvement on at least 2 key areas of the framework • Share disability role models more widely and recruit further role models.
2.1	Invite staff with a disability to review our recruitment and selection processes to identify and address barriers faced by people with a disability and parts of the process, including potential for bias (conscious and unconscious) to influence decision making.	• No action to date	• Roll action forward for ASAP following COVID-19
2.2	Continue to roll-out Inclusion and Unconscious Bias training to all Trust	• Monthly sessions delivered through 2019-20 • Disability examples included in training	• Begin to roll-out Inclusion and Unconscious Bias training to a wider audience through inclusion in Clinical Block

	managers, and make reference within this to recruiting people with disabilities.	• Manager compliance rate at **55%** as at 31 March 2020 • E-learning option introduced from April 2020	Week training from February 2020 and through 2020-21.
Action No	**Action Detail**	**Action taken / Progress made**	**Action still to be taken**
2.3	Introduce a new training programme on unconscious bias in recruitment, including focus on disabilities.	• New programme under development by Ami Stonier, Recruitment Lead	• Pilot session delivered and evaluated • To be mainstreamed from April 2020 onwards
3.1	Continue to apply inclusive leadership in managing capability (poor performance) cases	• Ongoing by the HR Team and line managers • No capability cases involving staff with a disability in 2019-20	• continue

4.1	NO NEW ACTION INDICATED.
	To continue to develop a culture of inclusion and zero tolerance of harassment, bullying and abuse of NHS workers through the work of our Inclusion Council, including a specific focus on visible and non-visible disabilities.
		• Project group led by Frazer Macdonald extended and widened to encompass disability
		• Agreement gained on use of 'Zero Tolerance' terminology:-
		  • *Zero Tolerance: No incident left ignored.., No person left alone..*
		  • *Logo being developed to support this*
		  • *Poster campaign planned to support*
			• Progress report to Inclusion Council following end of COVID19 restrictions
			• Roll-out 'Keep my xxx safe' posters

4.2	To continue to promote reporting of all incidents of harassment, bullying or abuse at work by all staff via the Trust's Ulysses incident reporting system and via the appropriate HR procedures.	• Message conveyed at Diversity & Inclusion Meeting	• Continue to promote reporting of all incidents
5.1	Continue to develop a culture of inclusion through the work of our Inclusion Council, Trust Directorates, Workforce Team and Diversity and Inclusion Lead.	• High visibility on inclusion continued throughout 2019-20 in Trust communications • Trust Autism Strategy Group established led by Alastair Forrester and Matt Johnson	• Develop more communications with specific focus on disability
6.1	In addition to the development of our recently established Neurodiversity Staff Network, establish a new Disability Staff Network with a chair with a direct link to the Senior Management	• Neurodiversity Staff Network established and becoming more embedded as a safe place for disabled employees to share concerns and develop Trust practice • Kenny Laing identified as Board member to act as Disability Champion and to be Board link to Disability Staff Network Chair and Neurodiversity Staff Network Chair	• Disability Staff Network still to be established as a safe place for disabled employees to share concerns. (LF)

NHS North Staffordshire Combined Healthcare NHS Trust

Action No	Action Detail	Action taken / Progress made	Action still to be taken
7.1	Empower the proposed Disability Staff Network and the existing Neurodiversity Staff Network to develop experience and engagement for people with disabilities across the Trust.	• Further action required • Funding for 2019-20 and 2020-21 of £1000 in place for Trust Staff Networks	• Disability Network Chair to be identified • Roll action forward: Disability Network Chair and Neurodiversity Network Chair to meet with Board Champion on two occasions by end March 2021 to discuss environment of the group and allocated potential time to deliver on this • protected time in place for group attendance and chair admin time • network chairs report feeling supported and empowered to develop their network
8.1	HR to continue to follow up reasonable adjustments made with individuals to review adequacy and effectiveness post-implementation. Seek feedback about reasonable adjustment process, particularly including from people who declared a disability in the Staff Survey but are not identified as having a disability in ESR.	• Each reasonable adjustments case reviewed for adequacy and effectiveness on implementation • Feedback gained on reasonable adjustments process	• Task & Finish Group to review findings when established

Action No	Action Detail	Action taken / Progress made	Action still to be taken
Supp Action	i. Identify and train at least one physical, one sensory and one mental health or neuro diversity FTSU Champions	• More FTSU Champions being trained throughout 2019-20	• Review progress
Supp Action	ii. Engage with a local group representing people with disabilities such as Disability Solutions to provide critical friend support and challenge on our action plans	• Disability Solutions approached by email communication at least twice during 2019-20 with no response	• Write letter following end of COVID-19 to seek to develop a joint working relationship • Alternatively, link with UHNM Disability Staff Network
Supp Action	iii. Engage with staff side organisations and our Patient Experience lead and Volunteer Coordinator to provide further support and challenge on our action plans	• ongoing	• Ongoing
Supp Action	iv. Ensure the voice of our disabled staff is heard loud and clear throughout development and delivery against the WDES	• The Trust has reached out to staff with disabilities on a number of occasions through 2019-20. • Neurodiversity Staff Network growing in membership and confidence	• Continue to develop multiple opportunities to hear voice of staff with disabilities and to link with Trust action and outcomes • Focus particularly on empowering our disability and neurodiversity networks to be a key voice and enabler of change for people with disabilities

END

NHS
North Staffordshire Combined Healthcare NHS Trust

REPORT TO PUBLIC TRUST BOARD

Enclosure No: 18

Date of Meeting:	14th May 2020		
Title of Report:	People, Culture & Development Committee Summary		
Presented by:	Janet Dawson, Non-Executive Director		
Author:	Janet Dawson, Non-Executive Director		
Executive Lead Name:	Shajeda Ahmed, Director of Workforce, OD, & Inclusion	**Approved by Exec**	☒

Executive Summary:		**Purpose of report**	
A summary of the People, Culture & Development Committee meeting held on 7th May 2020 and chaired by Mrs Janet Dawson.		**Approval**	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☐ Date: N/A	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Resource Committee ☐ • Audit Committee ☐ • People, Culture & Development Committee ☒ • Charitable Funds Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration.☒ 2. To provide the highest quality, safe and effective services ☒ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☒ 5. Attract, develop and retain the best people. ☒ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☐		
Risk / legal implications: Risk Register Reference	The Committee reviews risks which all have mitigating plans in place to address the concerns		
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	The Committee plays a significant role in actions and assurance related to Diversity and Inclusion and the oversight of the Public Sector Equality Duty under the Equalities Act. This duty requires the Trust to: • Eliminate unlawful discrimination • Advance equality of opportunity • Foster good relations		
STP Alignment / Implications:	N/A		
Recommendations:	The Board are asked to receive for assurance.		
Version	Name/group	Date issued	

Assurance Report to the Trust Board
People and Culture Development Committee

7 May 2020

1.0 Introduction

1.1 This paper details the items discussed at the virtual People, Culture and Development Committee meeting held on May 7th 2020. The meeting was quorate with minutes approved from the previous meeting held on March 5th 2020.

1.2 It should be noted that as the NHS is currently in the midst of the Covid-19 pandemic, this update contains a workforce, organisational development and inclusion update relevant to the current and dynamic situation.

2.0 Staff Story

The Committee heard a powerful and insightful story from Dr Rebecca Chubb, Clinical Lead for Older Person's Services and Locum Consultant for Mental Health Liaison Team, Care Home Liaison Team, Ward 4, CCG beds and the Memory Clinic, on the impact that Covid-19 has had on personally and her team and staff.

Dr Chubb reflected on what she viewed as an interesting opportunity to present to the Committee as it allowed her time to reflect back to start of the Covid-19 pandemic. From the Prime Minister's announcement of the imminent pandemic she realised the magnitude of the situation when she called her Ward 4 senior team together to discuss preparations for their most frail and vulnerable patients. In anticipating imminent deaths they started to assess the practical items they would require including end of life medication and death certificates. A WhatsApp group was also set up to allow her team to communicate, and whilst it was a difficult conversation to have, she had never been more proud of her team as they pulled together to address the issues and need.

As national guidelines then started emerge, ceilings of care conversations with families over what they would like to happen in the unfortunate situation of losing their loved one had to be held, and whether or not transfer to UHNM was in the patient's best interests. This was also rolled out to the other wards and created a large degree of anxiety amongst staff.

Post-Its became the diary, being only able to plan no more than two days ahead, and the Post-Its became a metaphor for learning not to plan more than 24 hours in advance as there would always be a need to be somewhere else,

decisions were made in terms of teams (6 different ones) and which required the greatest support at any one time.

In terms of the workforce implications, Dr Chubb felt that that the situation had not registered for staff, they had not had a chance to breathe with the pandemic hitting them in waves; but throughout it all there had been an overwhelming sense of pulling together, a sense of camaraderie and the shared purpose was incredible. Whilst the expectation had been for sharp short bursts it had actually felt like waves and not an anticipated peak, and this was difficult to deal with from a workforce perspective. Notes made in meetings were no longer a source of information moreover a reflection at what was happening, decisions were made on a daily basis and she felt that the ripple effects of these will eventually come at some point. Staff anxiety and staffing levels continue to fluctuate as staff try to cope with uncertainty and unpredictability about when the pandemic will end, and with no end in sight this is difficult for staff to process. The challenging environment at work is usually separate to home life, however Dr Chubb could not recall being in a situation at work that affected her home life just as much; and when both sides of her life were impacted upon by the same situation.

There has been a positively overwhelming sense of empowerment amongst staff and managers, with their clinical voice feeling stronger than ever before, and this needed to be harnessed. The pandemic has seen the absolute best in people with the desire to do the right thing by people and she was grateful for having being part of it. The liberation from not attending so many meetings was palpable.

In terms of the future, Dr Chubb had reflected that nothing had gone to plan, predictions were wrong, everything she planned was altered and so she had learnt not to plan too far ahead, and that people did not have all the answers which was an unprecedented situation to be in. Twitter had proved to be a wonderful resource as the situation and national guidance changed so rapidly. There was a real need now to harness the sense of pride and confidence in the clinical voice, and the difference between availability and presence. Staff have felt extremely supported, the communications have been excellent and as clear as could be in an ever-changing environment.

The Committee agreed that the story should be presented at Trust Board, due to the powerful and moving account of what it has been like to work on the front-line for our workforce and the long-term implications of this.

A recording of the story presented by Dr Chubb has been made available.

3.0 National and Regional Highlights

3.1 Both NHS England and NHS Employers have put in place the following mechanisms to support the workforce agenda nationally.

3.2 **NHS England Updates**

- Weekly national NHS HR Directors Webinar Briefings from the Chief People Officer, Prerana Issar.
- National NHS HR Directors WhatsApp Group
- FutureNHS Collaborative Platform – a central repository for HR Directors to share best practice / templates.
- The national 'Supporting Our People' Offer for all NHS staff

3.3 **NHS Employers Updates**

- COVID-19 new guidance for the NHS workforce leaders.
- Supporting the Regional HR Directors Network.
- Regional HR Directors WhatsApp Group.

4.0 System Highlights

4.1 **System Wide Staff Mobilisation Group**

A System Wide Staff Mobilisation Group has been established attended by all system partners to manage the escalated workforce supply requests made by partners to the system.

The national NHS Bring Back Scheme, is supporting Nurses and Doctors who had either retired or left the NHS to return to support the COVID-19 major incident (without an impact to their pension). Thus far two individuals that had been linked with the Trust on further exploration, possessed skills and experience which could be best utilised elsewhere in the system. As such these individuals have been transferred to supporting the system via the System Mobilisation Team. An additional 4 volunteers have also been shared across the system.

Additionally we have completely reshaped the Trust mandatory and statutory offer for returning bring back staff. This is available electronically in its entirety and is fully functional and ready for any returning workforce.

In addition to the above support NSCHT are also providing further support to the system by offering additional bed capacity and staffing this capacity from the existing establishment.

4.2 **Psychological Health and Wellbeing: Covid-19 System Workforce and Co-ordination Group**

Our Head of Psychology, Matt Johnson, is leading on the above group and working in collaboration with system partners on defining the psychological health and wellbeing provision across the system.

The remit of the Group is outlined as below:

- To ensure that system partners stay connected and provide a joined up approach of support for staff across the system.
- Make use of our resources in the most efficient way and share examples of good practice.
- Pulling together a system wide gap analysis to ascertain what resources will be required in term of a system wide solution as demand needs change/increase.

4.3 **System Coaching Support**

NSCHT are about to lead on a system wide coaching offer which has been adapted in response to COVID-19 to offer additional developmental support to staff to help them cope, increase their resilience and enable them to find solutions to overcome the challenges that they face. This is an exceptionally useful piece to empower and upscale the coaches we already have in each of the partner organisations so that we can share this resource for the benefit of our workforce across the local health economy.

4.4 **System Wide HR Directors Meeting**

To ensure sharing of good practice and consistency of approach, where possible, a weekly meeting is held with the system HR Directors to discuss system wide workforce priorities.

5.0 NSCHT Highlights

5.1 **Health and Wellbeing Support**

A tremendous amount of work has gone into developing our internal health and wellbeing offer in collaboration with psychology, staff support counselling, workforce and OD colleagues. This offer comprises of an extensive wide range of support and resources and also includes the national NHS Supporting Our People Offer which again features substantial resources to support NHS staff.

Access to all these resources and forms of support is available through a new intranet section dedicated to the health and wellbeing support for staff during and post Covid-19. There are 3 sections to improve accessibility and the user experience; ‘Supporting You’, ‘Supporting Managers and Leaders’ and ‘Speak to Someone’. Resources will continue to be populated on these pages, ensuring a broad range of high quality resources are available to our people.

5.2 In addition to the mental health wellbeing the OD Team and Facilities Team have been working in collaboration to support our staff on the physical and environmental health and wellbeing offer as summarised below:

Repurposed rooms along the therapies corridor at Harplands Hospital to create the following:

- Lounge and adjacent garden

- Shower Room
- Fully kitted out kitchen.

The “Rainbow Suite” as it is now known will provide much needed respite and a downtime area for any staff wishing to take a break from front line duties. Although already in use, once all the finishing touches are in place the suite will be formally launched in the Trust.

- Over the Easter period we received a volume of donations from several local businesses including Tesco, Morrisons, Marks and Spencer, Costco, Bookers, and Costa Coffee which included Easter eggs, bottled water and 900 loaves.

- Health and Wellbeing Boxes for every ward containing comforts and niceties including laundry bags made by an army of volunteers from corporate service areas and friends of the Trust; these will also include kind donations of products from Boots, Lush, Avon and the Body Shop.

5.3 **Supporting our BAME colleagues through Covid-19**

BAME staff are adversely affected by the Covid-19 pandemic and we have worked hard to provide additional support for our BAME colleagues during these challenging times. We have developed a number of offers, including;

A new risk assessment form has been devised to help managers and staff have discussions about their concerns. The purpose of these risk assessment conversations are to identify factors including age, gender and pre-existing underlying health conditions, as well as ethnicity, that may potentially increase the risks for staff undertaking frontline duties. This in-turn will help managers identify what further support may be appropriate for individuals to carry out their roles.

Free MOT Health Checks with Team Prevent for BAME colleagues has been launched to provide further support and to compliment the risk assessment. Staff can discuss any underlying health issues that could potentially put them at increased risk whilst undertaking frontline duties and receive recommendations for further support that may be appropriate. This offer extends to all Bank Staff too.

5.4 **Ramadan**

To support our colleagues through Ramadan, we are promoting staff to have discussions with their line managers about suitable flexible working arrangements, for example, taking time out for prayers, and arranging breaks during evening/night shifts to facilitate timely meals in conjunction with the start or finish of daily fasting. Specific advice and resources has also been shared directly with staff through our BAME staff network.

5.5 **Strengthening Infection Prevention and Control**

We have also strengthened our infection prevention steps for BAME staff during this time by making available;

- Single person prayer mats (available via staff at Harplands reception)
- Disposable cultural/religious headwear for use at work, may be worn over or in place of items such as Jewish Yarmulke/Kippah's or Muslim Khibar/Hijab or Sikh Turban (Contact Lesley.faux@combined.nhs.uk or Chris.McGinley@combined.nhs.uk)

5.6 **Workforce and OD Virtual Team Engagement Away Day**

The Workforce & OD Directorate has led the way in adapting to new ways of working during Covid-19 by running a team development session virtually using WebEx, Slido and using lots of innovative exercises. These included polls, engagement activities and creating meaningful outputs to help improve our offer of support to our people through these challenging times and how we can support new ways of working following lockdown.

This virtual interactive approach has received focus from central NHS bodies as a way for engaging staff more effectively during Covid-19 and also provides the blueprint for further virtual engagement activities in the Trust.

5.7 **Workforce Hub (HR advice)**

This hub has been specifically created to provide staff with HR advice, guidance and templates during COVID-19. The hub also includes Frequently Asked Questions which are updated on a regular basis and included as part of the regular staff communications/briefings.

5.8 **Internal Workforce Mobilisation Process**

A Workforce Mobilisation meeting - named Workforce Huddle coordinates, monitors and manages the demands of any capacity surges experienced both internally via the Incident Control Room and externally via the System Wide Workforce Hub.

5.9 **Corporate Capacity Review**

As part of the COVID-19 Incident response HR have compiled a list of corporate staff who have the capacity to support the delivery of services whether this be internal to the Trust or offering mutual aid support to the wider healthcare system providers.

6.0 Workforce Summary, including the IQPR

- **Appraisals** – 92% during M12 which remains well above target. During the Covid-19 pandemic achievement of completing appraisals has been categorised as non-critical as aligned to national guidance.

- **Statutory/Mandatory Training** – performance has improved during M12 to 92%, with the future workforce transformation around the standard being met consistently across all Directorates.

- **Clinical Supervision** – performance was 80% in M12. It is anticipated that the new culture, technology and working arrangements due to Covid-19 would enhance supervision, and remote working should not impact on the recording of supervision into the Learning Management System (LMS). Directorates have been reminded of the importance of conducting and recording supervision differently.

- **Agency Spend** – spend has remained at 11% greater than the ceiling in M12, and has been steadily increasing since June 2019, the agency cap, as anticipated has not been achieved for 2019-20.

- **Staff Turnover** – this has decreased throughout the year and further improved from 12.3% in M11 to 11.8% in M12, although this remains over the threshold of 10%.

- **Vacancy Rat**e – performance in M12 has increased to 10.7%, however, the Trust is incorporating a number of strategies to recruit and retain staff in order to reduce the vacancy rate. National schemes, such as the Bring Back Scheme (BBS) and the early release of student nurses into the Trust is expected to significantly inject additional workforce supply to support both Covid-10 activity and baseline vacancies.

- **Sickness Absence** – the sickness levels for December, January and February have been refreshed and the figure for March was 5.49%, however, levels are expected to rise dramatically due to Covid-19. The HR Advisory Team are ensuring that all absences are being managed in accordance with the national guidelines and Trust policy.

7.0 Recruitment and Vacancy Update

7.1 Time to Hire KPI by Profession and Role

The Recruitment Team continue in their concerted focus to reduce the Time to Hire which since 2018 has reduced by almost 7 days, from 60.3 to 53.4 days as at Quarter 4 (Q4). On average Band 5 and above roles were significantly lower than the 60 day KPI, with a range in performance at Q4 across the bandings of 22.6 days; and an overall improved response time between the Recruitment Team and the Recruiting Managers leading to a positive impact on KPI performance.

7.2 Vacancies Position

Whilst there has been an improvement on time to authorise vacancies this

remains currently and unfortunately outside of the KPI. Band 2/3 vacancies remain on the high side whilst still within the KPI, and this is thought to be because these vacancies typically attract higher volumes of applicants that take longer to shortlist. Submission of suitable ID checks also remains challenging with some applicants not in receipt of the correct documentation required to fulfil the Right to Work checks. It was expected that Assessment Centres would help to reduce this area of delay, in terms of reducing shortlisting timescales and ID checks conducted on the day, however, Covid-19 has temporarily halted the Assessment Centres with a digital format being reviewed in order to ensure these can continue.

Performance by profession including medical posts has highlighted that in Q4 whilst performance had improved this was not the case for nursing roles, however, there has been an increase in applications of band 5 nurses due to qualify this year.

The team continues to review authorisation processes, and start dates which typically exceed the KPI's in all areas. In summary, work continues to improve Time to Hire performance.

7.3 **Impact on recruitment – Covid-19**

NHS Employers have acknowledged that the Covid-19 pandemic will directly impact on recruitment practices for the foreseeable future in what is already a challenging market; mandated checks may be more difficult to obtain and waiting for some checks i.e. DBS certificates may be detrimental to essential services. To that end NHS Employers has provided guidance for fast track checks for those roles seen as essential.

The Recruitment Team where possible are remote working, with working hours staggered to ensure minimal impact on service delivery and limiting network bandwidth impact. All employment checks are still being completed, with fast track solutions for staff identified as essential by NHS Employers; substantive employment remains subject to satisfactorily passing all of the necessary checks.

It is expected that Covid-19 will impact on some of the recruitment KPIs, however, anticipation is that the overall time to hire will reduce as a consequence of the pandemic and the fast-track processes initiated for essential staff.

7.4 **Recruitment Proposition 2020/21**

The Recruitment Team has mobilised significant and innovative changes at pace during the pandemic, and in recognition of the success of these changes it is felt that these should be sustained moving forwards.

The team will continue to review, refresh and evolve the Trust's Recruitment Proposition as it emerges from the pandemic to meet the requirements of the future.

8.0 Board Assurance Framework

8.1 A hybrid version of the Q4 version into 2020/21 was presented and given the Covid-19 challenges indications have been made on what the Q1 and Q2 2020/21 BAF may look like for the Committee; these will be better informed once the new strategic objectives have been agreed.

8.2 Concerns remain with regards to the Apprentice Levy. Covid-19 has delayed new sign ups and recruitment in Q4; however, the enhanced pay package is impacting with a marked increase in applicants for recent positions.

8.3 It was noted that the Trust has made significant progress towards being more representative of our local population in relation to the Equality Delivery System (EDS2).

8.4 Talent Management/Talent Management Strategy continues as work in progress and will be carried over to 2020/21 due to capacity issues.

9.0 Workforce Disability Equality Standard – WDES

9.1 The WDES Annual Report 2019 reviews workplace representations and career experiences of staff with disabilities.

Due to Covid-19, both the WDES and Workforce Race Equality Standard (WRES) have decided to suspend the data collection process for 2020, instead they will produce short data reports later this year based upon date already available for NHS Trusts.

9.2 The Trust has performed well in relation to the 10 WDES indicators. The best performing areas were:

- Presenteeism
- Harassment
- Bullying and abuse by both managers and other colleagues
- Workplace adjustments.

Areas for improvement were around:

- Recruitment (almost twice as difficult to be appointed from interview with a disability compared to those without a disability)
- Disability declaration rates
- Harassment, bullying and abuse by patients.

9.3 Key progress with the WDES action plan has been made in the following areas:

- Developing membership of our Neurodiversity Staff Network
- Establishment of a Trust Autism Strategy Implementation Group
- Staff with no information recorded in ESR contacted to ask them to update their record
- Various activities and communication pieces throughout 2019-20 to raise awareness and profile about disability at work and to encourage staff to feel more confident to be open about disability

Key work still to progress includes:

- Developing membership of a Disability Staff Network
- Embedding of our Disability Staff Network and our Neurodiversity Staff Network as key voice for people with disabilities, consulted and influential in the development of Trust policy and practice
- Task and Finish Group to be established to deliver progress against the Disability Confident Framework

9.4 Whilst improvement on a significant number of the WDES measures have been delivered, and considerable progress made against the WDSE 2019-20 action plan, work will resume again on the action plan following the end of Covid-19 restrictions, with outstanding deadlines extended to December 2020.

10.0 Freedom to Speak Up Update (FTSU)

10.1 The Q4 update and annual FTSU review will be presented to the July Committee. The main concerns remain with behaviours and line manager relationships with staff. Action is being taken to actively resolve these issues, with a need to review how responses are made and owned particularly at bands 8A and above level.

10.2 A weekly regional Guardians meeting has taken place during Covid-19, and as a Trust we have performed particularly well in relation to the communications that have proved extremely valuable for staff. Issues have been responded to immediately which has prevented a disparity of approach on the wards. PPE issues have been a prominent topic regionally, however the Trust has had no issues of its own with regard to PPE supplies and issue.

10.3 Staff have experienced anxiety at having to nurse Covid+ patients, but these anxieties have been addressed locally, with support from the Infection Prevention Control team and Staff Support and Counselling. FTSU Champions have stayed in contact via a fortnightly meeting, with the main themes being anxiety issues which are being sensitively managed. There is

an overwhelming consensus that staff have been going above and beyond what is expected of them. Staff have found information from a variety of sources including regular communications from the Comms Team, the FTSU website which is due for update, and the Director of Operations regular communications.

10.4 The Trust now needs to ensure that staff continue to raise any non-Covid-19 issues too. The Safer Staffing forum creates an excellent forum to convey this message. Whilst concerns are still being raised via the FTSU route, it appears that Dear Peter is being used more so with Covid-specific queries as is the Director of Operation route, all concerns are being responded to. It is hoped that moving forward the empowerment that teams are experiencing will lead to a reduction in the amount of concerns raised via the more conventional FTSU route.

11.0 Apprenticeship Levy Update

11.1 The levy update related to the 24 new apprenticeship starts up to the end of Quarter 4 2019-20 against a public sector target of 37 (internally adjusted to 47), in addition to spend against the apprenticeship levy and targets for 2020-21.

Current levy funding is £497,590, and during the last financial year the Trust spent £124,666, with a projected spend of £208,312 during the next 12 months, however, this figure is based on projections pre Covid-19 which do not account for potential breaks in learning, delayed start dates or pausing payments.

There is a risk that the Trust will lose funding from the levy once monies reach their 24 month expiry date. Based on actual starts it is estimated that £35,688 will have expired October 2019 – March 2020. Funds will continue to expire from the account during 2020-21 as income exceeds the value of new apprentice starts.

11.2 It should be noted that, 'Framework' apprenticeships promoted in 2019-20, which applied to two of the Trust's most popular apprenticeships – Level 2 and 4 Business Administration, which accounted for 37.5% of new starts in 2019-20 are due to be withdrawn by the Government, to be replaced by new-style 'Standards'. As there are currently no plans to replace these options, this may further impact on numbers moving forward.

11.3 Work will continue to promote the benefits of apprenticeships within the Trust, and to strengthen staff development in providing upskilling opportunities for staff groups who have not historically had access to recent investment e.g. corporate staff and HCSWs. Improved pay rates have also resulted in the Trust being aligned to partner organisations and evidence to date suggests that since this was implemented apprentice numbers have increased.

Apprenticeships also need to be fully included in robust business and workforce planning processes to support individual and organisational development and help to meet projected skills gaps.

12.0 Workforce & Organisational Risks

12.1 The Committee continues to regularly assess and update the risks associated with the workforce, in relation to:

Risk 12 There is insufficient staff to deliver appropriate care to patients because of staffing vacancies and increased referrals. **The Committee noted:**

- Recruitment remains ongoing where possible utilising digital tools, however, the Recruitment and Retention action plan has been impacted on by Covid-19 as Open Days can no longer be held.
- The Trust is also utilising national schemes including the Bring Back Scheme.
- The Q4 Time to Hire position remains less that the 60 day KPI across all posts and the Trust is working to retain student nurses with early offers of employment.

Risk 868 The Trust will breach its Agency cap for the use of temporary staffing with a consequence of increased spend and reputational harm due to reduced segmentation by NHSI. **The Committee noted:**

- The risk has not been mitigated and will be reviewed by the Finance and Resource Committee and included in the Finance Director's report to Board. Once national guidance is received this will be further reviewed.

Risk 900 The Trust does not provide inclusive services that recognises the diverse nature of our service users, therefore services may not be accessible or of sufficient quality and the Trust may not be responsive to the diversity & the inclusion needs of our local communities. **The Committee noted:**

- The Trust is awaiting a new EDS3 framework for 2020-21, but is performing strongly against the EDS2 outcomes levels 1 & 2.
- Guidance regarding supporting staff through Ramadan has been circulated, and individual prayer mats provided.
- The Trust's D&I Strategy has been approved and a new action plan will be developed as part of the annual planning process for D&I.
- A Reverse Mentoring programme is being established to develop perspectives and understanding of senior leaders through the insights of our diverse frontline staff.
- A Trans Inclusion group has been established to develop trans inclusion for staff and service users.

Risk 901 The Trust does not have an inclusive and diverse workforce as reflected in the WRES, thus impacting on our ability to support the needs of diverse communities and ability to attract and retain staff. **The Committee noted:**

- The Sanctuary Room has been opened at Lawton House and can be used for religious purposes, in addition to digital solutions which are being used where possible to support staff, such as the availability of iPads meaning staff do not have to leave the wards duding Covid-19.
- The Inclusion and Diversity Group continues to meet virtually during the pandemic, in addition to leading with the STP on collaboration across the local Trusts in development of the Stepping Up Alumni.

Risk 992 (now aligned to PCDC from the former Business Development Committee) Risk to Trust operations as a result of capacity and capability of technical skills within Digital and to resolve training post implementation of Lorenzo. **The Committee noted:**

- In order to improve resilience a Software Development Manager has been appointed, and the Trust is working with DXC on the 'Get to Green' programme.

Risk 1034 Staff are not effectively engaged, do not have sufficient clarity of purpose and do not realise their potential through not having an up to date PDR. This can adversely affect their ability to work efficiently and impacting on delivery of services. **The Committee noted:**

- PDR compliance at 31.03.2020 was 92%, and there has been a key focus in all teams to meet the required standard.

Risk 1072 Staff may not be accessing clinical supervision on a regular basis to ensure that they fulfil requirements or their professional responsibilities and as a result may not feel supported in practice. **The Committee noted:**

- The supervision compliance at M12 was 80%, and the SLT Performance Group will continue to monitor compliance on a regular basis.

Risk 1204 (now aligned to PCDC from the former Primary Care Committee) - risk of recruiting practice staff roles in a challenging recruitment climate which could impact on service provision. **The Committee noted:** In January all GP sessions at Tier 2 level were filled.

Risk 1313 Risk to the delivery, governance and development of psychological services in the Trust due to the reduced number of Senior Clinical Psychologists resulting in reduced provision of specialist

psychological therapies, a reduction in Trainee numbers, low staff morale and recruitment challenges. **The Committee noted:**

- A Psychological Professions conference was arranged for May 18th which is now postponed due to the pandemic.
- Workstreams for the Psychological Profession strategy are underway and meetings being conducted remotely at present.
- A new consultant Clinical Psychologist working across the Stoke Directorate CMHTs has been appointed.

12.2 The Committee agreed that in recognition of national recommendation on supporting BAME staff due to the impact of Covid-19, this will be added as an additional risk to the organisation.

12.3 A further review of the need to record the appointment of disabled applicants will be conducted.

13.0 Policies

13.1 The Committee approved the following policy for 3 years:

- 3.37 On Call

13.2 The following policy was extended for an additional 6 months:

- 5.30 Stress at Work

13.3 The Committee also approved the following policies in January 2020, which now also require ratification from the Board:

- 3.02 Resolution of Grievance and Dispute Policy
- 3.04 Recognition Agreement
- 3.08 New Starters Relocation Policy

14.0 Committee Reporting Groups

14.1 The Committee noted the minutes from the Inclusion Council held on the 4 March 2020.

15.0 Any Other Business

15.1 Concerns regarding recent publications that have highlighted how BME nurses have 'felt targeted' to work on Covid-19 wards were raised. The Nursing Times is launching a survey on nurse mental health and Covid-19.

15.2 Recognising the adverse impact of COVID-19 on BAME staff and investigation by Public Health England, NHS England have advised that as a precautionary basis employers risk assess staff at potentially greater risk. To that end NSCHT have put in measures over and above the risk assessment to support its BAME workforce as articulated in Section 5.2

15.3 The Committee approved a change to the Moving & Handling competency requirements for Statutory/Mandatory Training from one year to two, following a recently conducted Core Skills Training Framework alignment exercise. The Committee approved the change with immediate effect.

15.4 Further discussions will be held with the Trust's Fire Officer to establish a safe compromise for Fire e-learning provision during Covid-19 restrictions placed on face-to-face training.

16.0 Next Steps

16.1 Recognising the challenges of the past few weeks and the direction moving forwards around restoration and recovery, the energies of the Workforce & OD Directorate will be focused on the following:

- Continued focus on the health and wellbeing of our people and in particular our BAME people.
- Providing significant OD support to the workforce transformation agenda.
- Sustaining the workforce & OD service delivery internally.
- Continuing to lead on the Leadership OD agenda across the system with measures already being put into place around continuation of delivering the High Potential Scheme and determining next steps for the BAME Stepping up Alumni.
- Continuing to lead and be key player on the system wide Health & Wellbeing Agenda.

Shajeda Ahmed – Director of Workforce, OD & Inclusion
On behalf of Janet Dawson – Chair

7 May 2020

NHS
North Staffordshire
Combined Healthcare
NHS Trust

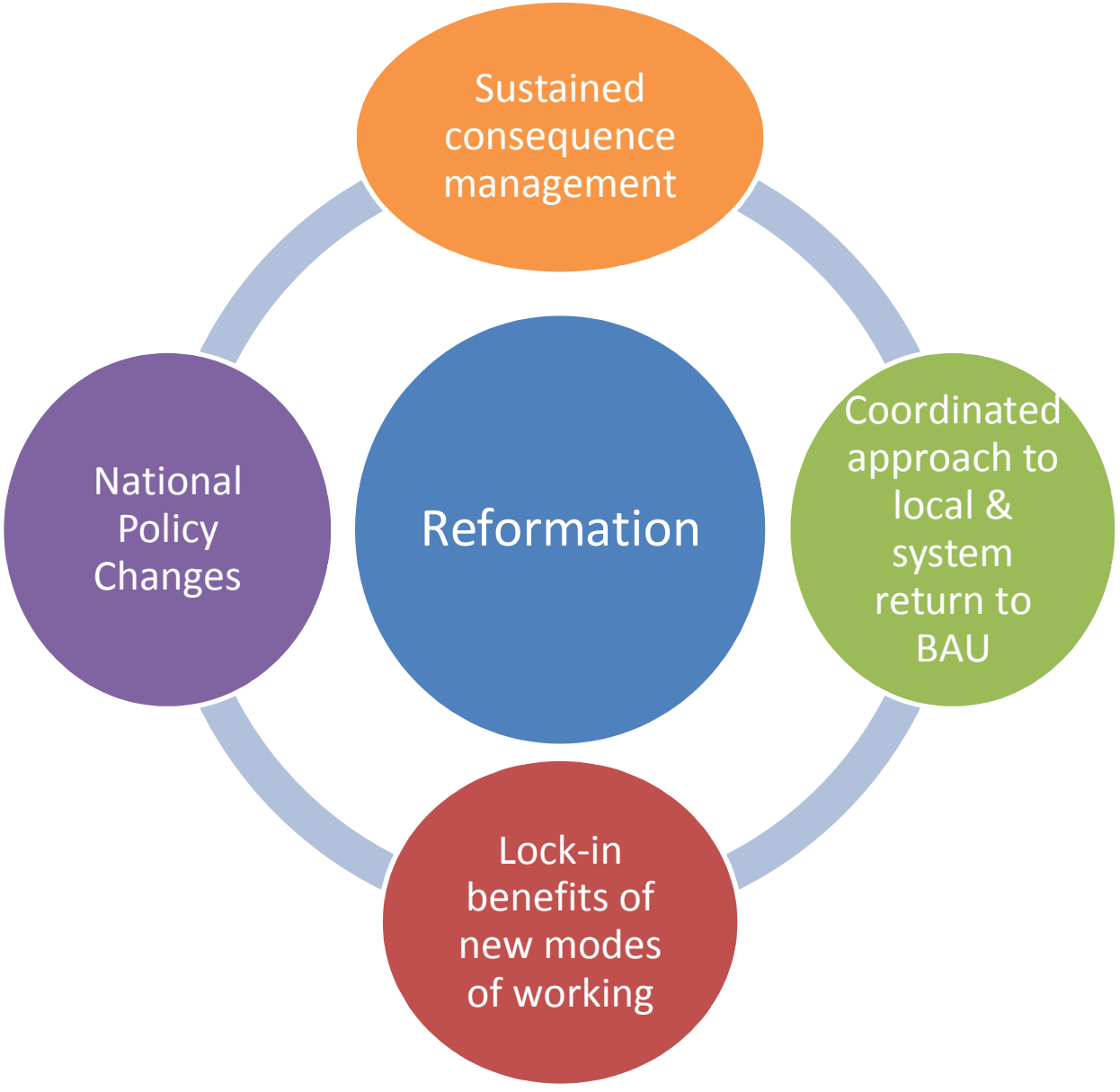
NSCHT Restoration & Transformation Framework

Trust Board

12th May 2020

North Staffordshire Combined Healthcare NHS Trust

Why is this important?



Where are we now?

North Staffordshire Combined Healthcare NHS Trust

- Initial modelling showed a short, sharp peak – now refined to show flatter trajectory over a prolonged period

- Response phase has been managed well:
  - Patients have been protected and kept safe
  - Staff have been supported
  - New ways of working have been deployed at pace

- Repurposing of NHS and Trust services, staffing and capacity to support a focus on COVID-19 response

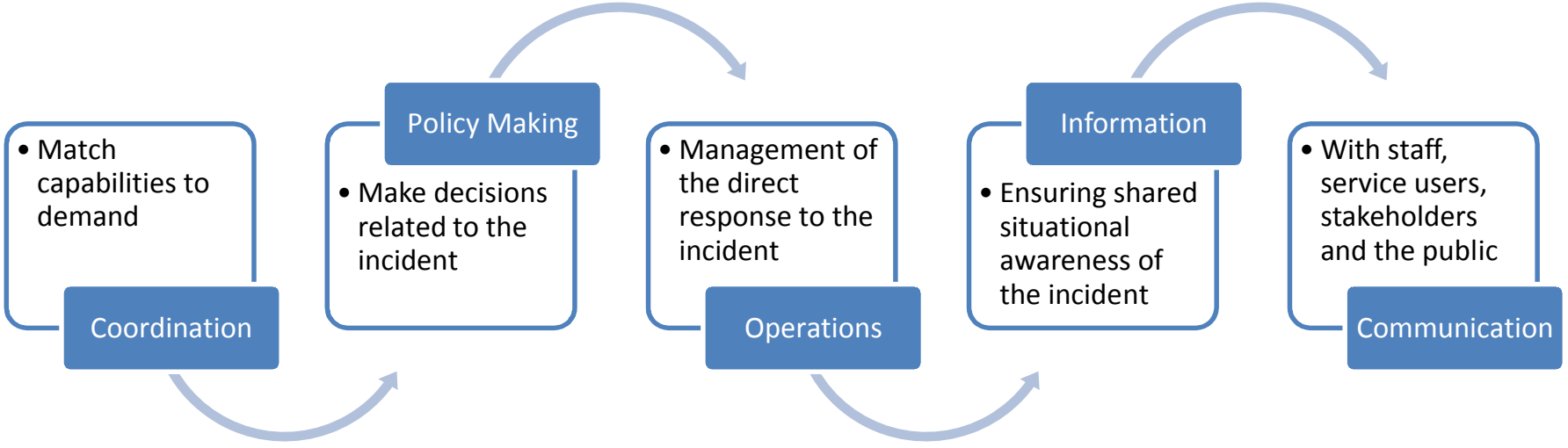
- Now entering into second phase of NHS response to support on-going management of the pandemic, restore services and 'lock-in' beneficial changes

Where are we now?

North Staffordshire Combined Healthcare NHS Trust

- In response to the Level 4 Major Incident being declared across the Staffordshire & Stoke region each public sector has established an Incident Control Centre

- The role of the ICC is to:



- The ICC brings a discipline and rigour to the Trust's response. It is anticipated there will be an enduring need for incident response arrangements over several months

Where do we want to get to

North Staffordshire Combined Healthcare NHS Trust

Quality

- Service Development Priorities
- Improved clinical practice, reinforced through effective supervision
- Use of PHM to drive predictive modelling & demand profiles

Workforce

- HWB support for staff
- Proactive engagement to understand lessons learnt and opportunities for future
- An empowering culture supported by agile & remote working

Partnership

- Strengthened commitment to partnership via Northern Staffordshire ICP
- Collaboration with stakeholders to directly inform our approach
- Enhanced support and cooperation with the third sector

Sustainability

- Maximise the use of digital and other innovative approaches to drive improvement
- Improved financial stability
- Promote research & development to scale up service improvement across the Trust

How will we get there?

North Staffordshire Combined Healthcare NHS Trust

RESTORE

Re-establish services

REIMAGINE

Stop / Start / Continue

TRANSFORM

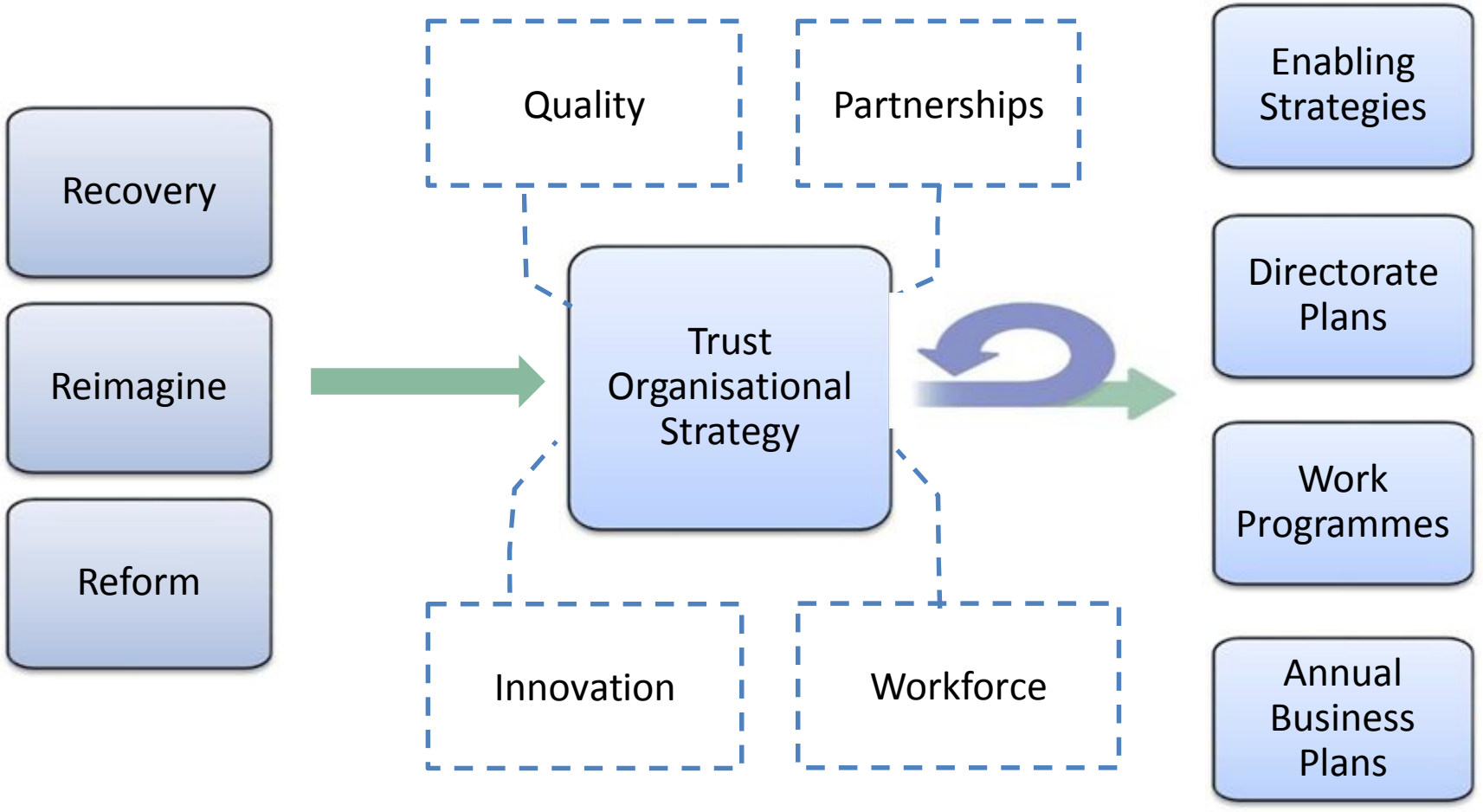
Embed & scale-up

07/05/2020

How will we know?

- Developed resilience to deal with prolonged response & consequences of that response
- Understand and have adapted to increased demand for services
- Return to compliance with national &/or contracted standards
- Staff feel supported and valued
- Positive innovations are retained and scaled up across the Trust
- Financial stability is maintained, investment opportunities enhanced
- Active partner & collaborator across Northern Staffordshire region

Continued Evolution



NHS
North Staffordshire Combined Healthcare NHS Trust

REPORT TO PUBLIC TRUST BOARD

Enclosure No: 20

Date of Meeting:	14th May 2020		
Title of Report:	Board Effectiveness		
Presented by:	Tosca Fairchild, Assistant Chief Executive		
Author:	Laurie Wrench, Associate Director of Governance		
Executive Lead Name:	Tosca Fairchild, Assistant Chief Executive	**Approved by Exec**	☒

Executive Summary:	**Purpose of report**	
In November 2019 the Board undertook a full skills assessment alongside a full review of committee effectiveness which resulted in a restructure of committee function, membership and skills. As such, and ahead of the cycle of business for Trust Board, a Board development session was held in November 2019 and February 2020 to discuss and agree the next steps regarding overall governance arrangements which have since been through Committee approval. Further changes to governance arrangements have been made on a temporary basis in response to COVID-19. Trust Board members have already been sighted on the outcomes of the review therefore this summary is included for information purposes.	**Approval**	☐
	Information	☒
	Discussion	☐
	Assurance	☐

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☒ • Finance & Resource Committee ☒ • Audit Committee ☒ • People, Culture & Development Committee ☒ • Charitable Funds Committee ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer collaboration. ☐ 2. To provide the highest quality, safe and effective services ☐ 3. Inspire and implement innovation and research. ☐ 4. Embed an open and learning culture that enables continual improvement. ☐ 5. Attract, develop and retain the best people. ☐ 6. Maximise and use our resources effectively. ☒ 7. Take a lead role in partnership working and integration. ☐		
Risk / legal implications: Risk Register Reference	N/A		
Resource Implications: Funding Source:	N/A		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	N/A		
STP Alignment / Implications:	N/A		

Front Sheet Template V12

Recommendations:	Trust Board is asked to note the changes made to governance arrangements since November in terms of Board and Committee effectiveness as discussed in previous Board Development sessions	
Version	Name/group	Date issued

Front Sheet Template V12