NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST
TRUST BOARD MEETING HELD IN PUBLIC

THURSDAY 10TH FEBRUARY 2022, 10.00AM VIA MS TEAMS

ITEM	TIMING	REF	TITLE	LEAD	ACTION	ENC
1	1000	P200/22	Welcome and Apologies for Absence.	David Rogers	**Note**	
2	1002	P201/22	Declarations of Interests – and changes to be notified	David Rogers	**Note**	
3	1003	P202/22	Minutes of the Previous Meeting held on 13 January 2022	David Rogers	**Approval**	**Enc 1**
4	1005	P203/22	• Action Monitoring Schedule • Matters arising not covered by the rest of the Agenda	David Rogers	**Note**	**Enc 2**
5	1010	P204/22	Patient Story	Kenny Laing	**Note**	**Video**
6	1025	P205/22	REACH Recognition Individual Award *Gail Stanyer, Primary Care Directorate*	Dr Adeyemo	**Note**	**Verbal**
7	1040	P206/22	Chief Executives Report	Dr Adeyemo	**Note**	**Enc 3**
8	1050	P207/22	Chairs Report	David Rogers	**Note**	**Verbal**
9	1102	P208/22	Questions from Members of the Public	David Rogers	**Note**	**Verbal**
			10 minute break			
			QUALITY			
10	1125	P209/22	Safer Staffing Monthly Report December 2021	Kenny Laing	**Assurance**	**Enc 4**
11	1130	P210/22	Quality Committee Assurance Report from the meeting held on 3 February 2021	Patrick Sullivan	**Assurance**	**Enc 5**
12	1135	P211/22	Mortality Surveillance Report Q3	Dr Okolo	**Assurance**	**Enc 6**
13	1145	P212/22	Serious Incident Report Q3	Dr Okolo	**Assurance**	**Enc 7**
14	1150	P213/22	Improving Quality and Performance Report (IQPR) Month 9	Eric Gardiner	**Assurance**	**Enc 8**
			PEOPLE			

19	1220	P214/22	People, Culture and Development Committee Assurance Report from the meeting held on 7 February 2022	Janet Dawson	**Assurance**	**Verbal**
PARTNERSHIPS						
SUSTAINABILITY						
22	1230	P215/22	Finance Report Month 9	Eric Gardiner	**Assurance**	**Enc 9**
23	1235	P216/22	Finance and Resources Committee Assurance Report from the meeting held on 3 February 2022	Russell Andrews	**Assurance**	**Enc 10**
25	1245	P217/22	Board Assurance Report (BAF) Quarter 3	Laurie Wrench	**Assurance**	**Enc 11**
26	1250	P218/22	Data Warehouse Business Case	Eric Gardiner	**Approval**	**Enc 12**
CONSENT ITEMS						
27	1255	P219/22	Any Other Business	David Rogers	**Note**	**Verbal**

Date and Time of Next Public Board Meeting
Thursday 10 March 2022 at 10.00am Via MS Teams

TRUST BOARD

Minutes of the Public Section of the North Staffordshire Combined Healthcare NHS Trust Board meeting held on Thursday 13th January 2022 At 10:00am via MS Teams

Present:

Chair:

Janet Dawson
Non-Executive Director / Vice Chair

Directors:

Patrick Sullivan
Non-Executive Director / SID

Pauline Walsh
Associate Non-Executive Director

Dr Buki Adeyemo
Interim Chief Executive

Tony Gadsby
Associate Non-Executive Director

Phil Jones
Non-Executive Director

Chris Bird
Director of Partnerships, Strategy and Digital.

Joan Walley
Non-Executive Director

Dr Dennis Okolo
Interim Medical Director

Kenny Laing
Executive Director of Nursing and Quality

Elizabeth Mellor
Interim Director of Operations

Eric Gardiner
Executive Director of Finance, Performance and Estates

Laurie Wrench
Associate Director of Governance

Sue Tams
Chair, Service User and Carer Council

In attendance:

Mandy Brown
Senior Executive Assistant

Joe McCrea
Associate Director of Communications

Kerry Smith
Associate Director of People

Members of the Public
Ian Syme
Ben Richards

REACH Team Award
Carol Hinds, Team Leader CAMHS
Alexandra Clyne
Karen Best

The meeting commenced at 10:00am

176/2021	**APOLOGIES FOR ABSENCE** David Rogers, Chair Shajeda Ahmed, Director of People, OD and Inclusion Toyin Higgs, Trainee Non-Executive Director (NExT Director Programme) Dr Keith Tattum, GP Associate Director, Janet Dawson, Vice Chair announced the recent board changes and congratulated Dr Buki Adeyemo on her appointment as Interim Chief Executive,	**Action**

	Dr Dennis Okolo on his appointment as Interim Medical Director and Liz Mellor on her appointment as Interim Director of Operations. She also welcomed Kerry Smith, Associate Director of People who attended on behalf of Shajeda Ahmed and Ben Richards who has been appointed substantive Director of Operations and commences his role with the trust on 1st March 2022. The meeting was undertaken remotely due to the COVID19 pandemic and was completed in accordance with the governance guidance circulated within the Trust in relation to the functioning of the Board and Committees.	
177/2021	**DECLARATION OF INTEREST RELATING TO AGENDA ITEMS** There were no declarations made. ***Noted***	
178/2021	**MINUTES OF THE OPEN AGENDA – 11TH NOVEMER 2021** The minutes of the open session of the meeting held on 11th November 2021 were approved. ***Received***	
179/2021	**ACTION MONITORING SCHEDULE AND MATTERS ARISING FROM THE MINUTES** The Board reviewed the action monitoring schedule and agreed the following:- ***144/21Health and Safety Annual Report*** ***14.10.21 -Tony Gadsby suggested reviewing and updating Health and Safety Policies to align with current working from home arrangements.*** *Annual report complete* ***147/21 (1) Service User Carer Council Update (1)*** ***14.10.21 - Tony Gadsby felt given the pressure at the moment in terms of primary care it would be helpful to have an update of what was happening in primary care in terms of service user and their experience within those practices. Kenny Laing to include in the next report.*** ***11.11.21 - Add to cycle of Business a report to come from Associates. Laurie Wrench to discuss with Dr Adeyemo outside of the meeting. Dr Buki Adeyemo noted Associates had attended Board previously and suggested inviting them to attend a future meeting.*** *Mental Health Act Associates will be invited to Trust Board in March to present a paper on their work and on a 6 monthly basis thereafter.* ***159/21 Patient Story - Chaira Barbaro - Parent and Baby Day Unit*** ***11.11.21 - Joan Walley asked if it might be possible to have sight of our response to the maternity services review. David Rogers advised this would be circulated.*** *Showcase items to be built into Trust Board cycle of business* ***171/21 Assurance Report from the Finance and Resource Committee - Digital*** ***11.11.21 - Patrick Sullivan requested an update on digital programmes. Chris Bird advised he was happy to provide a digital update to Board Development for all colleagues***.	

	All NEDs have been offered digital updates outside of board development as a deeper dive session; however this will be discussed as part of the board development programme for next year. ***173/21 Board Assurance Framework (BAF) Quarter 2*** ***11.11.21 - Janet Dawson noted an error within the report under objective 4 as the COVID 19 risk was out of date. Laurie Wrench confirmed this would be updated for Quarter 3.*** *Completed* ***Received***	
180/2021	**REACH RECOGNITION TEAM AWARD** The REACH Recognition Team Award for January 2022 was presented to North Staffordshire CAMHS Team. Dr Buki Adeyemo presented the award. The North Staffs Core CAMHS Team have been nominated due to their hard work, creativity and compassionate approach to CYP. The team members work daily to meet the increasing demand on their service, they assess and support unplanned contacts as well as well as planned and routine appointments. They use a holistic and collaborative approach to ensure they formulate the best plan of care for CYP and their families. The diverse team has a variety of experience and skills, are supportive of each other and always keen to share its knowledge for the best interests of CYP and their families. The team continues to meet targets while ensuring commitment to the best possible outcome for CYP. The whole team has embraced and supported the waiting times initiative. Referrals are now reviewed as they are received and action taken to maintain effectiveness and efficiencies. Reviewing referrals daily and assigning any to the urgent slots to a duty team has supported the maintenance of waiting times. Carol Hinds, Team Leader, Alexandra Clyne and Karen Best who were in attendance on behalf of the team were congratulated on their award. ***Received***	
181/2021	**CHIEF EXECUTIVES REPORT** Dr Buki Adeyemo updated the Board on activities undertaken since the last meeting and drew the Board's attention to other issues of significance or interest. **Changes to Executive Team** As outlined by the Chair **NHS Staff Survey** It was noted that even in these difficult times staff had completed the staff survey and the response rate of 64% was an improvement on last year and thanks was given to everyone who took the time and effort to respond. The survey results will help to shape and improve the ambitions of the trust going forward.	

	Latest External Awards There have been a number of external awards, the Learning Disabilities Team were finalists in three categories of the RIDI (Recruitment Industry Disability Initiative) Awards 2021 in December 2021; Jessica Fitzgerald and Jessica Sinden were both nominated at the recent Student Nursing Times Awards and the Trust was a finalist in the 'Staff Engagement Award' category at the recent HSJ Awards led by Shajeda Ahmed and her team. **Staff Achievements** Our staff continue to do great things, in particular the Trust's contribution to the recent Signal 1 radio station 'Mission Christmas' appeal. Over 150 gifts were donated for disadvantaged children in our local area. Dr James Boardman and Dr Waheed Abbasi were recently interviewed by BBC Radio Stoke about the subject of teenage mental health. **Our Films for 2021** The trust teamed up with the Stoke Sentinel to provide further details of the range of help available and there are a number of films available supporting people with their mental health in a time of need. **EMU Open Morning** Dr Adeyemo opened the Edward Myers Unit Virtual Open Morning shining a light on what remains one of 6 substance misuse treatment units in the country. The unit continues to deliver important work despite a reduction in funding and the trust is very proud of the unit and the staff. Tony Gadsby commented that he had attended the open day which was an excellent event and showcased the breadth of service and their ambition going forward. Tony suggested that the trust could showcase other areas for example the Darwin Centre. Joe McCrea responded that the Communications Team were producing promotional videos for service areas which included a virtual reality walk-through of the facilities. Joan Walley added that having achieved accreditation for its medical model of detox, the trust has a responsibility to play a leading part and develop our strategic role in working with the other units across the country and also with local commissioners in Stoke-on-Trent and Staffordshire. Dr Buki Adeyemo responded that one of the difficulties is the funding from the NHS but the trust will continue to make the point about the funding if it is not available. Joan Walley further added that in the light of the Stoke on Trent budget consultation which ends in mid-February the trust could stress the importance of the commissioning role via the ICS and budget consultation. ***Received***	
182/2021	**CHAIRS REPORT** There was no Chair's report as David Rogers had given his apologies. Janet Dawson reiterated on the Chair's behalf that the Non-Executive Directors would do their best to support the Executive Team through this very difficult time.	

	They recognised the huge amount of pressure everyone is under within the NHS and the staffing pressures due to omicron and would do what they could to mitigate the demands on their time. ***Noted***	
183/2021	**QUESTIONS FROM MEMBERS OF THE PUBLIC** The Trust continued to encourage the use of Ask the Board Online as part of its ongoing commitment to openness, transparency and innovation. 4 questions were received in relation to the Kniveden Project: **Question 1**: *Richard Woodward - When you say there are other things to do what are they and why has there not been any proper consultations about this from the Ashcombe centre in the past few years the Brandon centre shut walking group stopped art and social group stopped all at a minutes notice to clients and nothing else found for them to do* **Question 2**: *Judith Johnson - As the Kniveden Partnership Leek transitions to a Recovery College, the current service users , some with learning difficulties and enduring mental health conditions are about to be discharged from the partnership late Jan.2022.This established group supports in a non-judgemental, safe ,low key relaxed way a group of vulnerable people who are shunned by society. In the midst of a pandemic, they need continuing from people they trust,having endured mental health problems for a large part of their lives. A few precious hours of respite for the users, carers, parents and supporters knowing they are safe and supported must not be underestimated. Please would you confirm what support the Ashcombe Centre are planning to provide for their ongoing support following their enforced discharge from the Kniveden? The lack of information of a support plan is causing stress and anxiety. The service users do not understand why this group cannot run alongside the Recovery College on this large site when there are 7 days in a week.* **Question 3**: *Geraldine Casey - My Question is why is Kniveden closing to the current attendees? My son attends Kniveden and has benefited greatly from his time there. The gardening work has increased his self-esteem, confidence and helped him to keep his mental health stable. He has made friendships with his peers who support each other during their time there. The leaders at Kniveden are professional and caring in their approach to the clients. My son has severe enduring mental health problems and has spent long periods of time in the Harplands and community hospital Summer View and Florence house. Now stable for 8 years and living independently in shared housing. The recovery model has always been central to his treatment plan. Contrary to disabling him Kniveden has helped him to remain stable and happy. As a carer I am very concerned about the changes at Kniveden and the effect this will have on him, attendees and carers.* **Question 4**: *Maureen Roberts - The 25 gardeners who remain at Kniveden will under the terms of the present consultation will be forced to leave Kniveden the week commencing 17th of January. Can I please ask what provision has been made for the future of clients and what will replace the respite for the carers once Kniveden is closed to them?*	

	Response: The above 4 questions collectively were responded to by Kenny Laing, Executive Director of Nursing and Quality: The Kniveden Partnership remains a part of the mental health service offer for people in the Staffordshire Moorlands and the service has no consultation currently in place. All current users of the service have reviews with the staff who run the service under the supervision of an occupational therapist. These reviews include the development of plans to agree the purpose and goals for how they use the service, which, if relevant, includes any support they require to meet their needs after they leave Kniveden. The Kniveden Partnership does not offer respite services, however the needs of carers are always taken into account when working with people who use mental health services, including at the Kniveden Partnership. I have asked that all the users and carers who have taken the time to raise specific questions about their care are contacted and their queries answered by the team overseeing Kniveden. Joan Walley was concerned that as a trust it is important we accept the enduring needs of people with learning difficulties. It was her understanding that the trust are setting up a working a group including members of the trust and Peter Dartford from the CCG. The trust has a moral commitment to provide an ongoing service and take a leadership role for joint care and partnership working through the ICS to recognise the role that Kniveden plays as we do not want added strain on GPs in Leek and people going back into hospital. Patrick Sullivan sought clarification that the group of individuals who historically received a service from Kniveden will not be discharged unless their needs are not being met and that this would be in consultation with the user and their family. Kenny Laing confirmed that any discharge and planning process will be done in collaboration with the individual and that the staff at Kniveden will follow up with the individuals who have raised questions. Liz Mellor added for assurance the progress being made through the Community Mental Health Transformation Programme and the relationships with the voluntary sector and new commissioning arrangements for collaboration and joint delivery of provision over the next year. Liz and will bring the detail to a future public trust board to demonstrate. Janet Dawson noted that there appeared to be an area of communication that needs strengthening to avoid any confusion. A renewed communication exercise with families of Kniveden users to be undertaken **Question 5**: *Jean Amison asked why wasn't all our hospitals each given designation of being either Covid or non Covid status so that normal NHS duties and operation backlogs could continue to operate in some. This would better utilise the time of staff who did not work on Covid wards.* **Response:** The NHS follow the national direction of policy and process in response to Covid 19 and the trust continues to follow the strict management outbreak guidance when designating wards and service areas where Covid 19 transition has occurred. These procedures determine the designation and at no time over the last 2 years has the trust needed to designate sites or the hospital so therefore	**EM** **KL/JMc**

	have not experienced delays and have continued to deliver services throughout the pandemic. Janet Dawson thanked the members of the public for the questions directed to the board. ***Noted***	
184/2021	**NURSE STAFFING MONTHLY REPORT (OCTOBER AND NOVEMBER 2021)** Kenny Laing, Executive Director of Nursing and Quality presented the report. The October and November safer staffing reports were received for assurance. Both months achieved a fill rate of 96.8% of shifts filled. The position for registered nurses has improved and in November had increased to 85.5%. However, there is still an underlying problem with significant registered nurse vacancies and therefore the trust continues to use bank and agency staff to mitigate the vacancy position of approximately 35 whole time equivalents (WTE). ***Received***	
185/2021	**SERIOUS INCIDENTS REPORT QUARTER 2** Dr Dennis Okolo, Interim Medical Director presented the report. The report contains information, themes and learning from serious incidents within the trust covering July to September 2021. The trust continues to monitor the serious incident reports and occurrence within the trust, any incidents that do not meet the criteria for serious incidents are covered by the Mortality Review Group. Early learning indicates that there are no factors relating to the pandemic that specifically impacted or contributed to any incident. However, it was acknowledged that the pandemic has caused unusual pressure on our patients and the ability to receive the care they need. The report breaks down incidents by directorate and, in quarter two, seventeen incidents were reported which have all gone through the serious incident process. Having reviewed all the serious incidents there were no major themes in terms of learning from the incidents. Learning from serious incidents is not completed in isolation and the trust continues to monitor through different groups and within the Quality Committee. ***Received***	
186/2021	**MORTALITY SURVEILLANCE REPORT QUARTER 2** Dr Dennis Okolo, Interim Medical Director presented the report. The Mortality Review Group monitors the care of patients in any incidents or deaths that do not meet the criteria of a serious incident. Usually these patients have died from natural causes and the group reviews the care they have received to assure the trust and check there were no apparent gaps in their care. Of the cases reviewed all were classed as excellent or adequate. There was only one case that the group felt the care the patient received was less than desirable. This was mainly related to the lack of support from a care coordinator	

	during the period preceding the death. However, it was concluded that this factor did not contribute to their death. Phil Jones asked Dr Okolo to explain the significance of the lack of a care coordinator in the death of the patient. Dr Okolo responded that normally when a care co-ordinator is absent from work the system reallocates the case within the team to provide cover and we would write to the patient explaining the arrangements and emergency numbers. However, due to staffing levels the trust were unable to provide cover for that case. ***Received***	
187/2021	**QUALITY COMMITTEE ASSURANCE REPORT** Patrick Sullivan, Non-Executive Director / Chair presented assurance report from the committees held on the 2nd December 2021 and 6th January 2022. Patrick highlighted the following: The report related to two meetings in December 2021 and January 2022. Due to staff pressures the January meeting was restricted to one hour and focused on assurance of the papers and urgent issues. Across the two meetings there were a number of areas scutinised prior to being received at board. A number of reports were considered for assurance: • Learning from Experience Report Q2 2021/22 • Clinical effectiveness Report Q2 2021/22 • Infection Prevention and Control Report Q2 2020/21 • Safeguarding Children and Adults Report Q2 2021/22 • Restrictive Practice Report Q2 2021/22 • Cost Improvement Programme (CIP) and assurance that it has not impacted on quality in a negative way • Getting it Right First Time - Acute and Crisis Care The IQPR month 7 and 8, the Board Assurance Framework (BAF) Q2 report, and Risk Registers were reviewed along with headline reports from directorates. **Covid 19 Update** The committee was briefed on the Covid situation relating to the number of outbreaks and the impact on the directorates. **CQC Update** The committee was also briefed on the Care Quality Commission and the expectation that they will visit our services this year as part of their routine review. **Getting it Right First Time - Acute and Crisis Care** The information within the Getting it Right First Time report would make a helpful discussion around the future and transformation of services for the board at a strategic level. **Directorates** The Covid situation is impacting on the directorates as expected with a high level of work and pressure on staff. However some issues are longer term relating to vacancies, recruitment and the use of bank and agency. There are	

	demanding pressures between transformation work and managing operational services. Positive feedback from Ofsted inspection visit at Short Breaks Service, Dragon Square and staff should be commended. There were improvements in relation to delays around Section 136. **Policy Report** The following policies were approved for 3 years: • 1.19 Chaperoning Policy • 1.41 Clinical Risk Assessment and Management Policy • 4.33 Clinical Photography policy • 5.42 Display Scree Equipment Policy • 5.45 COSHH Policy • SOP 065 Naloxone Supply Removal of the following policies: • 1.24a Sub-Cutaneous Hydration (sub-cut) • 1.62a SOP to support the Physical Health Policy • 1.78a End of Life Care of the Deceased • 5.44a Oxygen Therapy (in on-emergency situation ***Received / Ratified***	
188/2021	**IMPROVING QUALITY PERFORMANCE REPORT (IQPR 2020/21) – Month 8** Eric Gardiner, Executive Director of Finance, Performance and Estates presented the report: The IQPR is in a good position and has improved slightly for month 8. 22 rated measures have met the required standard which has increased by one from last month and 10 measures did not meet the required standard which has decreased by two from last month. 5 special causes for variation which is the same as last month. • Childrens and young people's compliance with 4 week waits • Vacancy rates • Agency spend • Mental health liaison 4 hours waits • Statutory and mandatory training 2 special cause variations show significant improvement • The number of CPA service users in employment • settled accommodation 2 PIPs remain in place but both are on plan to hit their trajectory before the end of the year, they relate to: • referral to assessment within 4 weeks • IAPT patients waiting no longer that 90 days between first and second treatment Pauline Walsh commented that is was good to see that the trust continues to improve performance despite the current situation over the last 20 months and this is something we should recognise positively.	

	Received	
189/2021	**SERVICE USER CARER ENGAGEMENT STRATEY 2021-2024** Kenny Laing, Executive Director of Nursing and Quality presented the report. The content of the strategy was developed last year with service users, carers and families. A number of workshops were held which discussed the strengths and areas for development around involvement and co-production. It was recognised that there are areas of good practice but also areas for improvement. The draft strategy has been to the Service User and Carer Council (SUCC) for their input and oversight. 3 themes emerged: • Communication and engagement – making shared decisions with service users, carers and families when undertaking clinical practice, • Listening and responding - making sure we are responsive in terms of peoples experience in delivering care • Working together and co-production – how service users and carers can support us, lived experience can enhance the care we deliver If approved the SUCC will oversee the delivery of the strategy. Sue Tams advised that it had been a really good experience working with everyone on the strategy which had been presented to the council several times for comments and changes and that the hard work now is making it happen which is the most important thing. Joan Walley commented that when taking the strategy forward, could the trust be mindful of the questions the board received in relation to Kniveden and that we make sure the carers involved at Kniveden are fully involved and part of process. Phil Jones asked what number of carers the trust were able to consult with as a proportion of the patients the trust is treating across the complex variety of services. Kenny Laing responded that less than 100 carers were directly involved in the production, but was unable to quantify the number of people who have viewed the strategy via the various groups within the organisation. When the strategy is delivered it will incorporate everything the trust does with all those that use the services. Pauline Walsh added that the strategy should include a statement regarding the difference between engagement and co-production for leaders who may not be used to terminology and it is important to note that we are moving from one to the other. Kenny Laing responded that the strategy would include a glossary and explanation The next stage is to implement the plan which should be in place by the end of this financial year. ***Approved***	

190/2021	**ASSURANCE REPORT FROM THE PEOPLE, CULTURE AND DEVEOPMENT COMMITTEE** Janet Dawson, Non-Executive Director / Chair presented assurance report from the meeting held on the 6th December 2021. The report was taken as read and Janet highlighted the following: **Staff Story** The committee received the staff story from Ward 2 who have gone the extra mile to keep themselves going through this the pressures of Covid investing in regular wellbeing sessions with staff. **Health and Wellbeing** Ongoing health and wellbeing initiatives continue across the trust which are being augmented by Shajeda Ahmed visiting a number of sites which has been a valuable addition. **Recruitment and Retention** An enormous amount or work and success continues to take place with recruitment, however retention and recruitment still remain a challenge for all within the NHS. The report detailed under section 5 the work and initiatives that are being carried out in relation to this. **Policies** The Committee approved the following policies for 3 years: • 1.15 Dress Code Policy • 1.76 Job Planning Policy Joan Walley asked how the trust were auditing staff availability in terms of the current strand of the pandemic and its impact on specific services Janet Dawson responded that this was reported to Quality Committee in terms of the impact on services and reported to the People, Development and Culture Committee in terms of vacancies. Kerry Smith added that the trust has an escalation process in place to monitor safe staffing which is monitored on a daily basis. There is a process for redeployment of staff to ensure we keep levels of safety. Challenges and discussions take place at the Clinical Effectiveness Group (CEG) and the trust monitor health and wellbeing to ensure support programmes are in place. The national guidance changes frequently so regularly communication is sent out trust wide to staff to keep updated. Liz Mellor also added that the Staffordshire and Stoke Resilience Forum announced a major incident last week relating to staff absence rates across the NHS and this was managed through emergency planning arrangements and business continuity to monitor quality, safety and risk. ***Received / Ratified***	
191/2021	**MONTH 8 FINANCE REPORT (2021/2022)** Eric Gardiner, Executive Director of Finance, Performance and Estates presented the report. We continue to report a strong financial position across the trust.	

	Underspent by £32k in month 8 which gives a year to date underspend of £614k against our plan of break even. When the trust submits its' accounts for month 9, it will be asked to provide a control total which the trust will be expected to deliver to year end. This is expected to be a small surplus which the trust will need to maintain for the remaining months of the year. The trust has delivered its savings target for the year with thanks to Jonathan O'Brien and his team. The trust are now in a good position for next year and is planning for a savings target of approximately 3%. Agency spend remains an issue, however it is within the trust forecast and therefore does not cause any financial problems. Capital spend is behind target and this is being discussed in various meetings. The trust needs to provide an estimated capital figure by Monday 17th January which it will be held to until the end of the year and will be expected to deliver. The Better Payment Practice Code (BPPC) statutory target in relation to paying 95% of our invoices within 30 days has slipped predominately due to the TCP and Project 86. This is an area of focus for the team, however the trust is still performing well in comparison with partner organisations. ***Received***	
192/2021	**ASSURANCE REPORT FROM THE FINANCE AND RESOURCES COMMITTEE** Russell Andrews, Non-Executive Director / Chair presented assurance report from the committees held on the 2nd December 2021 and 6th January 2022. Russell highlighted the following Russell Andrews reported on the committee that took place on 6th January. **Estates** The committee noted the delays to some projects which is primarily due to the availability and rising costs of building materials and these have impacted on the trusts' capital programmes. Project Chrysalis, the inpatient reconfiguration programme, is experiencing the same issues and delays. The committee considered the scope for re-prioritising the work on this project, this will be discussed in private trust board. The committee discussed nugatory spend on buildings that might be refurbished or rebuilt in a short space of time and received assurance that the Estates Team is reviewing where the trust is deploying the capital spend in order that the trust is efficient. **Finance update** The month 8 position continued to show a small surplus for the month. Agency costs continued to be in excess of the ceiling in M8. Capital spend remained materially behind plan in M8 and is forecasting that this will be spent the full allocation by year end. **Autistic Spectrum Disorder Proposal**	

	The trust has received a proposal to appoint Caudwell as extra capacity for the autistic spectrum disorder assessments which was approved. **Holmcroft** The committee received an update on the vertical integration of Holmcroft surgery. The integration which has now taken place is a significant achievement for the trust and takes our patient commitment across the three GP surgeries to 27000 which is within distance of the size of a Primary Care Network (PCN). **Green Plan** A draft plan was received at the December committee, the January committee noted that the revised draft plan had addressed the feedback previously received. ***Received***	
193/2021	**ASSURANCE REPORT FROM THE AUDIT COMMITTEE** Phil Jones, Non-Executive Director / Chair presented assurance report from the committee held on the 1st December 2021. Phil highlighted the following **Internal Audit Progress Report** The committee was satisfied that the internal audit work plan would be focusing on the appropriate areas including Project 86 and Transforming Care Partnerships (TCP) in terms of governance and financial management. **Grant Thornton – External Auditors** Grant Thornton has been appointed as the new external auditors as the most cost effective option for the trust and the trust is looking forward to working with them. A further paper will be discussed in private trust board. **Policies for Approval** The following policies were presented and approved. • Petty Cash Policy • Local Counter Fraud policy • Anti-Bribery • Security of Assets • Disposal of assets and surplus to requirements • Standing Financial Instructions (SFIs) • Scheme of Delegation ***Received / Ratified***	
194/2021	**REGISTER OF DECLARATIONS FOR BOARD MEMBERS** Laurie Wrench, Associate Director of Governance presented the report The report was a 6 monthly update of declarations for board members. Following approval the report will be published on the trust external website. Laurie Wrench to check the declaration made by Joan Walley prior to publishing. ***Approved***	**LW**
195/2021	**THE GREEN PLAN** Chris Bird, Director of Partnerships, Strategy and Digital presented the plan for approval.	

	All NHS Trusts are required to have a board approved green plan by 14th January 2022. The plan sets out the trusts commitment to make a net zero health service over three year period commencing April 2022. The plan has been developed with subject matter experts within the trust. The plan adheres to the national policy but has a degree of flexibility and the trust is confident it has met the minimum requirements. The trust needs to complete a detailed action plan by the end of March 2022. Once each NHS trust has published, the individual plans will be aggregated up to an ICS plan by the end of March 2022. Joan Walley thanked Chris for all his work on producing the plan on time and ready for submission following approval. Joan noted how important the NHS Five year plan was in relation to zero carbon and once the plan is adopted the trust need to make progress across all departments. It is also important for the trust to Influence the ICS plan and promote integrated working across all partners. The plan does not preclude further ambition and following the action plan should include key performance indicators (KPIs). Pauline Walsh asked whether there was an opportunity for the NHS to produce its own energy supply across the NHS footprint. In relation to the travel section and reducing travel and the use of electric vehicles, were there plans for electric charging points. Chris Bird responded that the requirement for an ICS green plan is helpful as it allows conversations in relation to an electric charging infrastructure with local authorities and other partners to take place. The trust energy supply is purchased from tariffs that meet the definition of being renewable. Discussions are taking place with other NHS trusts regarding adopting solar panels on buildings to generate energy. ***Approved***	
196/2021	**EPRR CORE STANDARDS: ANNUAL DECLARATION OF COMPLIANCE** Liz Mellor, Interim Director of Operation presented the report The core standards for emergency planning are a statutory responsibility for all trusts. For the third year running the trust has been fully compliant as assessed by NHSEI. The system return received following the assessment of our core standard has commended the trust for the high level of that submission. ***Received for assurance***	
197/2021	**2022/23 PLANNING GUIDANCE** Chris Bird, Director of Partnerships, Strategy and Digital provided an update. The guidance was published on Christmas Eve and sets out ten priority areas for the NHS to pursue throughout the planning period and beyond. Six priority areas were included in the comparative document for 21/22 and the remaining derived from national policies in relation to Covid. The categories fall into 3 categories for our trust • Invest in workforce • Response to Covid 19 • Grow and improve mental health services There are two headline priorities for Combined Healthcare	

	• F1: Grow and improve mental health services • F2 Meeting the needs of people with a learning disability and autistic people Some of the sub components of F2 are more likely to be taken forward by other partners within the system. The trust will continue to work with partners in primary care to deliver the additional role reimbursement schemes and pursue developing provider collaboratives. The Original target date for transition to Integrated Care System (ICS) and establishment of the Integrated Care Board (ICB) has been replaced by a new target date of 1st July 2022. This has raised questions around the existence of the Care Commissioning Group (CCG) and the guidance provides some clarity around the CCG. It has been confirmed that as all plans will be submitted at system level, there are no requirements to publish a trust plan. The trust will use the organisational system submission in relation to finance activity and workforce and add a one page summary for each operational directorate and corporate directorate to pick up key areas of risks and priorities. Janet Dawson asked how once the funding arrangements revert to the normal control total arrangements, this will affect delivery of the ten priorities. Chris Bird responded that there are specific funds available for elements of Covid recovery i.e. waiting lists backlogs, funding available for specific objectives i.e. the eradication of dormitories and also an allocation of funding for the transition to ICS arrangements. Eric Gardiner added that the system are discussing finances for next year with three broad options: • Option 1 - go back to IFP contracting principles • Option 2 – H2, using funding received for the last 6 months of this year times two, which is broadly in line with the national guidance. • Option 3 based on run rates, which the CCG and 3 providers are not in agreement with at this time. Kenny Laing commented that the plan and priorities were ambitious and had concerns around the delivery due to workforce pressures and vacancy rates which continue to be an issue for the trust. Janet Dawson noted that this point was absent from the priorities and without the workforce we would be unable to deliver the plan. ***Received***	
198/2021	**NHS SYSTEM OVERSIGHT FRAMEWORK** Chris Bird, Director of Partnerships, Strategy and Digital The report was received as a consent agenda item. The rating of the trust was considered at private board in November 2021. ***Received***	
199/2021	**ANY OTHER BUSINESS** There were no items of other business.	

	DATE AND TIME OF NEXT MEETING The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday 10th February 2022 at 10.00am via MS Teams.	
	MOTION TO EXCLUDE THE PUBLIC The Board approved a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted.	

The meeting closed at 11.46am

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	14-Oct-21	147/21 (1)	**Service User Carer Council Update (1)** **14.10.21** - Tony Gadsby felt given the pressure at the moment in terms of primary care it would be helpful to have an update of what was happening in primary care in terms of service user and their experience within those practices. Kenny Laing to include in the next report. **11.11.21** - Add to cycle of Business a report to come from Associates. Laurie Wrench to discuss with Dr Adeyemo outside of the meeting. Dr Buki Adeyemo noted Associates had attended Board previously and suggested inviting them to attend a future meeting.	Laurie Wrench	9-Mar-22	**Complete**
2	13-Jan-22	183/21(1)	**Community Mental Health Transformation Programme** Liz Mellor will bring the detail to a future public trust board to demonstrate the progress of the programme	Elizabeth Mellor	**Post April 2022**	**The MH Community Transformation and specifically the commission activity will be brought back to a board dev session – date tbc from April 2022.**
3	13-Jan-22	183/21(2)	**Kniveden** A renewed communication exercise with families of Kniveden users to be undertaken	Kenny Laing/Joe McCrea	10-Feb-22	**Complete - all users at Kniveden have been informed of the current position in relation to the service.**
4	13-Jan-22	194/21	**Register of declarations for Board members** Laurie Wrench to check the declaration made by Joan Walley prior to publishing	Laurie Wrench	10-Feb-22	**Complete**

REPORT TO PUBLIC TRUST BOARD

Enclosure No: 3

Date of Meeting:	10th February 2022		
Title of Report:	CEO Board Report		
Presented by:	Dr Buki Adeyemo, Interim Chief Executive		
Author:	Dr Buki Adeyemo, Interim Chief Executive		
Executive Lead Name:	Dr Buki Adeyemo, Interim Chief Executive	**Approved by Exec**	☐

Executive Summary:		**Purpose of report**	
This report updates the Board on activities undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest.		**Approval**	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Resource Committee ☐ • Audit Committee ☐ • People, Culture & Development Committee ☐ • Charitable Funds Committee ☐		
Strategic Objectives (please indicate)	1. We will attract, develop and retain the best people ☒ 2. We will actively promote partnership and integrated models of working ☒ 3. We will provide the highest quality, safe and effective services ☒ 4. We will increase our efficiency and effectiveness through sustainable development ☒		
Risk / legal implications: Risk Register Reference	N/A		
Resource Implications: Funding Source:	N/A N/A		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	There is no direct impact on the protected characteristics as part of the completion of this report.		
Shadow ICS Alignment / Implications:	N/A		
Recommendations:	To receive for information and assurance		

Version	Name/group	Date issued
1.0		28/01/2021

Keele UNIVERSITY TEACHING TRUST

NHS North Staffordshire Combined Healthcare NHS Trust

Interim Chief Executive's Report to the Trust Board
10 February 2022

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.

OUR "PEOPLE" STRATEGIC THEME

Omicron and January Pressures

The community transmission rate of Omicron is reducing and it is reported nationally we are past the peak of the Omicron variant. January has been a very hard and challenging month across the NHS and for colleagues working across the Trust, and we want to start this month's report by thanking our staff for their exceptionally hard work during this period. Many have stepped up to support others outside of their own work areas, and their dedication and collegiate spirit is much appreciated.

Saturday 29 January marked two years since the first COVID-19 patient was reported in the UK. This was just one day before WHO declared a global health emergency. Our thoughts are with those who have lost their lives during the pandemic, and our endless gratitude goes to all the key workers who have kept the country going over the past two years.

We continue to issue our COVID-19 Trust-wide bulletins to all of our staff through the Chair of the COVID-19 Incident Management Group and Interim Director of Operations Liz Mellor, and key information is regularly updated on our dedicated COVID-19 resource on the Trust's intranet.

Staff Achievements

Ward 6 has achieved the GOLD award standard in My Improvement Network's RITA (Reminiscence Interactive Therapy Activities) Awards 2021, which is fantastic news.

They were awarded the accolade in the 'Most Innovative Use of RITA' category, commended for 'thinking outside the box' and taking a consultative approach of introducing RITA to the patient in sessions including Reminiscence and Music and Art.

Well done to Vickie Washington, Ward 2 Manager, and colleagues for their 'Red January' rowing endeavours last month. Vickie set a rowing machine challenge for colleagues to keep moving every day throughout 'Red January', which is a national campaign to inspire people to move every day during a month which can be cold, wet and where people can feel a little low. Some rowed 500m, some 200m, and some even 2,000m, and the feedback was extremely positive in terms of boosting activity and wellbeing.

The HMP Stoke Heath Secondary Mental Health Team recently organised a charity cake sale for Shelter.

They raised a fantastic £93, with a thank-you letter sent to the team following the donation. Well done to all involved.

NHS People Pulse Survey

As mentioned in last month's Board Report, our staff have a more frequent opportunity to help us understand employee experience and to support decision making and actions for improvement; this is through the quarterly national NHS People Pulse survey with the latest now live. It complements and augments the full annual national NHS Staff Survey. We thank all staff who have completed the pulse survey and look forward to the results.

OUR "QUALITY" STRATEGIC THEME

Quality Strategy 2022 – 'Outstanding Our Journey Continues' – And QI Work

The Trust's Governance team will be visiting staff teams throughout 2022 to continue with the Trust's vision of 'Outstanding: Our Journey Continues', in line with our ongoing quality assurance monitoring and with health and social care regulations. The Quality Improvement team also continue to imbed their offer throughout the Trust and they have a range of sessions available to staff starting this month, including 'Drop into QI', 'Introduction to QI', 'QI Quickstart' and the Improvement Leaders Programme. The sessions are designed for staff at a range of levels with different responsibilities, and the team will be on hand during the training sessions to answer QI-related queries. This area of work is being led by Jayne Beasley, QI Lead, and Lisa Bellamy, QI Facilitator.

Digital Aspirants Programme – Community Aide Application

We were excited to announce the launch of the Community Aide app which is part of the outstanding Digital Aspirants Programme. The programme is continuing the Trust's NHS Digital Exemplar journey.

This project will see the Community Aide App offered for roll out to all Community Services. These teams will move away from using paper diaries and there will be a reduction in the need to travel to and from base to input patient notes into Lorenzo.

Community Aide will offer staff a digital solution to safely and efficiently manage patients note entries whilst in a community setting, using a disconnected mode.

A **podcast is available with the staff that piloted the app**.

Research and Development Team – Virtual Outreach Sessions

The Research and Development Team is launching its new Virtual Outreach sessions to reconnect with wider teams across the Trust.

Colleagues can book a session for teams to discover more about R&D's role in the Trust, the team's values and how it can help them get involved in NIHR studies at the forefront of research delivery.

AHP Support Worker Survey

Within Combined Healthcare, we are working on a project funded by Health Education England in which part of this is to help develop and enable learning, development, and progression for our Allied Health Professional (AHP) support workforce.

We are asking our current AHP support staff to please set aside 5–10 minutes to complete this survey to help us to understand the development training needs for the AHP support workforce. It will aid us to begin the process of scoping what we need to provide for our AHP support worker workforce in the future.

Community Mental Health Transformation Programme – VCSE Sector And Co-Production

As part of our delivery in the Community Mental Health Transformation Programme, VCSE (Voluntary, Community and Social Enterprise) organisations across Stoke-on-Trent and North Staffordshire were also invited to join a procurement event being held by Combined Healthcare and MPFT last month, which provided information about the Programme, and the procurement opportunities that will be available for VCSE organisations.

Co-Production is an essential element of the transformation and Programme, and the Trust is actively encouraging any service users who would like to be part of this work to please come forward and be involved. A Combinations podcast explores the topic of Co-Production in the Programme and you can **listen online here.**

Celebrating Awareness Days and Events

The third Monday of January is often referred to as 'Blue Monday', with lots of discussion across social media, the media and other communications channels about the day, self-care and what support is available. We published supportive messaging on our social media channels on this day, but also joined in the Samaritans national campaign to turn 'Blue Monday' into 'Brew Monday' – helping to reframe the narrative into a positive messaging day of support, having a chat and connecting with family and friends over a cup of tea or coffee.

Time to Talk Day took place on 3 February. The campaign, run by Mind and Rethink Mental Illness in England, in partnership with Co-op, is all about creating supportive communities by having conversations with family, friends or colleagues about mental health. We supported the campaign through our corporate communication channels.

February is LGBT+ History month and information is being published throughout the month across our communications channels to celebrate our LGBT+ colleagues and community.

We also marked the Jewish celebration Tu B'Shevat, which is often called the New Year of the Trees, Holocaust Memorial Day, NHS Safeguarding Learning Together Week and Red January.

OUR "SUSTAINABILITY" STRATEGIC THEME

Trust call for Sustainability Champions

Combined Healthcare has put a call out to its staff, looking for volunteers across the organisation to act as 'Sustainability Champions' to support us in developing a comprehensive and cohesive action plan which will encompass all elements of sustainability.

A short training module for volunteers is available on LMS called 'Environmentally Sustainable Healthcare (ESH)'. Once colleagues have completed the model, they are then asked to express their interest with Business Development Manager Karen Day in the Project Management Office

The Trust is focused on sustainability to help us make progress towards the sustainable development goals and deliver the national commitments set out in the NHS Long Term Plan.

REPORT TO PUBLIC TRUST BOARD

Enclosure 4

Date of Meeting:	10th February 2022		
Title of Report:	December 2021 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 December 2021 in line with the National Quality Board requirements. Key Findings: • During December 2021, an overall fill rate of 92.6% was achieved; this has decreased from 96.8% in November 2021. • The fill rate for RN shifts was 78.2% in December 2021, a decrease from 85.5% in November 2021. • Ward occupancy levels increased in 3 areas and decreased in 9 areas. • RN vacancies decreased by 0.47 WTE to 35.93 WTE. • The HCSW vacancy position continues to be over-established, increasing to +6.66 WTE. • Recruitment to vacancies continues to be challenging but has been helped this month by a number of graduate nurses commencing with the Trust. Recommendations: The Quality Committee and Trust Board are asked to receive the report, to note the challenges in filling shifts and with recruitment to nurse vacancies, and to acknowledge and support the mitigations that are currently in place. The Board should be assured that the Trust are continuing to maintain safe staffing levels within our ward inpatient areas.	**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. We will attract, develop and retain the best people ☒ 2. We will actively promote partnership and integrated models of working ☐		

	3. We will provide the highest quality, safe and effective services ☒ 4. We will increase our efficiency and effectiveness through sustainable development ☐	
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	There is no direct impact on the protected characteristics as part of the completion of this report.	
Shadow ICS Alignment / Implications:	Nil	
Recommendations:	To receive the report for assurance and information	
Version	Name/group	Date issued
1	SLT	
2	Quality Committee	

1.0 Introduction

This report details the ward daily staffing levels during the month of December 2021 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).

2.0 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 six monthly basis and report the outcome of the review to the Trust Board of Directors. A comprehensive annual report for 2020/21 was presented to the October 2021 Trust Board and the recommendations relating to safer staffing reviews are progressed and monitored through the Safer Staffing Group.

3.0 Trust Performance

During December 2021, the Trust achieved a staffing fill rate of 77.4% for Registered Nurses and 101.6% for care staff on day shifts and 80.0% and 104.0% respectively on night shifts. Taking skill mix adjustments into account an overall fill-rate of 92.6% was achieved; this has decreased from 96.8% in November 2021.

Details of the actions taken to maintain safe staffing levels are provided below. Staffing data, including established, planned (clinically required) and actual hours alongside details of vacancies, bed occupancy and actions taken to maintain safer staffing are provided in Appendix 1.

The impact of unfilled shifts alongside the additional contributory factors are also provided below and are summarised in Appendix 3.

The Safer Staffing Group continues to oversee the safer staffing work plan and Safer Staffing Action Plan.

4.0 Care Hours per Patient Day (CHPPD)

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

Using the Model Health System, a data-driven improvement tool that enables NHS health systems and trusts to benchmark quality and productivity both nationally and also with peer organisations; we can identify that the Trusts CHPPD for the latest data period were 13.1, placing the Trust in the highest quartile, against a national median and peer median of 11.2 CHPPD.

5.0 Impact

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

5.1 Incidents reported relating to staffing levels

There were five incidents reported in relation to ward staffing levels during December 2021. Three incidents were reported for Assessment and Treatment, these related to occasions when staffing on the unit fell below the required level, support was provided by the Intensive Support Team. Ward 2 reported one occasion when staff had to be deployed to maintain a safe level in other areas, resulting in the ward working below the required level during one night shift, support was provided by the Site Manager. PICU reported one incident when high levels of patient acuity impacted upon staffing levels, support was requested from the Site Manager.

None of the above incidents resulted in patient harm.

5.2 Impact on Patient Experience

Staff prioritise patient experience and direct patient care. COVID-19 restrictions continued to have an impact on patient activities during December 2021. There were 26 occasions (total 72.5 hours) reported of patient activities having to be cancelled due to shortfalls in staffing levels. On nine occasions activities were rescheduled. There were four occasions when activities were shortened due to shortfalls in staffing numbers.

5.3 Impact on Staff Experience

In order to maintain safe staffing levels the following actions were taken by Ward Managers during December 2021:

- 129 staff breaks were cancelled (equivalent to approximately 2.7% of total breaks). This figure has decreased from 3.4% in November 2021. Ward 4 reported the highest number of missed breaks – 29 in total (9 for RN's and 20 for HCSW's). Any time accrued due to missed breaks is taken back with agreement of the Ward Manager.

- Face to face, mandatory training sessions for MAPA and In Hospital Resuscitation (IHR) recommenced in May 2021. Where appropriate all other mandatory training is provided using the web-based Learning Management System or through a facilitated virtual presentation and discussion. During December 2021, 4 mandatory training sessions had to be cancelled as a result of staffing shortfalls, these occurred at PICU and Ward 4.

- During December 2021, there were nine reports of staff appraisals being cancelled due to staffing shortfalls.

5.4 Mitigating Actions

Ward Managers and members of the multi-disciplinary team have clinically supported day shifts to ensure safe patient care. 424 RN shifts were covered by HCSW's where RN temporary staffing was unavailable. RN staff covered 136 HCSW shifts 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.

There were 69 occasions in December 2021 (95 hours total) when members of the multi-disciplinary team provided additional support to maintain safe staffing levels. These occasions occurred most frequently within the adult acute wards. This mitigation continues to demonstrate the high level of flexibility provided by staff when responding to shortfalls.

There were 71 occasions (109 hours total) reported when staff worked additional unplanned hours to support ward staffing levels. These occasions occurred within the adult acute admission wards, Darwin Centre and Ward 4.

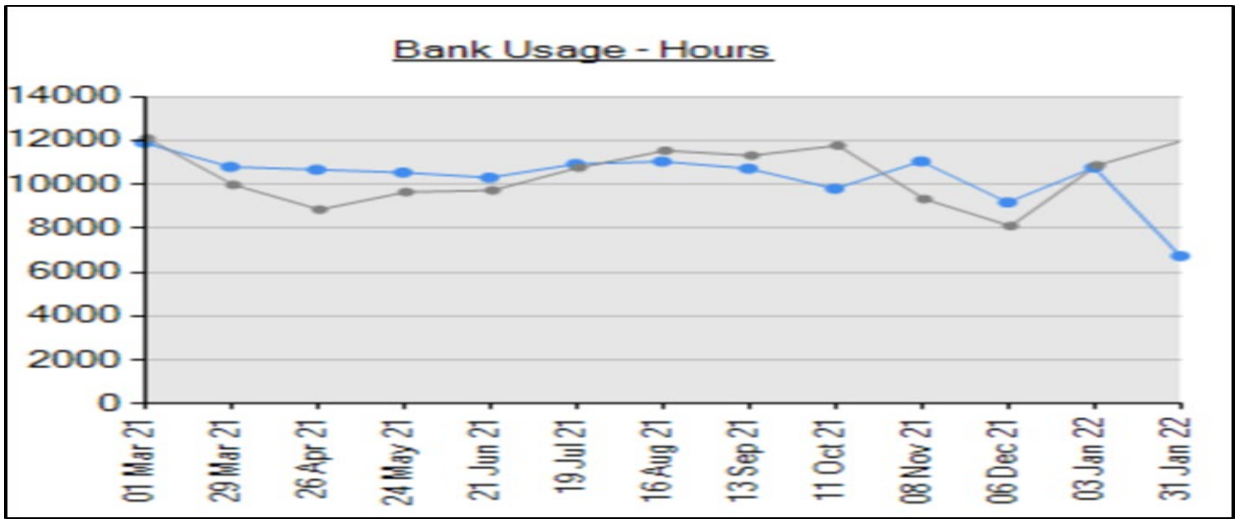
Safer Staffing Huddles continued during December 2021, providing an efficient and effective response to identifying and mitigating potential staffing shortfalls. The commitment and dedication of all Trust staff in supporting and responding to staffing requests continues to be recognised.

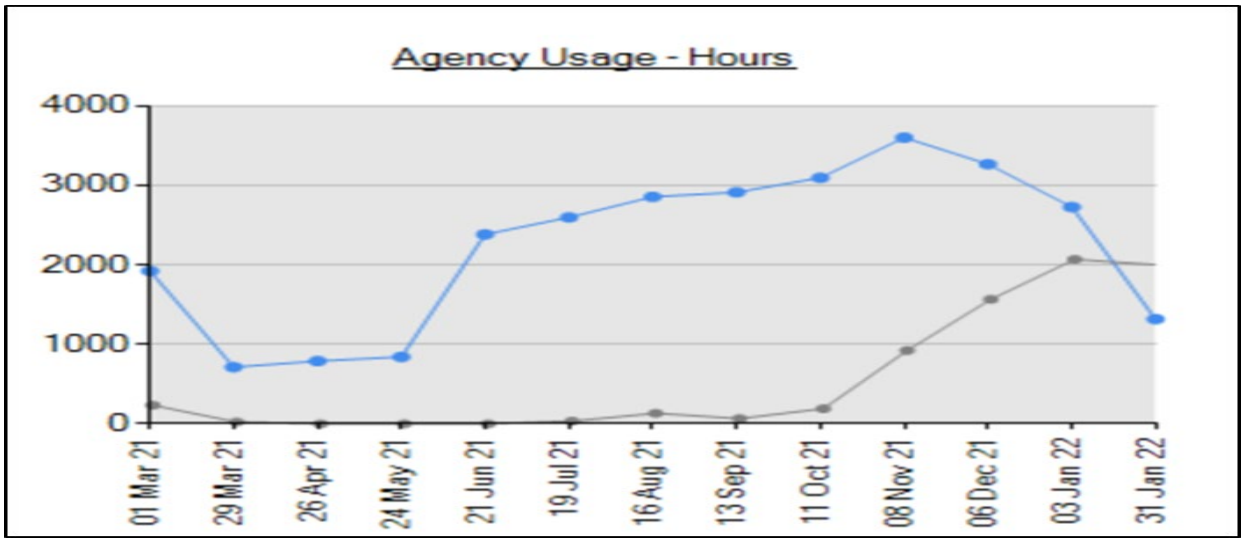
In addition, to support staffing shortfalls the Temporary Staffing Team have been given early approval to recruit to an additional twelve agency staff each day to support ward inpatient areas.

Bank and agency usage has increased significantly in the past 12 months; this has at times been essential for the maintenance of safe staffing levels. This is demonstrated in the two graphs below. There has been a noticeable decrease in the use of bank and agency staffing from October 2021; this is most likely as a result of a reduction in RN vacancies, the end of the school summer and half-term holiday periods and bank and agency staff choosing to take time away from work during the Christmas break.

Bank and Agency Usage within ward inpatient areas during 2020 / 2021/22

	2020
	2021/22





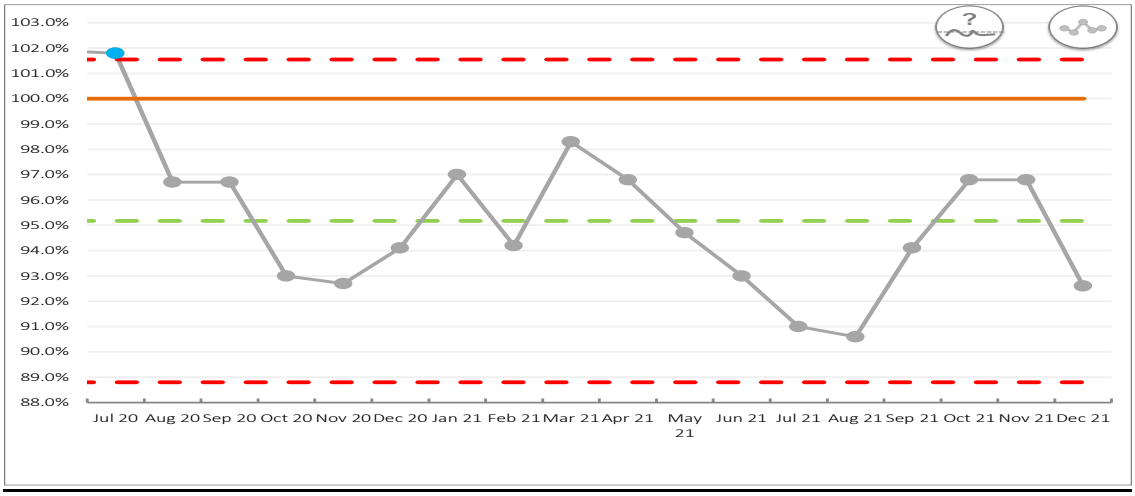
5.5 Overall Fill Rate

The overall staffing fill rate during December 2021 was 92.6%. This has decreased from 96.8% in November 2021 and is outlined in the SPC chart below. The chart provides an overview of the total fill rate for the past 18 months. During this period staffing fill rates have remained within the area of common cause variation and have most frequently fallen within the upper control limit.

A consistent and steady decline in the overall fill rate can be seen from March 2021 until September 2021. This has been more noticeable than in previous years due to the ending of March student nurse intakes and the resulting absence of spring graduates. As expected fill rates began to improve from September 2021 when a number of graduate RN's commenced with the Trust.

The Trust continues to take the required actions to mitigate any shortfalls in fill rate and this position is summarised in section 5.4.

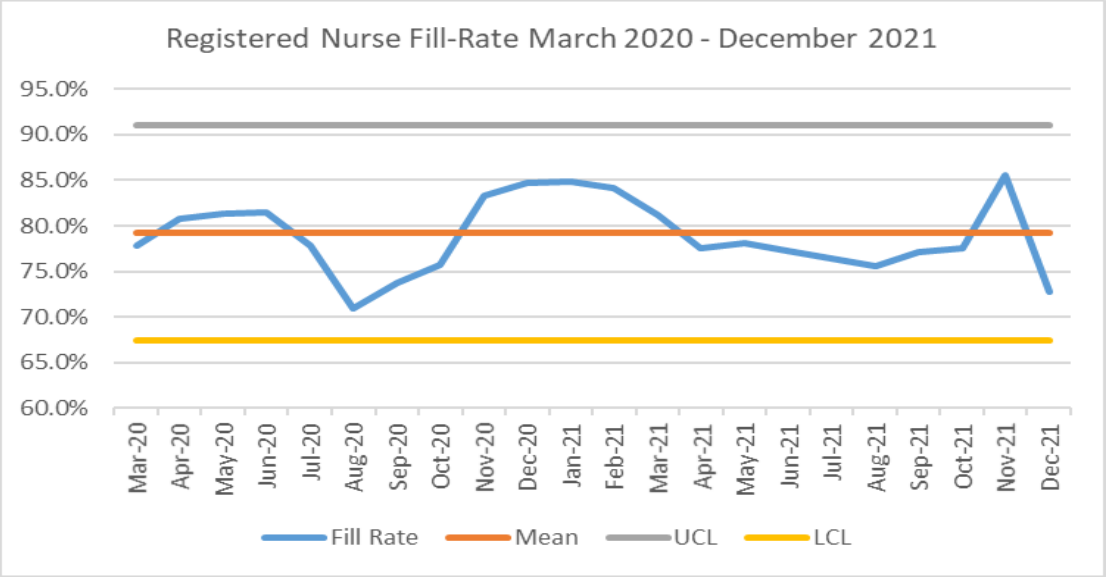
Overall Fill-Rate February 2020 – December 2021



5.6 Total Registered Nurse Fill-Rate

The total Registered Nurse fill rate during December 2021 was 78.2%. This has increased from the 85.5% fill rate reported in November 2021.

The trend over the past 18 months is presented in the chart below. We can see that the RN fill rate has consistently remained within the area of common cause variation though remains a challenge due to the reasons outlined above.



5.7 Recruitment

In line with the national picture, recruitment to all nursing posts continues to be difficult. Task and Finish Group is currently working to deliver 33 schemes that focus on improving retention and increasing recruitment, some schemes have clear output values e.g. completion of training programmes, whilst others are less quantifiable such as the development of extended recruitment campaigns.

The Trust continues to employ a majority of our RN's from the newly graduating student nurse cohorts. During October 2021, 27 nursing graduates commenced with the Trust. Relationships with both local HEI's, as well as those further afield remain strong and have helped to improve recruitment and attract the best graduates to join our workforce.

During April 2021, our first cohort of 14 Registered Nurse Degree Apprenticeship (RNDA) commenced their training on the mental health pathway with the University of Derby. Staff are funded by the Trust with some central funding being provided by Health Education England (HEE). In addition we have a further cohort of 7 BSc Nursing Apprentices commencing in March 2022 and we are currently planning for the commencement of 6 MSc Nursing Apprentices in September 2022.

Furthermore, we have secured funding (circa £100,000) from HEE to support up to 6 existing staff – Nursing Associates/Assistant Practitioners to undertake a 2 year nursing top up degree. We are aiming for a March 2022 start date with Staffordshire University.

We are continuing to support HCSW apprenticeships within our Acute and Urgent Care Wards; this includes our own apprentices and those who rotate through our ward areas as part of a Staffordshire wide programme.

The Trust continues to participate in the NHSE/I Retention Support Programme. This includes a number of initiatives including, involvement with national return to practice campaigns and the strengthening of the nursing career pathway through our partnership work with Staffordshire and Keele Universities.

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

In addition, we are currently expanding our support for nurses who trained overseas to enable their registration to be recognised in the UK. We are continuing to contribute to the regional NHSE/I international nurse recruitment programme for mental health and learning disability nurses and we have secured funding to support a collaborative bid to recruit 10 MH Nurses from overseas.

5.8 Registered Nurse and HCSW Retention

During December 2021, two Registered Nurses (2.00 WTE) left the Trust; both from Community Services. One nurse retired and another left to secure a better reward package.

Four HCSW's (3.80 WTE) left the Trust during December 2021. All were based within inpatient services. One taking retirement, one seeking an improved work life balance, one to relocate and one for a promotion opportunity.

5.9 Staff support and well-being

The Nursing Directorate continue to offer support and advice on staffing issues and they receive daily staffing updates from Ward Managers, Quality Improvement Nurses (Matrons) and the E-Rostering and Temporary Staffing Team as appropriate.

The E-rostering team have continued to maintain the co-ordination and allocation of the bank staff and the agency pool. The operational directorates have welcomed this support and intervention.

To further support the Nursing Teams we have a number of Registered Nurses who are undertaking a Professional Nurse Advocate (PNA) Training Programme. This is a Level 7 Accredited PNA Training Programme accessible to Bands 5 and above. It will support the facilitation of restorative clinical supervision in practise,

and lead and deliver quality improvement initiatives in response to the service demands and the ongoing changing patient requirements.

The Trust preceptorship programme has been enhanced, providing additional support and supervision for our newly registered staff. The initial induction programme has been updated to ensure that staff receive a thorough briefing regarding COVID-19 and the required Infection Prevention and Control (IPC) standards and expectations.

The Ward Managers Task and Finish Meetings take place each month. Dedicated time is provided for reflection, group supervision, and wellbeing discussions. Additionally, the senior nursing team continue to maintain visibility within ward inpatient areas.

6.0 Summary

Ward staffing remained challenging during December 2021. Patient acuity continues to be high within a number of wards although occupancy decreased in most areas. Ward Managers, Service Managers and Quality Improvement Nurses (Matrons) continue to review staffing levels on a daily basis to ensure that patient safety remains paramount. Any significant staffing concerns are escalated through the operational directorates and via the Incident Management Group.

RN vacancies within ward inpatient areas decreased by 0.47 WTE during December 2021 to 35.93 WTE. The highest level of RN vacancy remains at PICU (9.40 WTE).

Overall ward based HCSW positions continue to be over established increasing to +6.66 WTE during December 2021.

The national shortage of Registered Nurses and a reduction in university graduates has resulted in a steady increase in RN vacancies from March 2021. The Nursing, Operational and Workforce Directorates are continuing to employ a number of strategies to attract both RNs and HCSW's during this time, these are outlined in section 5.7. Recent targeted recruitment campaigns have focused upon our Acute and Urgent Care Services.

During November 2021 27 graduate RN's commenced employment with the Trust.

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

Appendix 1 December 2021 Safer Staffing

	Registered Nurses						Care Staff						Registered Nurse		Care Staff	
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 (%)
Assessment & Treatment	939.00	939.00	988.92	688.20	688.20	422.70	1162.50	2100.00	1494.25	688.20	1187.70	1578.90	105.3%	61.4%	71.2%	132.9%
Darwin Centre	1335.00	1335.00	1026.00	688.20	688.20	533.70	1162.50	2107.50	1731.25	688.20	1265.40	1193.07	76.9%	77.6%	82.1%	94.3%
Edward Myers Unit	963.00	963.00	651.75	344.10	344.10	266.40	1162.50	1162.50	525.75	688.20	688.20	432.90	67.7%	77.4%	45.2%	62.9%
Summers View	930.00	930.00	688.75	332.32	332.32	336.97	930.00	930.00	980.00	664.64	664.64	667.93	74.1%	101.4%	105.4%	100.5%
PICU	1428.00	1428.00	970.75	688.20	688.20	646.10	1674.00	1674.00	1817.50	1376.40	1376.40	1298.85	68.0%	93.9%	108.6%	94.4%
Ward 1	1335.00	1335.00	873.25	344.10	344.10	509.10	1162.50	1282.50	1219.75	688.20	1143.30	1084.70	65.4%	148.0%	95.1%	94.9%
Ward 2	1335.00	1335.00	1179.00	688.20	777.00	516.90	1162.50	1290.00	1247.50	688.20	965.70	1053.00	88.3%	66.5%	96.7%	109.0%
Ward 3	1335.00	1335.00	1007.00	688.20	688.20	411.60	1162.50	1230.00	1507.25	688.20	921.30	1117.75	75.4%	59.8%	122.5%	121.3%
Ward 4	1496.00	1496.00	1211.25	344.10	344.10	346.50	1162.50	1402.50	1936.67	1032.30	1376.40	1556.60	81.0%	100.7%	138.1%	113.1%
Ward 5	1335.00	1335.00	1042.75	688.20	688.20	456.00	1162.50	1912.50	1956.75	688.20	1587.30	1656.15	78.1%	66.3%	102.3%	104.3%
Ward 6	1179.75	1179.75	937.40	688.20	688.20	444.00	1162.50	1342.50	2023.00	1032.30	1165.50	1276.50	79.5%	64.5%	150.7%	109.5%
Ward 7	1335.00	1335.00	993.75	344.10	344.10	399.60	1162.50	1162.50	1438.73	1032.30	1032.30	987.90	74.4%	116.1%	123.8%	95.7%
Totals	14945.75	14945.75	11570.57	6526.12	6614.92	5289.57	14229.00	17596.50	17878.40	9955.34	13374.14	13904.25	77.4%	80.0%	101.6%	104.0%
Dragon Square	1102.50	1102.50	714.00	310.00	310.00	227.50	1162.50	1162.50	656.50	620.00	620.00	280.00	64.8%	73.4%	56.5%	45.2%

Appendix 2 - Bank and Agency Usage 2020 and 2021

	Total Nursing Staffing			Total Hours Per Day	Patients	CHPPD	Safe staffing was maintained by	RN Vacancies	HCSW Vacancies	Bed Occupancy December 2021	Movement
Ward	Overall RN %	Overall Care Staff %	Overall Staffing								
Assessment & Treatment	86.8%	93.5%	91.2%	4640.77	139.00	33.39	Nurses working additional unplanned hours and altering the skill mix	3.66	-2.66	67%	↓
Darwin Centre	77.1%	86.7%	83.1%	4788.52	338.00	14.17	Nurses working additional unplanned hours and altering the skill mix and support from the MDT.	3.56	-2.46	81%	↓
Edward Myers Unit	70.2%	51.8%	59.4%	1876.80	168.00	11.17	Nurses working additional unplanned hours and altering the skill mix	1.63	1.20	45%	↓
Summers View	81.3%	103.3%	93.6%	2970.65	279.00	10.65	Nurses working additional unplanned hours and altering the skill mix	3.60	1.00	88%	↓
PICU	76.4%	102.2%	91.6%	4965.70	132.00	37.62	Nurses working additional unplanned hours and altering the skill mix and support from the MDT.	9.40	-0.88	78%	↓
Ward 1	82.3%	95.0%	89.8%	4043.80	336.00	12.04	Nurses working additional unplanned hours and altering the skill mix and support from the MDT.	1.11	2.72	77%	↓
Ward 2	80.3%	102.0%	91.5%	4786.40	445.00	10.76	Nurses working additional unplanned hours and altering the skill mix.	4.94	-0.18	66%	↓
Ward 3	70.1%	122.0%	96.9%	4520.60	491.00	9.21	Nurses working additional unplanned hours and altering the skill mix and support from the MDT.	6.02	-3.40	78%	↑
Ward 4	84.7%	125.7%	109.4%	5691.02	439.00	12.96	Nurses working additional unplanned hours and altering the skill mix and support from the MDT.	-0.28	0.88	93%	↑
Ward 5	74.1%	103.2%	92.6%	5461.65	251.00	21.76	Nurses working additional unplanned hours and altering the skill mix	0.50	-1.95	81%	↓
Ward 6	74.0%	131.6%	107.0%	5236.90	350.00	14.96	Nurses working additional unplanned hours and altering the skill mix	1.79	-0.73	73%	↑
Ward 7	83.0%	110.6%	98.6%	4617.48	368.00	12.55	Nurses working additional unplanned hours and altering the skill mix	0.00	-0.20	69%	↓
Totals	78.2%	102.6%	92.6%	53600.28	3736.00	14.35		**35.93**	**-6.66**		
Dragon Square	66.7%	52.5%	58.8%	1878.00	63.00	29.81	Nurses working additional unplanned hours and altering the skill mix	0.40	0.00	71%	↑

Appendix 3 Staffing Issues

- An overall fill rate of 92.6% was achieved during December 2021; this has decreased from 96.8% in November 2021.
- The RN fill rate decreased to 78.2% in December 2021 from 85.5% in November 2021.
- RN vacancies decreased by 0.47 WTE to 35.93 WTE.
- The HCSW vacancy position continues to be over-established by +6.66 WTE.
- RN night shift cover continues to remain challenging particularly in those areas with this highest RN vacancies and where more than one RN is required for the night-time shift.
- Two Registered Nurses and four HCSW's have left the Trust during December 2021.
- Ward occupancy levels increased in 3 areas and decreased in 9 areas.
- Patient acuity remains high in a number of ward areas.
- Ward teams are supported by Quality Improvement Lead Nurses (Matrons), Nurse Practitioners and a Site Manager who in turn, is also supported by an On-Call Manager out of hours.
- Safer Staffing Huddles continued during December 2021, providing an efficient and effective response to identifying and mitigating potential staffing shortfalls.
- Staffing levels continue to remain under constant review, ensuring that the Trust is as alert as possible to changes, which could affect safe staffing levels within our ward inpatient areas, these being our most critical services.

REPORT TO PUBLIC TRUST BOARD

Enclosure No: 5

Date of Meeting:	10th February 2022		
Title of Report:	Quality Committee Summary Report		
Presented by:	Patrick Sullivan, Non-Executive Director		
Author:	Patrick Sullivan, Non-Executive Director/ Justine Scotcher Executive PA.		
Executive Lead Name:	Dr Dennis Okolo, Interim Medical Director and Kenny Laing, Director of Nursing and Quality	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 3 February 2022. .		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. We will attract, develop and retain the best people ☐ 2. We will actively promote partnership and integrated models of working ☒ 3. We will provide the highest quality, safe and effective services ☒ 4. We will increase our efficiency and effectiveness through sustainable development ☐		
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.		
Shadow ICS Alignment / Implications:	None as part of this report		
Recommendations:	Receive for assurance purposes and ratify policies highlighted		

Version	Name/group	Date issued

Report from the Quality Committee meeting held on 3 February 2022 for the Trust Board meeting on 10 February 2022

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. The meeting was completed using Microsoft teams. The meeting was quorate. The Committee commenced with a Patient Story from the perspective of a family member. It was a positive story that described the excellent care provided and the compassionate interventions by staff on Ward 6.

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

- **COVID-19 Update**
  The Committee received a verbal update regarding the current situation. The prevalence rates in the local community are high. Since the last Quality Committee, several clinical areas have been subject to outbreak measures. At the time of the report, A & T and ward 2 remain in such measures.

- **Safe Staffing Report –December 2022**
  The Committee received this paper which outlined the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during December 2021 in line with the National Quality Board requirements. During December 2021, an overall fill rate of 92.6% was achieved; this has decreased from 96.8% in November 2021. The fill rate for RN shifts was 78.2% in December 2021, a decrease from 85.5% in November 2021.

- **Learning from Experience Report Q3 2021/22**
  The Committee received this report which provided a summary of incidents reported and all patient related incidents/events for October to December 2022. Most incidents were in relation to violence and aggression, self-harm, use of restraint for clinical interventions and safeguarding. A high percentage of self-harm and violent incidents were due to a small number of patients. Other incidents reported include falls, tissue viability and medication. Assurances about learning were provided.

- **Infection, Prevention Control Annual Report Q3 2021/22**
  The Committee received this report which provided assurance in relation to the IPC arrangements within the Trust.

- **Restrictive Practice Report Q3 2021/22**
  The Committee received this report which provided information regarding the use of restrictive practices within the inpatient services of the Trust and progress against the annual restrictive practice reduction work plan. The report included details regarding restraint, seclusion and rapid tranquilisation.

The last quarter has seen a 23% increase in restraint incidents. Darwin, PICU and Ward 3 are the highest users of restraint. Assurances were provided about the governance and training initiatives in place to ensure good practice.

- **Serious Incidents Report Q3 2021/22**
  The Committee received this report which provided assurance relating to the nature and status of SI's currently open and the trend data forQ3 2021/22. The Duty of Candour report is also included. There have been no breaches in the Duty of Candour process. An increase in incidents has been noted.

- **Risk Register –**
  The Committee reviewed the risks contained in the Trusts Risk Register that fall under the remit of the Quality Committee.
  The risks are as follows:
  - Impact of COVID 19 on the quality of services – *score change current residual Score 15 increased to 20, rationale staffing absence rate in January 22.*
  - Anchored ligature points
  - Non- anchored ligature points
  - Impact of COVID 19 on demand
  - Compliance with Mental Health Act and Mental Capacity Act
  - Impact of reduced funding on substance misuse services
  - Meeting the 3-hour target for assessment in the place of safety
  - Prescribing costs in primary care
  - Risk that the GPs will withdraw from participating in (ESCAs) for patients with ADHD in both CAMHS and Adult services
  - Quality and capacity of the pharmacy services due to recruitment challenges and the impact of Covid 19. Gross Score 16, Residual Score 12 and Target Score 8 – *this is a new risk*

- **IQPR M9 2021/22**
  The Committee received this report at M9 as follows:
  In Month 9, there are 22 rated measures that have met the required standard (compared to 22 in M8) and 13 that have not met the required standard and highlighted as exceptions (compared to 10 in M8). There are additional quarterly metrics included in M9 reporting.
  There are 4 special cause variations (orange variation flags) - signifying concern, compared to 5 in M8.
  1. **IAPT Recovery**. Performance is at 50% during M9 (national standard is 50%).
  2. **Vacancy Rate**. The vacancy rate is 12.1% in M9 compared to 12.2% in M8. The 10% target remains challenging.
  3. **Agency spend** is exceeding the agency threshold by 79.2%, compared to 74.8% during M8 and continues to operate outside of the upper control limit.
  4. **Statutory and Mandatory Training.** Performance remains unchanged at 87% during M9, still above target. A special cause variation continues as performance is well below the operational average and outside of the lower control limits for the Trust. Issues associated with delivery of face to face training are being addressed with the move of the training function in the Trust to Lawton House.

There is 1 special cause variation (blue variation flags - signifying improvement) – numbers of CPA service users in employment.

- **Mental Health Compliance action plan**
  The Committee received the quarterly update on the Care Quality Commission, Mental Health Act reviewer compliance and assurance visits which have taken place in the Trust during Q3 2021-2022 – includes details of findings for both announced remote reviews and the recent re-introduction of face to face unannounced visits.

- **National Medical Examiner Bulletin**
  The Committee received this report which provides an overview of the latest update from the National Medical Examiner for England and Wales.

- **ePMA Document and Process Approvals**
  The Committee received this paper following the approval process undertaken at CEG. The process described ensures that the Trust has clinically robust guidance and procedures to ensure safe implementation of ePMA. This includes the prescribing SOP and the medicines administration SOP for ePMA.

- **Quality Account Project Plan**
  The Committee received the project plan developed to support the production of the Quality Account. The Committee asks the Board to agree, that it if required, it will have delegated authority to approve the Quality Account prior to its publication.

- **Update: Liberty protection safeguards. Implementation of the 2019 Mental Capacity (Amendment) Act**.
  The Committee received this report to provide an update outlining progress made since the last paper submitted in August 2021. Implementation will not commence in April 2022, the Trust is awaiting the consultation period on regulations and code of practice prior to the DHSC setting the new date for implementation.

- **Community Mental Health Survey Action Plan**
  The Committee received a paper regarding the most recent Community Mental Health Survey, which was published at the end of 2021. This briefing provides an overview of the findings and a detailed action plan to address the 5 priority areas of concern.

- **Board Assurance Framework Q3 2021/22**
  The Committee received the Board Assurance Framework (BAF) Q3 2021/22 which aligns the Trusts strategic objectives to its quality priorities and key risks for information purposes.

- **Clinical Professional Advisory Group (CPAG)**
  The Committee received this summary which provided information and assurance to the Quality Committee regarding the activities and outputs from the Clinical Professional Advisory Group (CPAG).

- **Reducing Restrictive Interventions Strategy**
  The Committee approved this strategy, which articulates the Trust's commitment to reducing restrictive practices and applying the least restrictive principles to all aspects of the Trust's business and service delivery.

- **SR Panel Review Action Plan & Section 28 Trust response**
  The Committee received for assurance purposes.

3. Policy Report

The following policies were approved for 3 years;

1.14 Risk Assessment Policy
4.32 Privacy, Dignity & Respect Policy
4.34 Policy for Management of Intellectual Property

The Board is asked to ratify the approval of each of these policies.
Next meeting: 3 March 2022
Committee Chair, Mr Patrick Sullivan, Non-Executive Director, 4 February 2022.

REPORT TO PUBLIC TRUST BOARD

Enclosure 6

Date of Meeting:	10th February 2022		
Title of Report:	Q3 Mortality Surveillance Report		
Presented by:	Dr Dennis Okolo, Interim Medical Director		
Author:	Jackie Wilshaw. Head of Patient and Organisational Safety		
Executive Lead Name:	Dr Dennis Okolo, Interim 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. This report refers to Q3 2021/22. (1st October to 31st December 2021).		**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. We will attract, develop and retain the best people ☐ 2. We will actively promote partnership and integrated models of working ☐ 3. We will provide the highest quality, safe and effective services ☒ 4. We will increase our efficiency and effectiveness through sustainable development ☐		
Risk / legal implications: Risk Register Reference			
Resource Implications: Funding Source:			
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	There is no direct impact on the protected characteristics as part of the completion of this report.		
Shadow ICS Alignment / Implications:			
Recommendations:	For the Committee to take assurance in the process by which Serious Incidents are monitored in the Trust.		

Version	Name/group	Date issued
1	Jackie Wilshaw	21/12/2021

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. The deaths reviewed under the remit of mortality surveillance (MS) are those categorised as natural cause deaths and are not subject to reviews under the Serious Incident policy or Inquest at HM Coroner's Court. This report is for the Q3 reporting period 2021/22 and provides information for the time frame October to December 2021.

2. Trust reporting and data collection

During Q3 the mortality surveillance group reviewed the care of 18 people (meetings took place on 9th November and 7th December. The October meeting was postponed due to 3 people identified for the review being deferred, as more information was required. Those people were reviewed effectively during the November meeting). 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
November 2021	**40145**	UN2Unexpected Natural	4. Good Care	No	No	Drugs and alcohol
	31028	UU Unexpected Unnatural.	3.Adequate Care	No	No	Drugs and alcohol
	30672	EN1 Expected Natural	4. Good Care	No	No	Physical Health
	40154	UN2Unexpected Natural	3.Adequate Care	No	No	Drugs and alcohol
	40780	UN1 Unexpected Natural	4. Good Care	No	No	Physical Health
	39770	EN1 Expected Natural	4. Good Care	No	No	Physical Health/Learning Disability
	40410	UN2Unexpected Natural	4. Good Care	No	No	Drugs and alcohol
	40944	UN1 Unexpected Natural	3.Adequate Care	No	No	Physical Health
	40614	UN1 Unexpected Natural	4. Good Care	No	No	Physical Health/Learning Disability
	38340	UN1 Unexpected Natural	3.Adequate Care	No	No	Physical Health
	39155	UN1 Unexpected Natural	3.Adequate Care	No	No	Physical Health
	39642	UN2Unexpected Natural	5.Excellent Care	No	No	Physical Health

December 2021	**40424**	UN1 – Unexpected Natural	4.Good Care	No	No	Physical Health/Learning Disability
	40705	UN1 – Unexpected Natural	2 Poor Care	No	No	Physical Health
	40009	UN1 – Unexpected Natural	4.Good Care	No	No	Physical Health
	41435	UN1 – Unexpected Natural	3.Adequate Care	No	No	Physical Health
	40767	EN1 - Expected Natural.	4.Good Care	No	No	Physical Health
	41388	UN1 – Unexpected Natural	4.Good Care	No	No	Drugs and alcohol

*denotes people who died and Covid-19 was written on the death certificate.

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.

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, the care was rated to be good in ten cases (56%); 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 compassion and support to people who were physically unwell. There are examples where the care co-ordinators were very active in providing support, made an extra effort to ensure the patients attended additional appointments, and completed various referrals based on needs identified (i.e. food bank, safeguarding, social care, etc.).

In one case the care was rated to be excellent and was delivered by Sutherland Team, with evidence of documented care being delivered with compassion and in timely manner, while

supporting the person to continue to receive mental health support whilst receiving palliative care support.

Of the reviews undertaken during this timeframe, there were six cases where the group considered the care to have been adequate. Although elements of good practice were identified in those cases (for example with arranging home visit when person not well enough to attend depot clinic), the group identified that due to annual physical care checks being out of date, follow up contacts not being completed in a timely manner and an out of date care plan and risk assessment, contributed to the lower scoring of care in those cases.
These factors however were not considered to be contributory to the death of the people involved but simply did not demonstrate the compassion associated with good care or the required standard of record keeping. The group accepts that the difference between good and adequate care may be in the manner in which the records are completed by staff.

There was also one case that the group considered to have been poor care. This was due to the person's risk assessment being out of date and then a delay in the completion of the clinic letter. The DNA (Did Not Attend) SOP was not followed for the most recent attempted contact. Whilst this did not contribute to the person's death, the group agreed that this was an example where care was not provided in line with the Trust value of being responsive. The MS group noted that this omission had been recognised by the service manager during the completion of the MS screening tool and that there was an action in place for the DNA SOP to be discussed at the next team meeting. This case was also to be included in the supervision session with the care co-ordinator involved. In addition, the CMHT have commenced a process where clinicians are alerted as to when risk assessments are due to be updated

Mortality surveillance is completed for people known to the Trust who have alcohol related issues, as drug related deaths are reviewed through the Serious Incident Framework. Therefore, of the deaths reviewed during Q3, 3 people, were known to Stoke Community Drug and Alcohol Services (CDAS) for alcohol related issues. In each case the person also had underlying physical health co-morbidities associated with long-term alcohol abuse.

3. LeDeR

There were three people with a learning disability whose care was reviewed during this time frame. In addition to the mortality surveillance reviews completed by the Trust all deaths of people with Learning Disabilities are reported to a national reviewing board. The deaths are then allocated to regional offices for review and where necessary addition mortality reviews may be undertaken. 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.

Whilst the newly implemented changes to the national and regional processes came into force in June 2021, the basic process of the Trust completing our own mortality surveillance reviews will continue to take place to ensure that any initial learning is captured in a timely manner. Following the change is process, it is expected that the national review team will utilise the Trust mortality surveillance reviews in order to determine if an additional review is to be undertaken. However from the initial response to the Trust MS reviews it is anticipated that very few additional reviews will be undertaken by the national team.

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 Q3, there was no evidence of deficits in the healthcare provided by the Trust that may be considered to have contributed to the death of any individuals.

REPORT TO PUBLIC TRUST BOARD

Enclosure 7

Date of Meeting:	10th February 2022		
Title of Report:	Q3 Serious Incident Report		
Presented by:	Dr Dennis Okolo, Interim Medical Director		
Author:	Jackie Wilshaw. Head of Patient and Organisational Safety		
Executive Lead Name:	Dr Dennis Okolo, Interim 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 Q2 and Q3 2021/22. The report also includes information regarding themes, learning and change arising from Serious Incident investigations. Q3 was an above average reporting month: Twenty SIs were reported. There were more suspected suicides of service users than in previous quarters. The Duty of Candour report is also included. There have been no breaches in the Duty of Candour process.	**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.** We will attract, develop and retain the best people ☐ **2.** We will actively promote partnership and integrated models of working ☐ **3.** We will provide the highest quality, safe and effective services ☒ **4.** We will increase our efficiency and effectiveness through sustainable development ☐		
Risk / legal implications: Risk Register Reference			
Resource Implications: Funding Source:			
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	There is no direct impact on the protected characteristics as part of the completion of this report.		
Shadow ICS Alignment / Implications:			
Recommendations:	For the Committee to take assurance in the process by which Serious Incidents are monitored in the Trust The focus in the Trust for Learning from Serious Incidents		

	The work done in the Trust and wider health economy with regards to Serious Incidents	
Version	Name/group	Date issued
1	Jackie Wilshaw	12/01/22

1. Introduction

This report provides assurance to Board regarding processes relating to Serious Incidents (SIs) and Duty of Candour. The report covers the Q3 period from 1st October 2021 to 31st December 2021 and details the following:

- The status of SIs currently open and trend data for Q3 2021/22.
- Serious Incidents by category reported by quarter.
- Themes, learning and change arising from Serious Incident investigations.
- The Duty of Candour report.

2. Serious Incidents

SI reviews are undertaken following incidents involving people in receipt of services or who have been in receipt of services in the previous 6 months. Reviews of the care provided are completed for incidents where death, serious injury or serious event has occurred. For the purposes of this report, reviews are not undertaken for those service users whose deaths are determined by HM Coroner to be the result of natural causes. These deaths are subject to reviews under the mortality surveillance process.

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

At present the Trust uses a blended mix of formal reports, the Learning Lessons framework, the forums across the directorates and the weekly Incident Review Group to share the learning from incident reviews. During Q2 there have been a number of workshops organised for multi-disciplinary teams to explore understanding and learning in relation to Serious Incidents. These workshops are ongoing.

Progress towards the implementation of the Patient Safety Incident Response Framework (PSIRF) is ongoing:

- NHSE have published the level 1 and 2 modules for the Patient Safety Syllabus: A paper has been prepared for the Trust regarding suggested implementation within the Trust.

- The transfer of the SI reporting system from StEIS (Strategic Executive Information System) on to the LFPSE system (Learning from Patient Safety Events) is currently postponed as further development is required before Trusts transfer from StEIS.

2.1 The table below illustrates the total number of SIs reported by quarter for the period starting April 2020.

StEIS Incident category	Q1	Q2	Q3	Q4	Total 2020/21	Q1	Q2	Q3	Q4	Total 2021/22
Apparent/actual abuse	0	1	0	2	3	1	1	0		2
Unexpected potentially avoidable injury causing serious harm: this is subdivided as shown below										
Apparent/actual/suspected self-harm criteria meeting SI criteria	1	3	5	2	11	2	3	2		7
Slip, trip, fall	1	2	1	2	6	1	2	1		4
Disruptive, aggressive behaviour meeting SI criteria	0	1	0	1	2	0	1	0		1
Unexpected/Potentially avoidable serious assault (inc Suspected Homicide)	1	0	0	0	1	0	0	0		0
Unexpected/potentially avoidable injury causing serious harm (New Q3 2021/22)								1		1
Unexpected potentially avoidable death: This is subdivided as shown below										
Pending review	5	2	9	8	24	9	8	6		23
Apparent/actual/suspected self-harm criteria meeting SI criteria (suspected suicide)	6	6	9	6	27	3	1	10		14
Disruptive/aggressive/violent behaviour (new Q4 2020/21)	0	0	0	1	1	0	0	0		0
Hospital Acquired infection	0	0	0	1	1	0	1**	0		1
Total	14*	15	24	23	76	16	17	20		53

*this figure is changed from that reported during the quarterly reports 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 were therefore transferred to the mortality surveillance process.

**multiple covid-19 deaths

2.2 Serious Incidents reported by team and directorate

Team	Oct 21	Nov 21	Dec 21	**Total**
Access	1	1	1	**3**
CAMHS Hub		1		**1**
CDAS	1	1	1	**3**
Greenfields Centre	1	1		**2**
High Volume Users/Lymebrook			1	**1**
Liaison and Diversion			1	**1**
Lymebrook Centre	1		1	**2**
N Staffs IAPT		1	1	**2**
N Stoke CAMHS	1			**1**
Outreach Team			1	**1**
Stoke memory clinic			1	**1**
Sutherland Centre		1		**1**
Ward 6			1	**1**
Total	**5**	**6**	**9**	**20**

Directorate	Oct 21	Nov 21	Dec 21	**Total**
Acute and Urgent Care	1	2	3	**6**
North Staffordshire Community	1		2	**3**
Specialist	1	1	1	**3**
Stoke-on-Trent Community	2	3	3	**8**
Total	**5**	**6**	**9**	**20**

During Q3, 20 incidents were reported onto StEIS and have undergone or are in the process of undergoing SI reviews.

The main points to note are:

- There were six incidents in the Acute and Urgent Care Directorate:
    - There were four unexpected deaths of which two are suspected to be suicide.
    - There was one incident of injury resulting in a fracture – the cause of the fracture is not known but is a likely result of a trip, slip or fall.
    - There was one potentially avoidable incident where the person sustained life threatening harm.

- There were three incidents in the North Staffordshire Community Directorate:
    - There were three unexpected deaths of which two are suspected to be suicide.

- In the Specialist Directorate, three incidents were reported:
    - All of the deaths relate to people in receipt of care in the CDAS service. Two of the deaths are likely to be drug related and the third is suspected suicide.

- There were eight incidents in the Stoke Community Directorate:
    - There were six unexpected deaths, five of which are suspected suicide and one which may be a drug related death.
    - There were two incidents of self-harm (overdose) requiring admission to the general hospital.

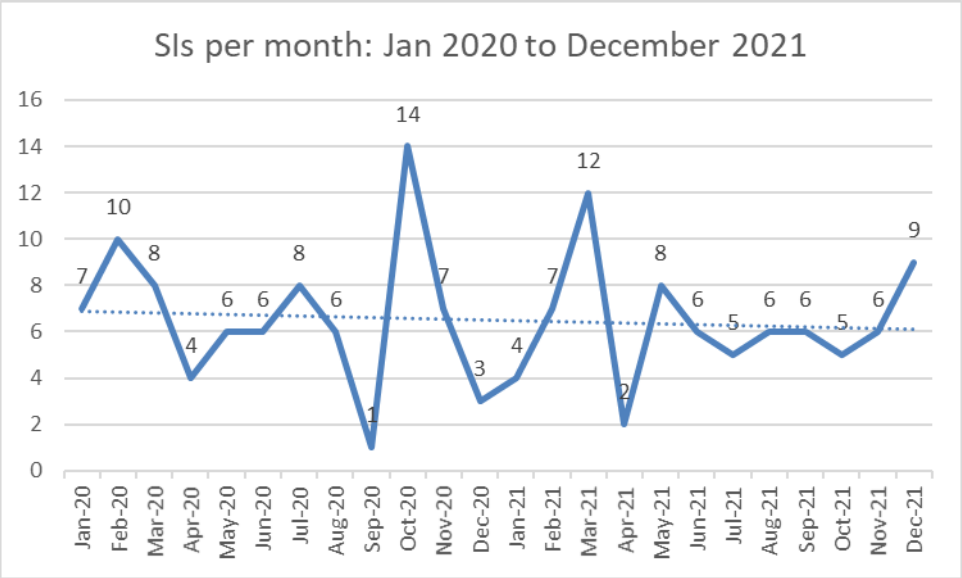
3. Themes and Trends

During Q3, there has been a slight increase in the number of SIs reported. At first sight, there appears to have been a significant rise in the number of suspected suicides (ten). In the same period in 2020/21, nine suspected suicides were reported and so in comparison this number appears to be almost identical and therefore not unexpected however the teams involved are largely very different for 2021/22 and there can be no suggestion of themes relating to care delivered. Closer analysis of unexpected deaths by suspected suicide in Q1,Q2 and Q3 and the teams involved suggests that there is a higher incidence of contact with Trust 'front door' teams by those people who go on to die by suspected suicide. This is not a reflection on the care delivered but rather an observation regarding the complexity of people presenting in crisis and to date there is no themes linking any of the incidents.

Nevertheless in the coming months it will be necessary for the Trust to maintain a close watch, monitoring for a possible increase in the number of suicides reported. The impact of the Covid-19 pandemic as a possible driver for an increase in suicides has been discussed at local and national level; it is widely accepted that the impact of the pandemic has not yet resulted in an increase in suicide rates/levels and future incidents should also be considered in the context of rising suicide rates across the country since 2018.

Since the onset of the Covid-19 pandemic and in consideration of the possible impact on suicide rates and levels, the Trust has asked the SI reviewers to take into account any Covid-19 related factors which may have contributed to the mental health distress of the people who died by suicide or who significantly self-harmed during this period. For incidents reported to date, early learning does not indicate that factors relating to the pandemic specifically impacted upon the events reported. However it is acknowledged that some service users found the use of digital technology rather than face to face meetings to be difficult when discussing their presenting problems.

The graph below shows the number of SIs reported by month for the two year period of January 2020 to December 2021. There is an average of 6.5 incident reported each month.



4. Learning from Serious Incidents

Recommendations and learning from investigations are disseminated upon completion of the SI reviews. The learning identified from closed SI reviews during Q2 and Q3 included the following:

- One team refreshed their understanding and management of distributed notes in Lorenzo: to be able to accurately record when actions are taken in response of the note being received by the team.
- The High Volume Users Team were enabled to have a direct digital link to the Greenfields MDT meetings, so allow for improved information sharing in the cases of service users being managed between two different teams. For this to be replicated across the other CMHTs.
- The CAMHS Operational Policy is being reviewed after it was found that team members required additional clarity regarding elements of the completion of the assessment, DNA and discharge processes.
- Summer's View and the rehab teams have introduced business/calling cards to improve communication with those people who do not attend their appointments and for who digital communications may be problematic.
- One team requested 'Rose on the Road' to update and refresh their practical use of Lorenzo after it was found that the use of unofficial short-cuts and 'work-arounds' meant that some assessment information was not immediately visible when staff were accessing notes.
- One team worked to strengthen their 'Nurse-in-Charge' process in order to ensure effective communication between the team on duty and the incoming next shift.
- The need to improve staff implementation of the Safe and Support Engagement with Patient's policy with regards to the management of falls was discussed at both team level and also at the Trust Falls Management Group. Whilst staff understanding of the policy and the delivery of care was found to be good, it was felt that the documentation regarding the care plan and evaluation could be improved to reflect the clinical decision making and actual care delivered.
- Practice notes were issued by one team to improve their documentation regarding the care planning narrative for the management of a deteriorating patient and a second practice note identified the need for improved completion of assessment documentation. These issues will be monitored by the team using the monthly audit process and reported back into the team meetings.

As in previous reports it should be noted that many of the SI reviews did not find any areas for concern and there are examples of good practice, both in the original review findings and also in the team responses to any early learning identified.

One example of this, is the evidence that teams appear to have improved their DNA follow-up responses. In the case of a person under the care of the Ashcombe Centre CMHT, there is clear evidence of the team following up each appointment that the person failed to attend. The team also looked for solutions to support the person to attend in person after they said that they had difficulty using the digital technology.

During Q3, the Trust has completed the Panel review regarding the care provided for a person under the care of CAMH Services, this report has now been submitted to NHSE specialist commissioning and we are currently awaiting for the report and action plan (to be finalised) to be reviewed. Initial learning from the internal Trust review and the local rapid review indicated that there was learning for multiple organisations across health, social care and education systems.

5. HM Coroner: Regulation 28. Preventing Future Deaths.

The Trust was issued with a Regulation 28. Preventing Future Deaths notice in October 2021 by the Area Coroner for Stoke-on-Trent and North Staffordshire. The concerns raised by the Coroner were regarding the transition of young people into adult services at the age of 18 years and the lack of specific in-patient provision for people between the ages of 14-25 years.
The Trust response addressed the issues raised and advised the Coroner that we have undertaken to revisit the Transition of Young People to Adult Mental Health Service Policy in order to provide clarity to staff regarding the need to consider reasonable adjustments dependent upon a person's need at the time of transfer.
The Trust also informed the Coroner that whilst there is no specific in-patient provision for people between the ages of 14-25 years, we are committed to working with our partner organisations as part of the community transformation programme. The Trust is working to align future services with the Royal College of Psychiatry good practice paper (2017), improving the transition experience as younger service users move into adult mental health services.

6. Duty of Candour

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.

During Q3 there have been 18 incidents which were rated as moderate harm or above. There have been no breaches in the DoC process.

- 14 incidents did not meet the criteria for reportable DoC incidents i.e. no act or omission of care that resulted in the person coming to moderate of above harm.
- There were four incidents being reviewed as part of the SI process. There is no initial indication that the incidents will meet the DoC threshold.

The Trust Head of Patient and Organisational Safety and Deputy Director of Nursing met with the CCG Quality leads in November 2021 to discuss DoC reporting. At this meeting the CCG leads agreed that the Trust management of the DoC is robust and did not given any cause for concern.

7. Conclusion

The Board is requested to note that the Trust continues to monitor all Serious Incidents monthly through the Clinical Safety Improvement Group, demonstrating compliance with Trust policies and processes.

The learning from investigations 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.

REPORT TO PUBLIC TRUST BOARD

Enclosure 8

Date of Meeting:	10th February 2022		
Title of Report:	Improving Quality & Performance Report (IQPR) Month 9 2021/22		
Presented by:	Eric Gardiner, Director of Finance, Performance & Estates		
Author:	Victoria Boswell, Associate Director of Performance		
Executive Lead Name:	Eric Gardiner, Director of Finance, Performance & Estates	**Approved by Exec**	☒

Executive Summary:	**Purpose of report**	
In Month 9 there are 22 rated measures that have met the required standard (compared to 22 in M8) and 13 that have not met the required standard and highlighted as exceptions (compared to 10 in M8). There are additional quarterly metrics included in M9 reporting. There are 4 special cause variations (orange variation flags) - signifying concern, compared to 5 in M8. • **IAPT Recovery**. Performance is at 50% during M9 (national standard is 50%). • **Vacancy Rate**. The vacancy rate is 12.1% in M9 compared to 12.2% in M8. The 10% target remains challenging • **Agency spend** is exceeding the agency threshold by 79.2%, compared to 74.8% during M8 and continues to operate outside of the upper control limit. • **Statutory and Mandatory Training.** Performance remains unchanged at 87% during M9, still above target. A special cause variation continues as performance is well below the operational average and outside of the lower control limits for the Trust. Issues associated with delivery of face to face training are being addressed with the move of the training function in the Trust to Lawton House. • There is 1 special cause variation (blue variation flags - signifying improvement) – numbers of CPA service users in employment.	**Approval**	☐
	Information	☒
	Discussion	☐
	Assurance	☐

Seen at:	SLT ☒ Execs ☐ Performance Review meeting – 25.01.22	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. We will attract, develop and retain the best people ☒ 2. We will actively promote partnership and integrated models of working ☒ 3. We will provide the highest quality, safe and effective services ☒ 4. We will increase our efficiency and effectiveness through sustainable development ☒		

<table>
<tr><td></td><td></td></tr>
<tr><td>Risk / legal implications:
Risk Register Reference</td><td>Performance Improvements Plans (PIPs) may be put in place for those national and contractual measures that have not achieved target. In addition, they may be required for those measures showing a special cause variation indicating concern.

PIPs in place in M9:

<table>
<tr><th>Metric</th><th>Directorate</th><th>Status</th></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>Referral to Assessment within 4 weeks</td><td>Specialist Services</td><td>Issued in M1
Remains open.
Performance is 89.8% during M9. The trajectory in place suggests the standard will be achieved in March 2022.</td></tr>
<tr><td>IAPT: Patients wait no longer than 90 days between 1st and 2nd treatment</td><td>Stoke Community</td><td>Issued in M2
Remains open. Performance is 18% during M9. An updated PIP has been provided during M8, with a revised trajectory set for March 2022.</td></tr>
</table>
</td></tr>
<tr><td>Resource Implications:

Funding Source:</td><td>A Data Quality Improvement Plan is in place and monitored through the Data Quality Forum. There is a particular focus on maintaining the Trust's performance in meeting the DQMI standard (Data Quality Improvement Index.

As of September, the Trust's DQMI rating was 97.8%, against a national average of 81.8%, placing the Trust in the top providers of Mental Health services in the country. This is the latest published national data.</td></tr>
<tr><td>Diversity & Inclusion Implications:
(Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance</td><td>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.

This will support the Heath Equity Assessments being undertaken at PCN level to inform the Mental Health Community Transformation programme and address health inequalities at a local level.</td></tr>
<tr><td>Shadow ICS Alignment / Implications:</td><td>None directly.</td></tr>
<tr><td>Recommendations:</td><td>SLT is asked to:
• Receive the report as outlined
• Note the Management actions</td></tr>
</table>

Version	Name/group	Date issued
1.1	N/A	27.01.21

North Staffordshire Combined Healthcare NHS Trust

IQPR

Improving Quality & Performance Report

Board Report

Month 9: December 2021

Contents

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

In Month 9 there are 22 rated measures that have met the required standard (compared to 22 in M8) and 13 that have not met the required standard and highlighted as exceptions (compared to 10 in M8). There are additional quarterly metrics included in M9 reporting.

There are 4 special cause variations (orange variation flags) - signifying concern, compared to 5 in M8.

- **IAPT Recovery**. Performance is at 50% during M9 (national standard is 50%).
- **Vacancy Rate**. The vacancy rate is 12.1% in M9 compared to 12.2% in M8. The 10% target remains challenging
- **Agency spend** is exceeding the agency threshold by 79.2%, compared to 74.8% during M8 and continues to operate outside of the upper control limit.
- **Statutory and Mandatory Training.** Performance remains unchanged at 87% during M9, still above target. A special cause variation continues as performance is well below the operational average and outside of the lower control limits for the Trust. Issues associated with delivery of face to face training are being addressed with the move of the training function in the Trust to Lawton House.

There is 1 special cause variation (blue variation flags - signifying improvement) – numbers of CPA service users in employment.

There are 23 metrics flagged with a common cause variation (grey variation flag).

Highlights

- 100% of children and young people with eating disorders, referred for assessment were seen within the national response times during Quarter 3
- 97.7% of adults referred for assessment were seen within 4 weeks during M9
- 97.6% of children and young people received treatment within 18 weeks during M9
- MH Liaison 4 hour response rate is 97% during M9 and all standards met for the service
- 100% of IAPT referrals were treated within 18 weeks
- 92% of patients referred to the early intervention team were treated within 2 weeks

Exceptions

Exceptions to be noted where targets have not been met (in addition to the 4 special cause variations above);

- **IAPT patients waited longer than 90 days between their 1st and 2nd treatment** – performance is at 18% during M9, although it is an improving position in line with the trajectory in the PIP
- **7 day follow up** - 93.9% people on **CPA** and 94% of **all patients** received a follow up
- **48 hour follow up** - 91.4% of people were followed up within 48 hours

- **DTOC** during M9 is 7.6%
- **Place of Safety** – out of 24 assessments in M9, 6 assessments occurred outside of 3 hours with no clinical grounds for delay
- **Care Plan Compliance** - 94.6% of people have a care plan in place
- **Complaints** - there are 2 complaint responses outside of the 40 working day deadline during M9
- **Staff Turnover** – performance is consistently above the 10% threshold at 12.6% during M9
- **Safe Staffing** – performance is at 92.6% during M9
- **Clinical Supervision** – performance is at 81% during M9

3. Performance Improvement Plans (PIPs)

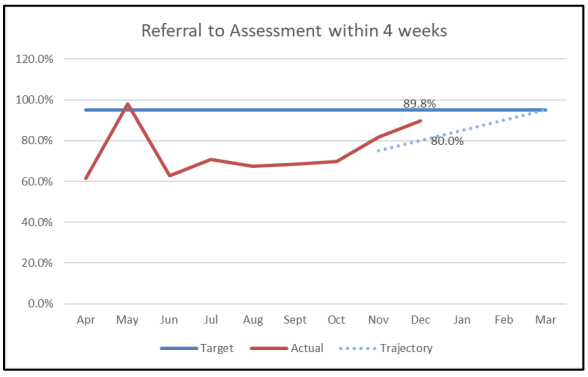
Performance Improvements Plans (PIPs) may be put in place for those national and contractual measures that have not met the target. In addition, they may be required for those measures showing a special cause variation indicating concern.

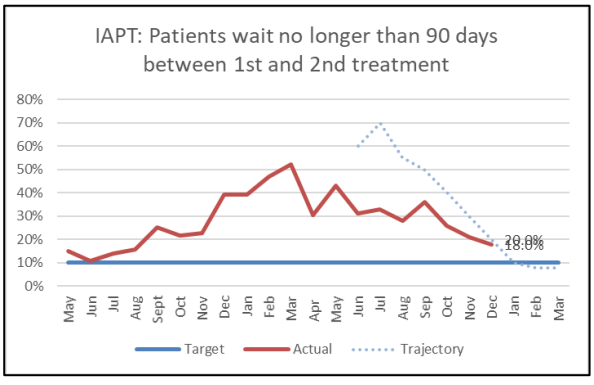
The PIPs require directorates to set out the issues, actions and a trajectory for improvement to mitigate any risks in achieving compliance and maintaining the standard required.

The PIPs are monitored on a monthly basis through the monthly Executive Performance Review meetings until the standard has been achieved for 3 consecutive months, or otherwise agreed. This will ensure that the actions outlined by the Associate Director are embedded and performance levels are sustained. This process takes into account that performance is unpredictable and often across multiple teams.

PIPs currently in place:

Metric	Directorate	Status
Referral to Assessment within 4 weeks	Specialist Services	Issued in M1 Remains open. Performance is 89.8% during M9. The trajectory in place suggests the standard will be achieved in March 2022.
IAPT: Patients wait no longer than 90 days between 1st and 2nd treatment	Stoke Community	Issued in M2 Remains open. Performance is 18% during M9. An updated PIP has been provided during M8, with a revised trajectory set for March 2022.





Measure	Met/Not Met	Assurance	Variation	Exception	Narrative
1 - Referral to Assessment within 4 weeks	Met				Performance is at 97.7% for M9. ***A PIP remains in place for Specialist Services.***
2 - Referral to Treatment within 18 weeks	Met				Performance remains within the required parameters at 97.7% during M9.
3 - CAMHS Compliance with 4 week waits (Referral to Assessment)	Met				Performance is at 95.6% and all directorates with the exception of Stoke Community are achieving the required standard.
4 - CAMHS Compliance within 18 week waits (Referral to Treatment)	Met				Performance is at 97.6% during M9 and all directorates with the exception of North Staffs Community are achieving the required standard.
5 - CYP: Eating Disorders - Referral to Assessment (Urgent) 1 Week	Met				Performance is at 100% during Quarter 3.
6 - CYP: Eating Disorders - Referral to Assessment (Routine) 4 Weeks	Met				Performance is at 100% during Quarter 3.
7 - Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment	Met				Performance is at 92% during M9.
8 - IAPT: Patients wait no longer than 90 days between 1st and 2nd treatment	Not Met				Despite improvement, performance continues to exceed the 90 day waiting time standard between the first and second treatment at 18% during M9. ***A PIP remains in place for Stoke Community with a trajectory set for March 2022.***
9 - MH Liaison 1 Hour Response (Emergency)	Met				Performance is at 97.2% during M9.
10 - MH Liaison 4 Hour Response (Urgent)	Met				Performance is at 97% during M9.
11 - MH Liaison 24 Hour Response (Urgent from General Hospital Ward)	Met				Performance is at 95.7% during M9.
12 - IAPT: Referral to Treatment (6 weeks)	Met				Performance is at 95.7% and remains above target.
13 - IAPT: Referral to Treatment (18 weeks)	Met				Performance remains predictably stable at 100%.
14 - Care Programme Approach (CPA) 7 day Follow Up	Not Met			*	Performance is at 94% - with the exception of Specialist services, directorates have not met the required standard.
15 - 7 Day Follow Up (All Patients)	Not Met			*	Performance is at 94% - with the exception of Specialist services, directorates have not met the required standard.
16 - 48 Hour Follow Up	Not Met			*	Performance is at 91.4%, all directorates have not met the required standard.
17 - IPS (individual placement and support)					506 patients received individual placement and support during Quarter 3.
18 - Delayed Transfers of Care (DTOC)	Not Met			*	Performance is at 7.6% during M9. The delays were attributed to Ward 5 and Summer Views.

19 - Emergency Readmissions rate (30 days)	Met				The emergency readmission rate is 4.9% and remains within the threshold.
20 - Place of Safety assessment carried out within 3 hours (where clinically appropriate)	Not Met			*	Out of 24 assessments in M9, 6 assessments occurred outside of the 3 hours with no agreed clinical grounds for delay.
21 - Friends and Family Test - Recommended					There have been 82 FFT returns of which 93% rated the Trust as good.
22 - Number of inappropriate OAP bed days that are either "internal" or "external" to the sending provider	Met				There have been no out of area placements during M9.
23 - Under 18 Admissions to all wards	Met				There have been no under 18 year old admissions during M9.
24 - Care Plan Compliance	Not Met			*	Performance is at 94.6% during M9. Stoke Community and Specialist Services have not met the required standard.
25 - Risk Assessment Compliance	Met				Performance is at 95.7% and all directorates have met the required standard, with the exception of Specialist Services.
26 - CPA 12 Month Review Compliance	Met				Performance is at 97.3% and has met the required standard.
27 - IAPT : Recovery	Met				Performance is at 50% and has met the required standard.
28 - Service Users on CPA in settled accommodation	Met				Performance is at 65.6% and continues to operate above the national mean.
29 - Service Users on CPA in Employment	Met				Performance is at 14.7% and continues to operate above the national mean. Improvements have been made for over 12 months.
30 - Serious Incidents					The number of serious incidents Trust wide is 9.
31 - DQMI					The Trust's DQMI rating remains static at 97.8% from the latest published national data.
32 - Perinatal: Number of women accessing specialist community perinatal mental health services					There were 41 women accessing perinatal services during M9.
33 - Average Length of Stay - Adult					The average length of stay for inpatients on an adult ward is 23 days.
34 - Average Length of Stay - Older Adult					The average length of stay for inpatients on an older adult ward is 37 days.
35 - Incident Reporting					The number of patient safety incidents Trust wide is 514.
36 - Complaints Open Beyond Agreed Timescale	Not Met			*	There are two outstanding complaint response, which are in their final review stages.
37 - Sickness Absence					September sickness figures are confirmed. December data is not yet available.
38 - Vacancy Rate	Not Met			*	The vacancy rate remains static at 12.1% and continues to challenge all directorates, with the exception of Corporate services.

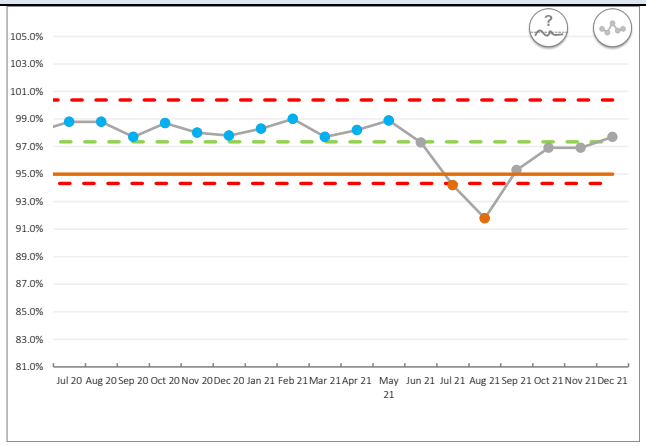
39 - Staff Turnover	Not Met			*	Performance is consistently above the 10% threshold at 12.6% and remains challenging for all directorates, with the exception of Corporate services.
40 - Safe Staffing	Not Met			*	The safe staffing performance is 92.6%.
41 - % Year to Date Agency Spend compared to Year to Date Agency Ceiling	Not Met			*	Agency spend continues to exceed the threshold by 79.2%.
42 - Clinical Supervision	Not Met			*	Performance is at 81%, although operating within normal control levels, is below the required standard for all directorates.
43 - Appraisal	Met				Performance is at 87%. All directorates, with the exception of Primary Care and Corporate Services are achieving the required standard.
44 - Statutory & Mandatory Training	Met				Performance remains unchanged at 87% with all Directorates having achieved the required standard.

Access and Waiting Times

Met - Referral to Assessment within 4 weeks

A Higher Value Is Better

Actual	97.7%	M9	**Executive Director of Operations**	Responsive
Target:	95.0%	Monthly	Trust Measure	



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

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 97.7% during M9 and is operating within normal control limits. All directorates with the exception of Specialist Services have achieved the aspirational target.

A fortnightly waiting time validation meeting has been established in Specialist services, supported by the Performance Team. Focus on Neuro Community waits following significant increase in demand for the team in respect of Long Covid. Recruitment of an additional senior clinical post in January and support from Assistant Psychologist will improve triage and treatment response.

A PIP is in place for Specialist Services, with the expectation that the trajectory to meet the standard will be achieved in March.

12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
98.3%	99.0%	97.7%	98.2%	98.9%	97.3%	94.2%	91.8%	95.3%	96.9%	96.9%	97.7%

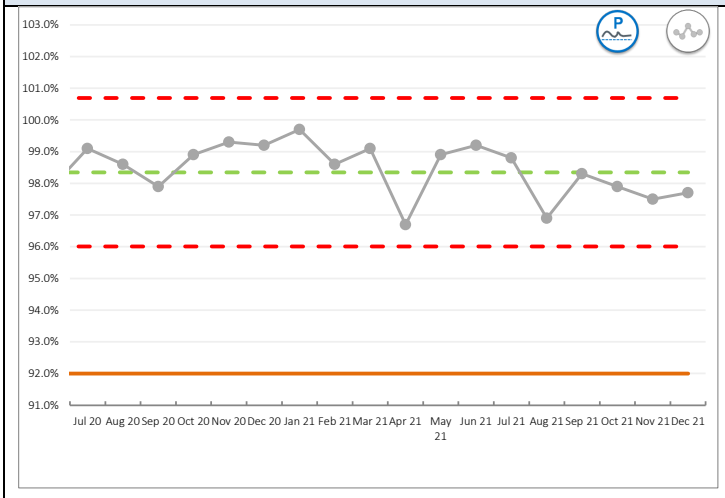
Trust	North Staffs Community	Stoke Community	Specialist Services	Acute and Urgent Care
✓	✓	✓	✗	✓
97.7%	96.8%	95.2%	89.8%	98.5%

1

Met - Referral to Treatment within 18 weeks

A Higher Value Is Better

Actual	97.7%	M9	**Executive Director of Operations**	Responsive
Target:	92.0%	Monthly	CCG	



-- 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) --
Performance remains within the required parameters at 97.7% during M9. All directorates, with the exception of Specialist Services, have achieved the required standard.

12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
99.7%	98.6%	99.1%	96.7%	98.9%	99.2%	98.8%	96.9%	98.3%	97.9%	97.5%	97.7%

Trust	North Staffs Community	Stoke Community	Specialist Services	Acute and Urgent Care
✓	✓	✓	✗	✓
97.7%	98.6%	97.5%	88.2%	98.3%

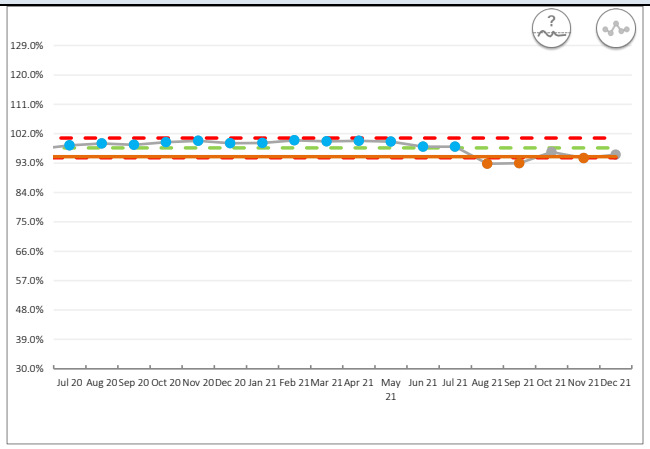
2

Met - CAMHS Compliance with 4 week waits (Referral to Assessment)

↗

A Higher Value Is Better

Actual	95.6%	M9	**Executive Director of Operations**	Responsive
Target:	95.0%	Monthly	Trust Measure	



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

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 95.6% during M9 and all directorates, with the exception of Stoke Community, are achieving the required standard.

12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
99.2%	100.0%	99.7%	99.8%	99.6%	98.0%	98.0%	92.8%	93.0%	96.4%	94.5%	95.6%

Trust	North Staffs Community	Stoke Community	Specialist Services	Acute and Urgent Care
✓	✓	✘		✓
95.6%	100.0%	40.0%	#N/A	96.2%

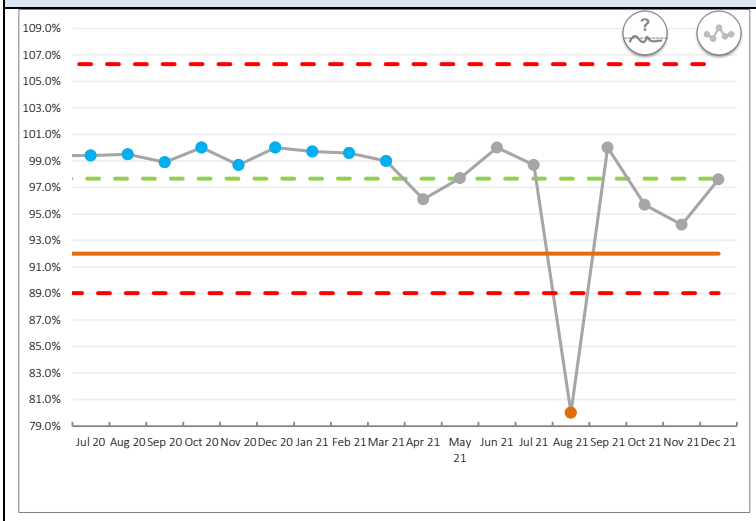
3

Met - CAMHS Compliance with 18 week waits (Referral to Treatment)

↗

A Higher Value Is Better

Actual	97.6%	M9	**Executive Director of Operations**	Responsive
Target:	92.0%	Monthly	CCG	



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

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 97.6% during M9 with performance operating within normal control limits. All directorates have achieved the required standard, with the exception of North Staffs Community.

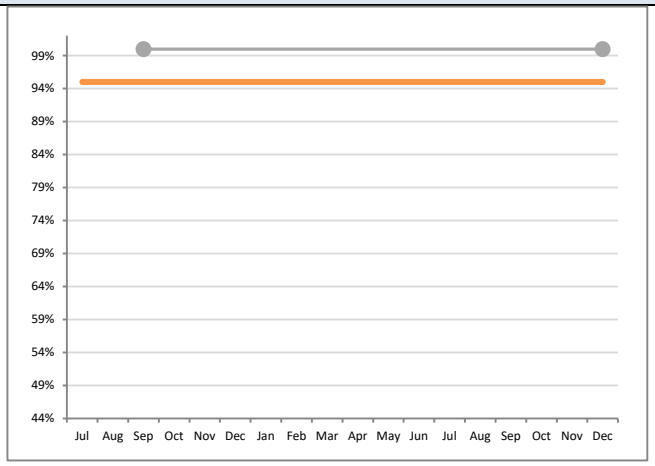
12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
99.7%	99.6%	99.0%	96.1%	97.7%	100.0%	98.7%	80.0%	100.0%	95.7%	94.2%	97.6%

Trust	North Staffs Community	Stoke Community	Specialist Services	Acute and Urgent Care
✓	✘	✓		✓
97.6%	85.7%	100.0%	#N/A	97.9%

4

Met - CYP: Eating Disorders - Referral to Assessment (Urgent) 1 Week A Higher Value Is Better	**Actual** 100.0% M9 **Target:** 95.0% Quarterly	**Executive Director of Operations** Responsive National



12 Month Trend

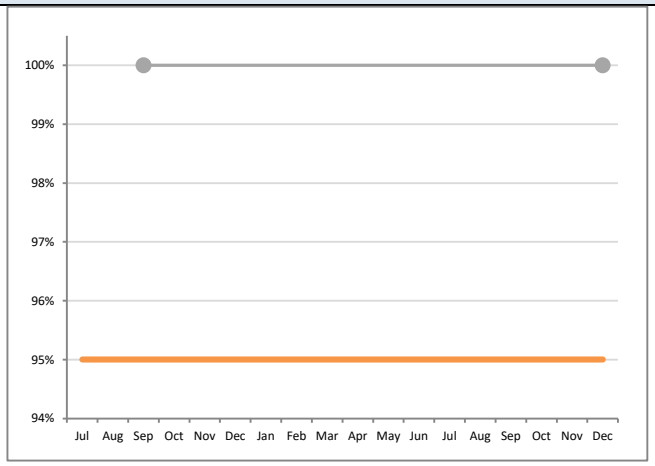
Trust
✓
100.0%

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

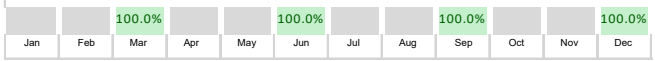
-- Monthly Narrative (Key Issues and Actions) --
All urgent assessments for Children and Young People with eating disorders have been seen within 1 week of their referral during quarter3.

5

Met - CYP: Eating Disorders - Referral to Assessment (Routine) 4 Weeks A Higher Value Is Better	**Actual** 100.0% M9 **Target:** 95.0% Quarterly	**Executive Director of Operations** Responsive National



12 Month Trend



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 second successful contact.

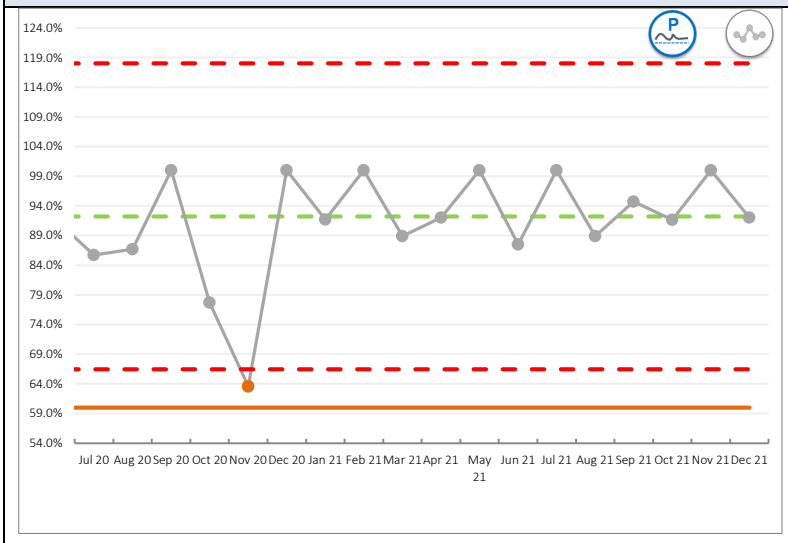
-- Monthly Narrative (Key Issues and Actions) --
All routine assessments for Children and Young People with eating disorders have been seen within 4 weeks of their referral during quarter 3.

6

Met - Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment ↘

A Higher Value Is Better

Actual	92.0%	M9	**Executive Director of Operations**	Responsive
Target:	60.0%	Monthly	National	



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

-- Monthly Narrative (Key Issues and Actions) --
Performance has reduced to 91.7% during M7 and is predictably operating within normal control limits, well above the national standard of 60%.

12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
91.7%	100.0%	88.9%	92.0%	100.0%	87.5%	100.0%	88.9%	94.7%	91.7%	100.0%	92.0%

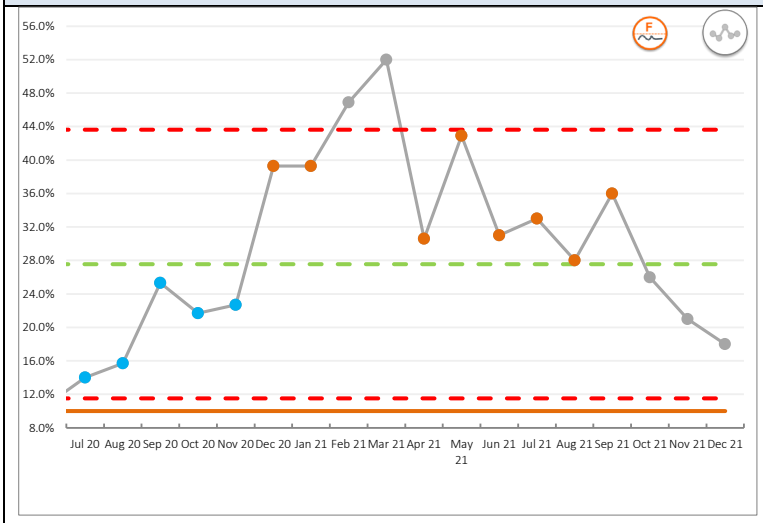
Trust
✓
92.0%

7

Not Met - IAPT: Patients wait no longer than 90 days between 1st and 2nd treatment ↗

A Lower Value Is Better

Actual	18.0%	M9	**Exec. Director of Operations**	Safe
Target:	10.0%	Monthly	National	



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

-- Monthly Narrative (Key Issues and Actions) --
Despite improvement, performance continues to exceed the 90 day waiting time standard between the first and second treatment contact at 18% in M9 (against a target of less than 10% of patients waiting 90 days).

Although the SPC chart is advising performance is back within normal control limits, it continues to exceed the waiting time standard**.**

An updated PIP has been provided by Stoke Community Directorate during M9, with a revised trajectory set for March 2022.

12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
39.3%	46.9%	52.0%	30.6%	42.9%	31.0%	33.0%	28.0%	36.0%	26.0%	21.0%	18.0%

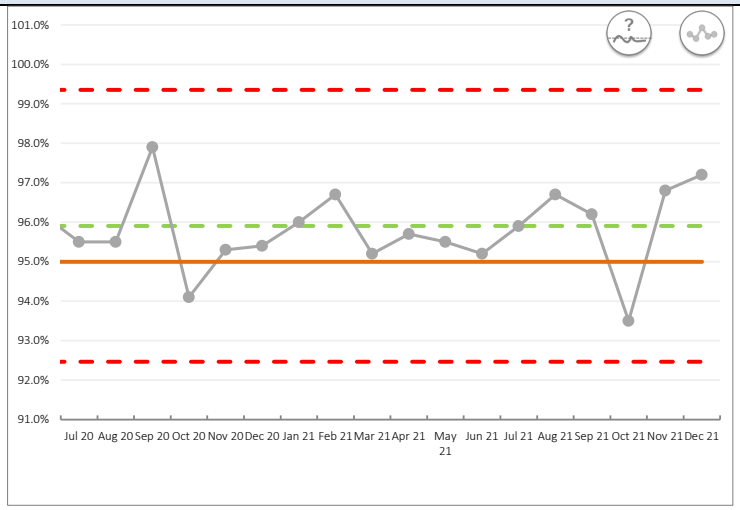
Stoke Community
✗
18.0%

8

Met - MH Liaison 1 Hour Response (Emergency) ↗

A Higher Value Is Better

Actual	97.2%	M9	**Executive Director of Operations**	Responsive
Target:	95.0%	Monthly	CCG	



12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
96.0%	96.7%	95.2%	95.7%	95.5%	95.2%	95.9%	96.7%	96.2%	93.5%	96.8%	97.2%

Trust
✓
97.2%

-- 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.

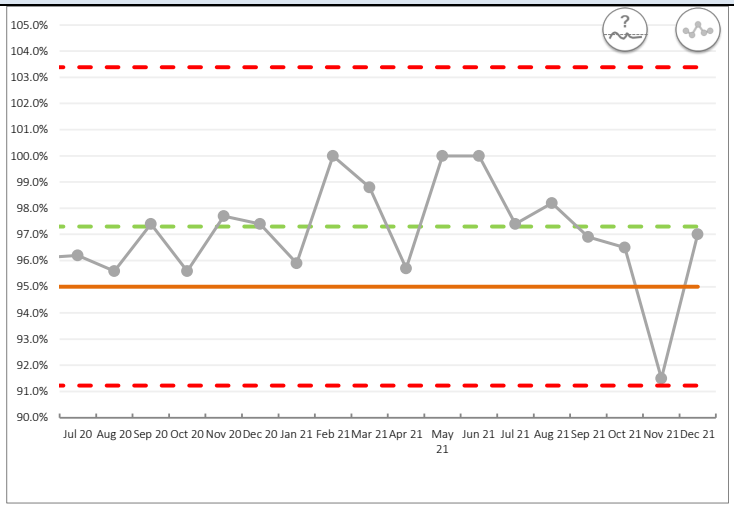
-- Monthly Narrative (Key Issues and Actions) --
Performance is at 97.2% and has met the required standard during M9. Performance during M7 was an unexpected exception due to 4 referrals that came into the service on one day at the same time.

9

Met - MH Liaison 4 Hour Response (Urgent) ↗

A Higher Value Is Better

Actual	97.0%	M9	**Executive Director of Operations**	Responsive
Target:	95.0%	Monthly	CCG	



12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
95.9%	100.0%	98.8%	95.7%	100.0%	100.0%	97.4%	98.2%	96.9%	96.5%	91.5%	97.0%

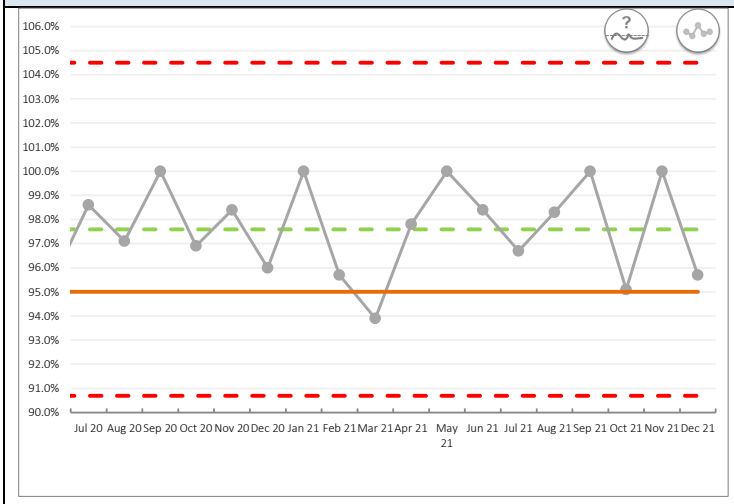
Trust
✓
97.0%

-- 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 is at 97% and has met the required standard during M9. Performance during M8 was an unexpected exception.

10

Met - MH Liaison 24 Hour Response (Urgent from General Hospital Ward) ↘ A Higher Value Is Better	**Actual** 95.7% M9 **Target:** 95.0% Monthly	**Executive Director of Operations** Responsive CCG	



-- 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 remains above the required standard at 95.7% and is operating within normal control limits.

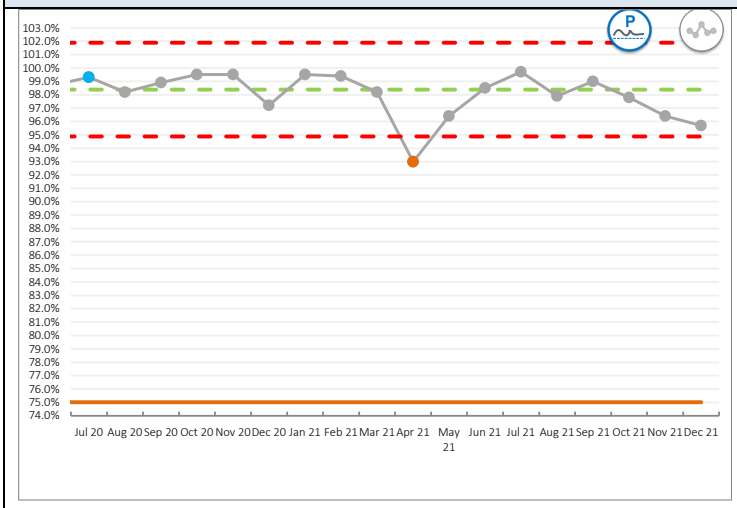
12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
100.0%	95.7%	93.9%	97.8%	100.0%	98.4%	96.7%	98.3%	100.0%	95.1%	100.0%	95.7%

Trust
✓
95.7%

11

Met - IAPT: Referral to Treatment (6 weeks) ↘ A Higher Value Is Better	**Actual** 95.7% M9 **Target:** 75.0% Monthly	**Executive Director of Nursing and Quality** Safe National	



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

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 95.7% and remains above target.

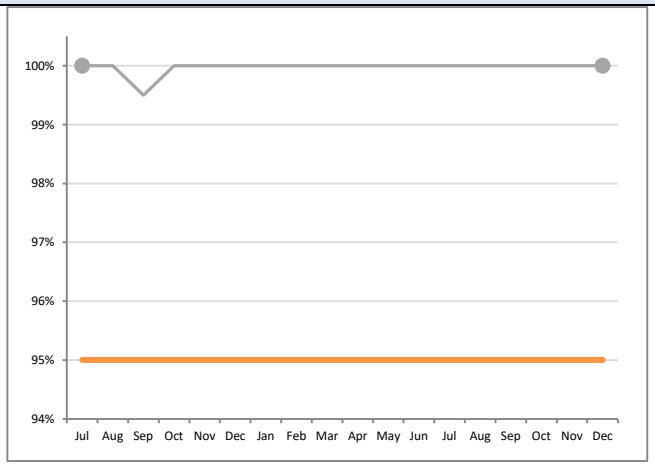
12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
99.5%	99.4%	98.2%	93.0%	96.4%	98.5%	99.7%	97.9%	99.0%	97.8%	96.4%	95.7%

Trust
✓
95.7%

12

Met - IAPT: Referral to Treatment (18 weeks) ↔	Actual 100.0% M9	Executive Director of Nursing and Quality	Safe
A Higher Value Is Better	Target: 95.0% Monthly	National	



12 Month Trend

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

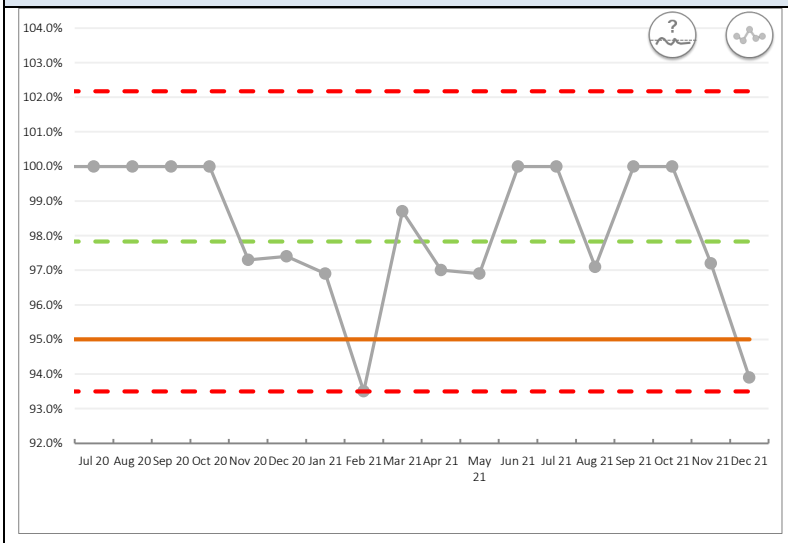
-- Context --
National indicator - 18 weeks or less from referral to entering a course of talking treatment under IAPT - treatment is defined as the2nd successful contact.

-- Monthly Narrative (Key Issues and Actions) --
Performance remains predictably stable at 100%.

Trust
✓
100.0%

13

Not Met - Care Programme Approach (CPA) 7 day follow up ↘	Actual 93.9% M9	Medical Director	Safe
A Higher Value Is Better	Target: 95.0% Monthly	National	



12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
96.9%	93.5%	98.7%	97.0%	96.9%	100.0%	100.0%	97.1%	100.0%	100.0%	97.2%	93.9%

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

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 93.9% during M9 under target, attributed 1 patient in to North Staffs Community and 1 in Stoke Community who were not followed up within 7 days of discharge.

Breach notification forms were completed for all. No risks or issues were identified.

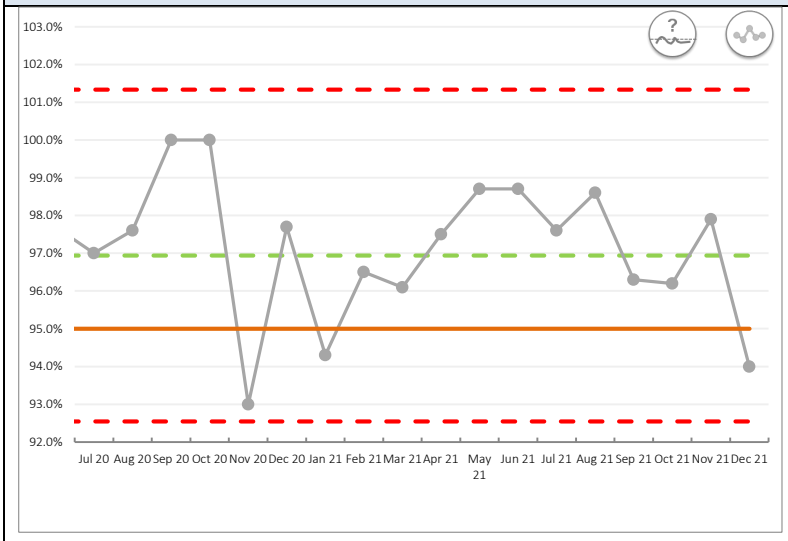
Trust	North Staffs Community	Stoke Community	Specialist Services	Acute and Urgent Care
✗	✗	✓		
93.9%	92.3%	95.0%	#N/A	#N/A

14

Not Met - 7 Day Follow Up (All Patients) ↘

A Higher Value Is Better

Actual	94.0%	M9	**Medical Director**	Safe
Target:	95.0%	Monthly	CCG	



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

-- Monthly Narrative (Key Issues and Actions) --
Performance is 94% during M9.

Breach notification forms were completed for all. No risks or issues were identified.

12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
94.3%	96.5%	96.1%	97.5%	98.7%	98.7%	97.6%	98.6%	96.3%	96.2%	97.9%	94.0%

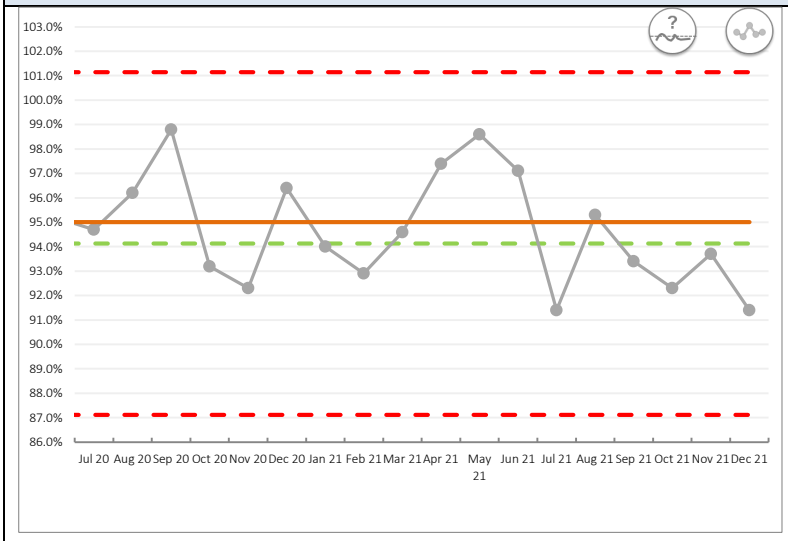
Trust	North Staffs Community	Stoke Community	Specialist Services	Acute and Urgent Care
✗	✗	✗	✓	✗
94.0%	92.9%	94.9%	100.0%	92.9%

15

Not Met - 48 Hour Follow Up ↘

A Higher Value Is Better

Actual	91.4%	M9	**Medical Director**	Safe
Target:	95.0%	Monthly	Trust Measure	



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

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 91.4% during M9. No directorates have achieved the required standard.

There were 8 breaches during December and all breach notices were received explaining why it had not been possible for the follow up to occur within 48 hours. No risks or issues were identified.

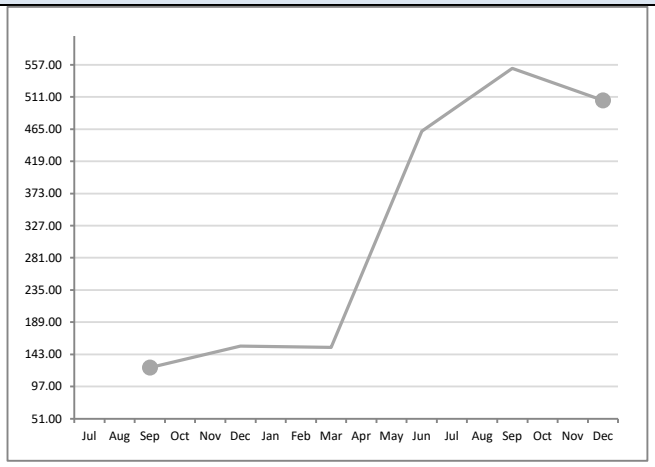
12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
94.0%	92.9%	94.6%	97.4%	98.6%	97.1%	91.4%	95.3%	93.4%	92.3%	93.7%	91.4%

Trust	North Staffs Community	Stoke Community	Specialist Services	Acute and Urgent Care
✗	✗	✗		✗
91.4%	92.9%	92.3%	#N/A	85.7%

16

- Individual Placement Support A Higher Value Is Better	**Actual** 506.00 M9 **Target:** Quarterly	**Executive Director of Operations** Safe National	



12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
		153			462			552			506

Trust
506.00

-- Context --
IPS is an employment support service integrated within community mental health teams for people who experience severe mental health conditions. It is an evidence-based programme that aims to help people find and retain employment.

-- Monthly Narrative (Key Issues and Actions) --
The numbers in IPS is 506 during Quarter 3.

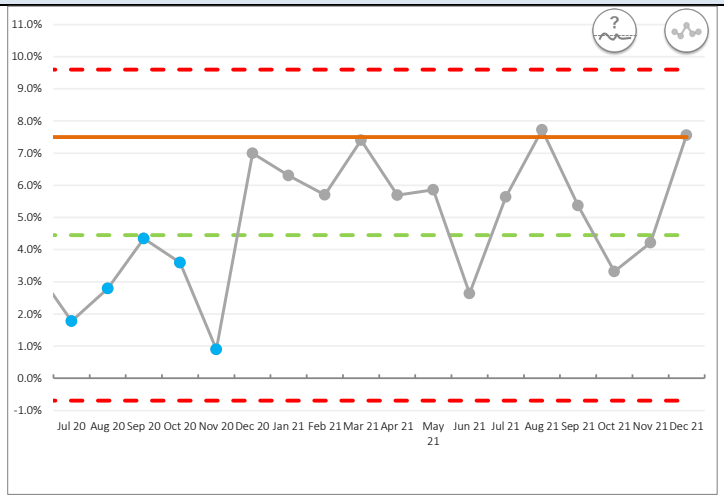
17


Inpatient and Quality

Not Met - Delayed Transfers of Care (DTOC) ↘

A Lower Value Is Better

Actual	7.6%	M9	**Executive Director of Operations**	Responsive
Target:	7.5%	Monthly	National	



-- Context --
National target - 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 is at 7.6% during M9. The delays were attributed to Ward 5 (30 days) and Summers View (46 days).

12 Month Trend

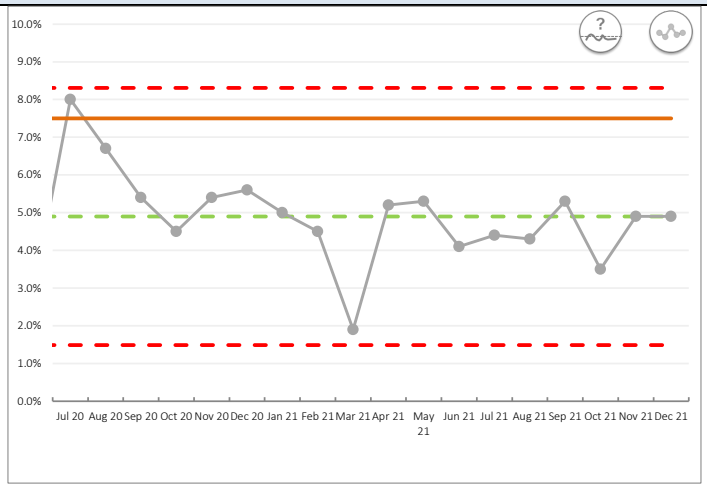
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
6.3%	5.7%	7.4%	5.7%	5.9%	2.6%	5.6%	7.7%	5.4%	3.3%	4.2%	7.6%

Trust	Specialist Services	Acute and Urgent Care
✖	✖	✓
7.6%	11.8%	6.5%

Met - Emergency Readmissions rate (30 days) ↔

A Lower Value Is Better

Actual	4.9%	M9	**Medical Director**	Responsive
Target:	7.5%	Monthly	Trust Measure	



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

-- Monthly Narrative (Key Issues and Actions) --
The emergency readmission rate during M9 is 4.9% and remains within the threshold.

12 Month Trend

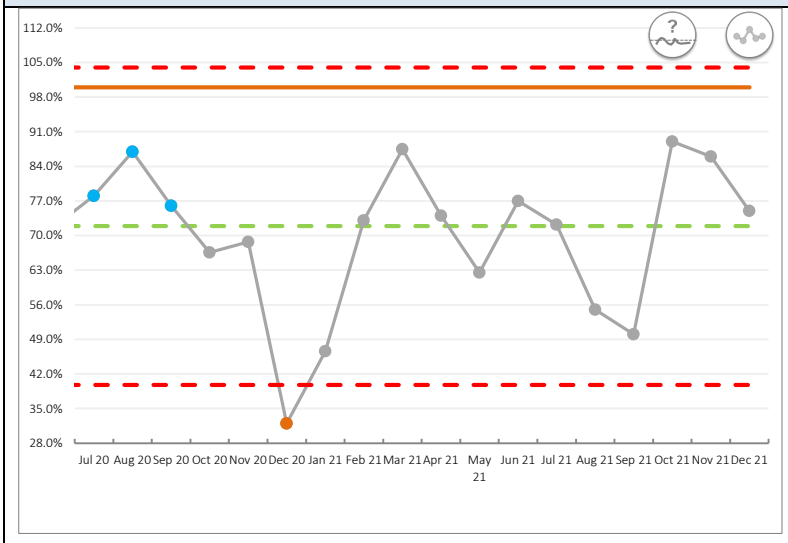
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
5.0%	4.5%	1.9%	5.2%	5.3%	4.1%	4.4%	4.3%	5.3%	3.5%	4.9%	4.9%

Trust	Specialist Services	Acute and Urgent Care
✓	✓	✓
4.9%	0.0%	5.0%

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

A Higher Value Is Better

Actual	75.0%	M9	**Medical Director**	Safe
Target:	100.0%	Monthly	Trust Measure	



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

-- Monthly Narrative (Key Issues and Actions) --
Out of 24 assessments, 6 occurred outside of 3 hours with no agreed clinical grounds for delay. These were due to unavailability of AMHP Doctors, Staffs EDS, and Stoke EDT.

All cases which are non-compliant with the 3 hour target without clinical grounds for delay are being investigated by the appropriate local social services authority. This information is being fed into both the Section 136 forum and a task and finish group which includes representatives from NSCHCT, MPFT, UHNM, Staffs LSSA and Stoke LSSA.

12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
46.6%	73.1%	87.5%	74.0%	62.5%	77.0%	72.2%	55.0%	50.0%	89.0%	86.0%	75.0%

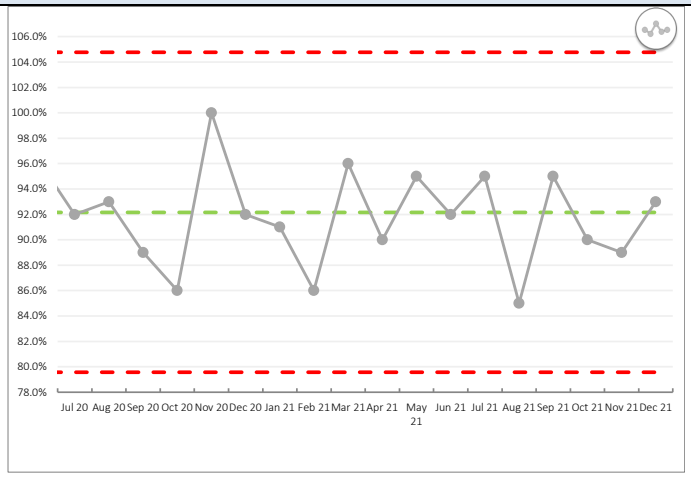
Trust
✖
75.0%

20

- Friends and Family Test - Recommended ↗

A Higher Value Is Better

Actual	93.0%	M9	**Executive Director of Nursing and Quality**	Caring
Target:		Monthly	National	



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

-- Monthly Narrative (Key Issues and Actions) --
There have been 82 FFT returns received of which 93% rated the Trust as good.

The Trust has deployed a digital solution to help to support an increase in patient engagement with the friends and family test. To date this has not significantly increased return rates. Actions are being taken, including a poster campaign and direct text links to the survey to improve engagement and the piloting of electronic FFT via tablets in the Crisis Care Centre and CMHT Bases. A QR code to link directly to FFT has now been included as part of the discharge letter template in Lorenzo.

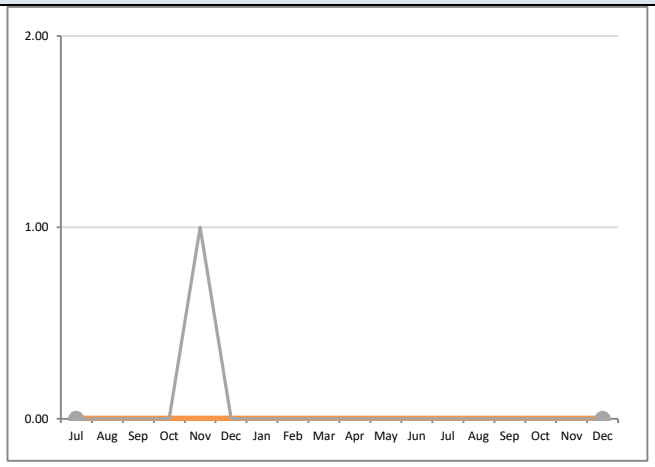
12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
91.0%	86.0%	96.0%	90.0%	95.0%	92.0%	95.0%	85.0%	95.0%	90.0%	89.0%	93.0%

Trust	North Staffs Community	Stoke Community	Specialist Services	Acute and Urgent Care
93.0%	100.0%	88.0%	100.0%	75.0%

21

Met - Out of Area ↔	**Actual** 0.00 M9	**Executive Director of Operations** Responsive
A Lower Value Is Better	**Target:** Monthly	National



12 Month Trend

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

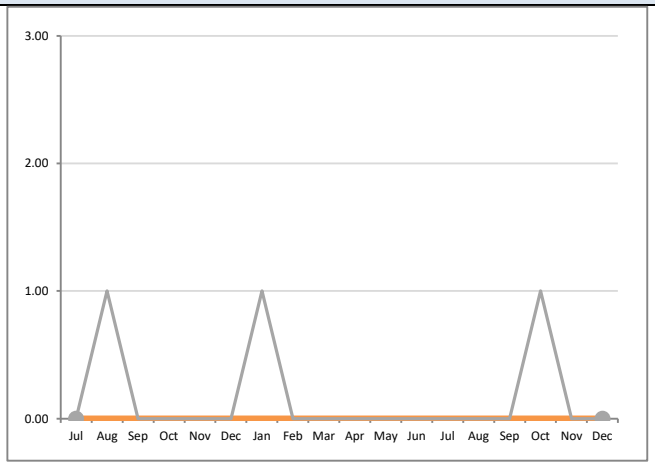
Trust
0.00

-- Context --
National indicator - Number of inappropriate OAA bed days that are either "internal" or "external" to the sending provider in the reporting period. This new national metric for 20/21 combines both adult/older adult acute and PICU out of area placements who were inappropriately redirected to out of area beds. For our reporting purposes this would be outside Staffordshire. This replaces the 4x OOA measures reported in 2019/20.

-- Monthly Narrative (Key Issues and Actions) --
There are no out of area admissions during M9 outside Staffordshire (considered to be local beds as accessible to family, friends and care coordinator).

22

Met - Under 18 Admissions to all wards ↔	**Actual** 0.00 M9	**Medical Director** Safe
A Lower Value Is Better	**Target:** 0.00 Monthly	National



12 Month Trend

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

Trust
✓
0.00

-- Context --
Trust stretch target - 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) --
There has been no under 18 year olds admitted to an adult ward during M9.

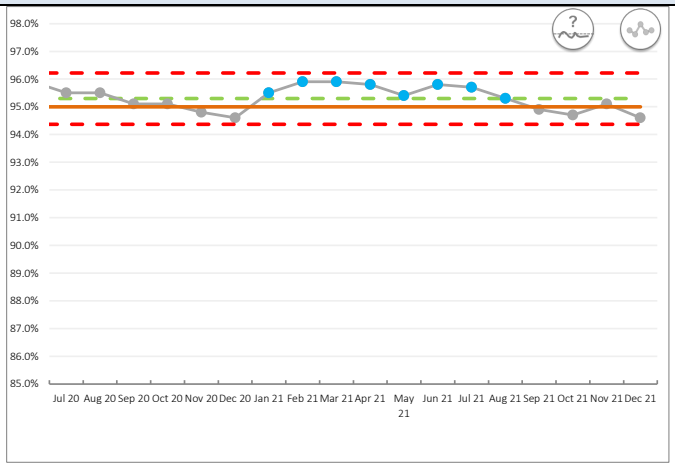
23


Community and Quality

Not Met - Care Plan Compliance ↘

A Higher Value Is Better

Actual	94.6%	M9	**Executive Director of Nursing and Quality**	Safe
Target:	95.0%	Monthly	Trust Measure	



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

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 94.6% during M9, under target. Stoke Community and Acute and Urgent Care have achieved the required standard. This metric is at risk of falling below the lower control limit.

12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
95.5%	95.9%	95.9%	95.8%	95.4%	95.8%	95.7%	95.3%	94.9%	94.7%	95.1%	94.6%

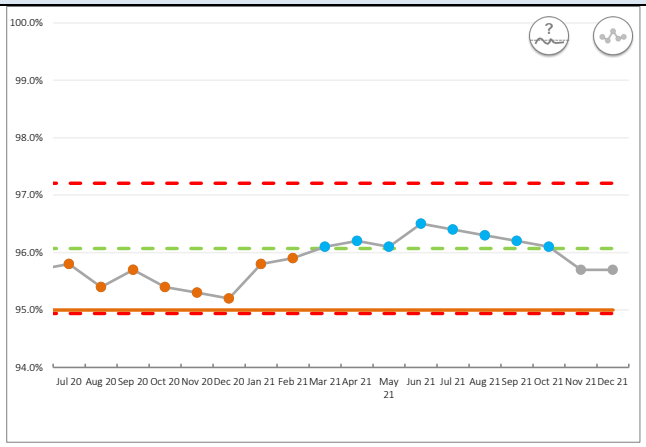
Trust	North Staffs Community	Stoke Community	Specialist Services	Acute and Urgent Care
✖	✖	✓	✖	✓
94.6%	93.2%	95.7%	94.3%	98.8%

24

Met - Risk Assessment Compliance ↔

A Higher Value Is Better

Actual	95.7%	M9	**Executive Director of Nursing and Quality**	Safe
Target:	95.0%	Monthly	Trust Measure	



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

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 95.7% with all directorates having met the required standard, with the exception of Specialist Services.

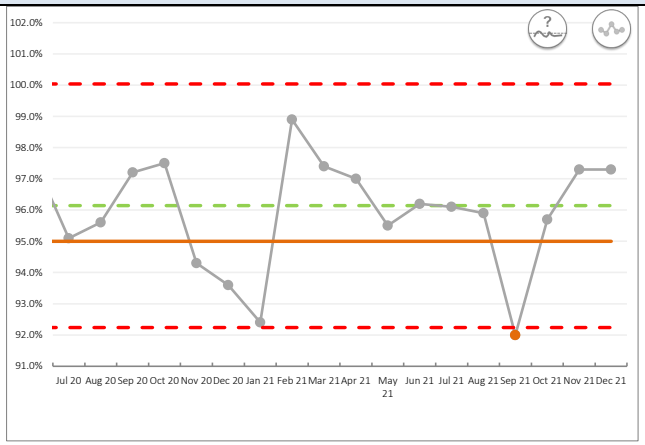
12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
95.8%	95.9%	96.1%	96.2%	96.1%	96.5%	96.4%	96.3%	96.2%	96.1%	95.7%	95.7%

Trust	North Staffs Community	Stoke Community	Specialist Services	Acute and Urgent Care
✓	✓	✓	✖	✓
95.7%	95.6%	96.2%	94.2%	98.8%

25

Met - CPA 12 Month Review Compliance ↔	Actual 97.3% M9	Executive Director of Nursing and Quality	Safe
A Higher Value Is Better	Target: 95.0% Monthly	National	



12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
92.4%	98.9%	97.4%	97.0%	95.5%	96.2%	96.1%	95.9%	92.0%	95.7%	97.3%	97.3%

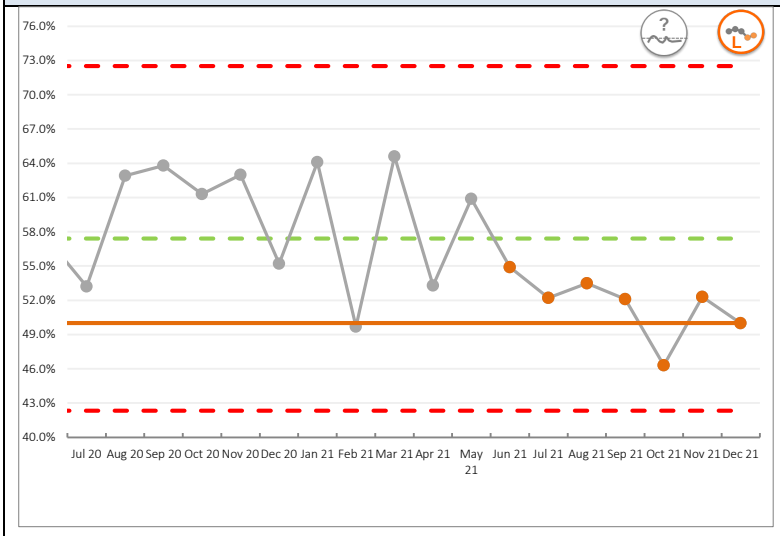
Trust	North Staffs Community	Stoke Community	Specialist Services	Acute and Urgent Care
✓	✓	✓	✓	
97.3%	97.8%	96.0%	98.0%	#N/A

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

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 97.3% during M9. All directorates have met the required standard.

26

Met - IAPT: Recovery ↘	Actual 50.0% M9	Executive Director of Nursing and Quality	Safe
A Higher Value Is Better	Target: 50.0% Monthly	National	



12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
64.1%	49.7%	64.6%	53.3%	60.9%	54.9%	52.2%	53.5%	52.1%	46.3%	52.3%	50.0%

Trust
✓
50.0%

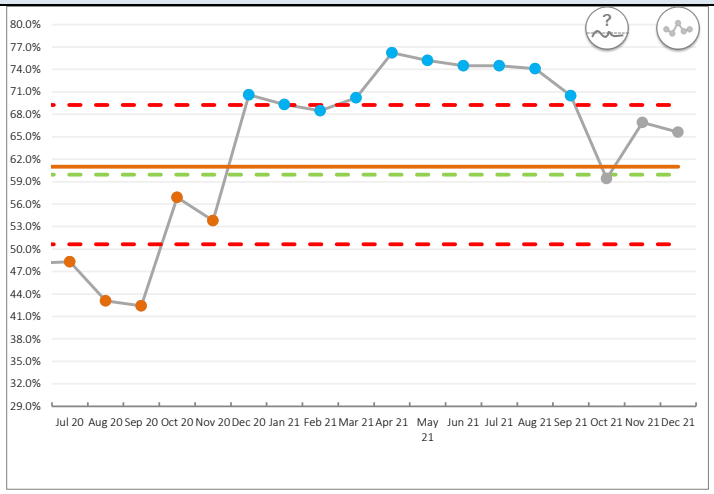
-- Context --
National indicator - This indicator shows how many people have shown a real movement in symptoms large enough to warrant the judgement that the person has recovered, moving from above the clinical threshold to below.

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 50% during M9.

It was anticipated that there would be a reduction in the recovery rate as the current model is asking for more complex clients to be seen in IAPT services. These clients may reliably improve if they have a severe presentation; however they may not reach full recovery and this may be reflected in performance against this metric. In addition, the pandemic may have had an impact as therapy has been delivered mainly by telephone, whilst the evidence base is built on step 3 therapy being delivered face to face. This is improving as vacancies are filled and the service moves the Step 3 team to deliver treatment as intended in the research trials.

27

Met - Service Users on CPA in settled accommodation ↘	Actual 65.6% M9	Executive Director of Nursing and Quality	Safe
A Higher Value Is Better	Target: 61.0% Monthly	National	



-- 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 is at 65.6% during M9 and continues to operate above the national mean.

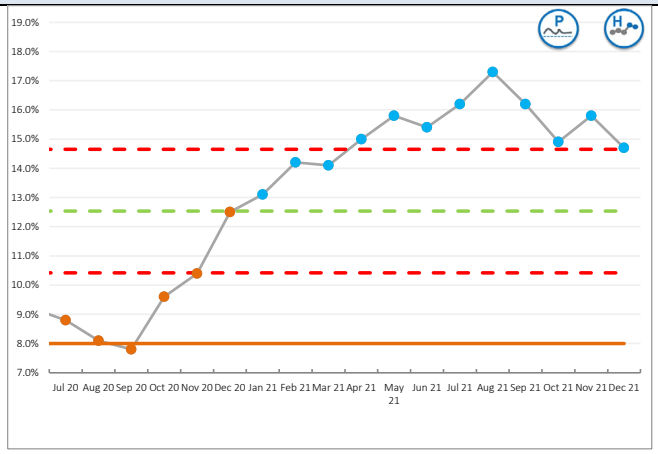
12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
69.3%	68.5%	70.2%	76.2%	75.2%	74.5%	74.5%	74.1%	70.5%	59.4%	66.9%	65.6%

Trust	North Staffs Community	Stoke Community	Specialist Services	Acute and Urgent Care
✓	✓	✓	✗	✓
65.6%	63.7%	73.1%	47.0%	100.0%

28

Met - Service Users on CPA in Employment ↘	Actual 14.7% M9	Executive Director of Nursing and Quality	Safe
A Higher Value Is Better	Target: 8.0% Monthly	National	



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

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 14.7% and continues to operate above the national mean.

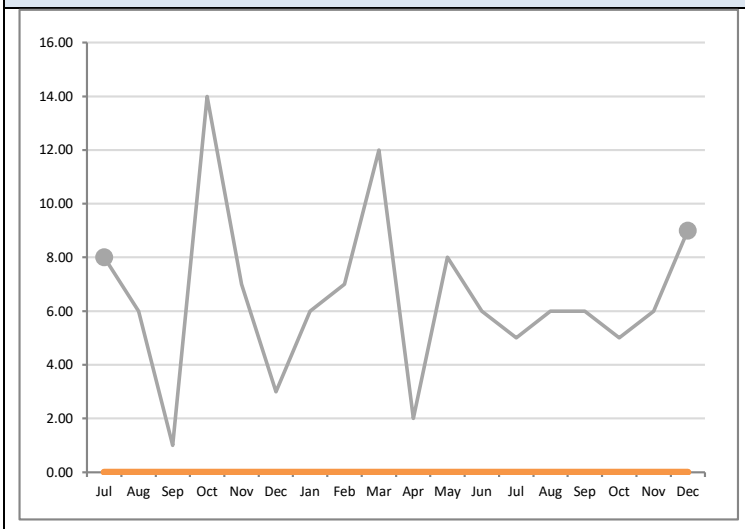
12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
13.1%	14.2%	14.1%	15.0%	15.8%	15.4%	16.2%	17.3%	16.2%	14.9%	15.8%	14.7%

Trust	North Staffs Community	Stoke Community	Specialist Services	Acute and Urgent Care
✓	✓	✓		
14.7%	8.7%	21.1%	#N/A	#N/A

29

- Serious Incidents ↘ A Lower Value Is Better	Actual 9.00 M9 Target: Monthly	Medical Director Safe Trust Measure



12 Month Trend

6	7	12	2	8	6	5	6	6	5	6	9
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec

Trust	North Staffs Community	Stoke Community	Specialist Services	Acute and Urgent Care
9.00	2.00	3.00	1.00	3.00

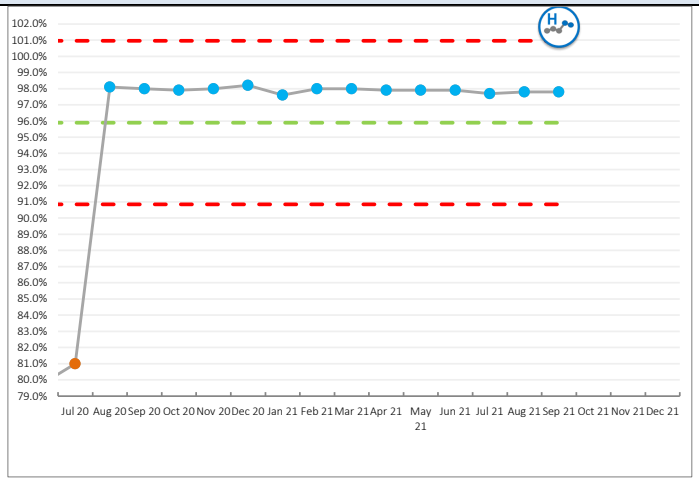
-- Context --
Responding appropriately when things go wrong in healthcare is a key part of the way that the NHS can continually improve the safety of the services we provide to our patients.

-- Monthly Narrative (Key Issues and Actions) --
The number of serious incidents Trust wide is 9.

There are no themes linking Patient Safety Incidents and SIs. There were six suspected suicides, one incident of potentially avoidable incident causing serious harm, one slip, trip, fall and one incident where the cause of death is still to be determined. Although there has been an increase on suspected suicides than in previous months there appears to be no obvious trends.

30

- Data Quality Maturity Index (DQMI) A Higher Value Is Better	Actual #N/A M9 Target: Monthly	Director of Finance, Performance & Estates Caring National



12 Month Trend

97.6%	98.0%	98.0%	97.9%	97.9%	97.9%	97.7%	97.8%	97.8%			
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec

Trust
#N/A

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

-- Monthly Narrative (Key Issues and Actions) --
The Trust's DQMI rating during September was 97.8%, which is the latest published national data.

31

- Perinatal: Number of women accessing specialist community perinatal mental health services ↗

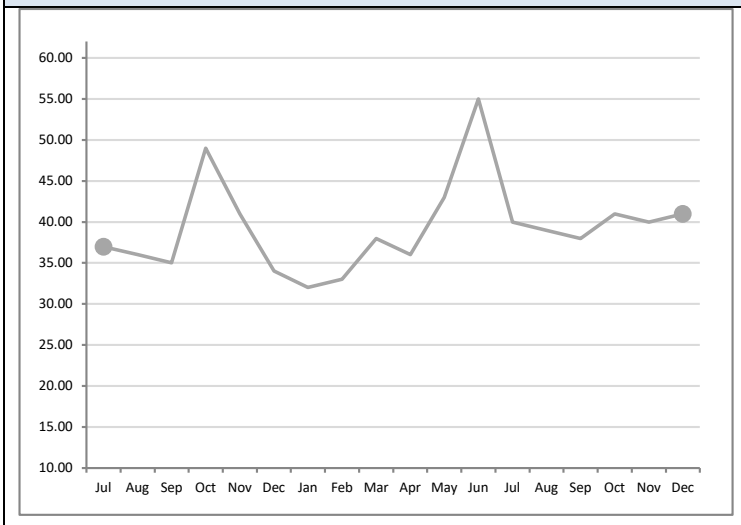
A Higher Value Is Better

Actual 41.00 M9

Target: Monthly

Executive Director of Operations Responsive

National



12 Month Trend

32	33	38	36	43	55	40	39	38	41	40	41
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec

Trust
41.00

-- Context --
This metric is designed to demonstrate the Trust's progress in increasing access to NHS funded specialist community perinatal mental health (PMH) services.

-- Monthly Narrative (Key Issues and Actions) --
There were 41 women accessing the Trust's perinatal service during M9.

32

- Average Length of Stay - Adult ↘

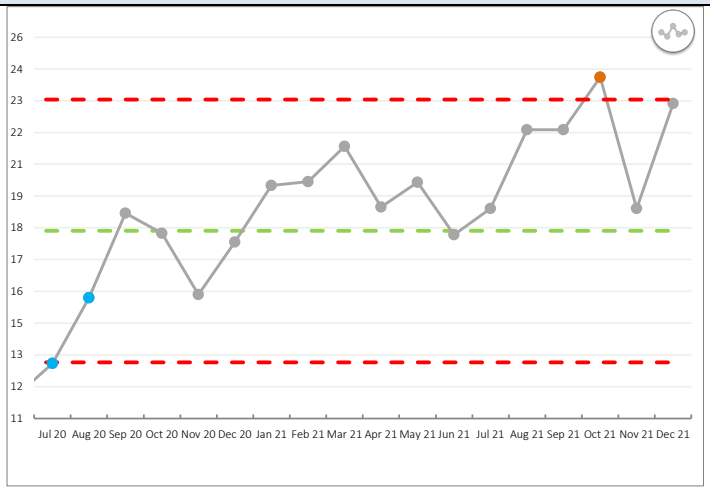
A Lower Value Is Better

Actual 23.00 M9

Target: Monthly

Executive Director of Operations Responsive

Trust
Measure



12 Month Trend

20	20	21	19	20	18	19	22	22	24	19	23
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec

Trust
23.00

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

-- Monthly Narrative (Key Issues and Actions) --
The average length of stay for inpatients on an adult ward during M9 is 23 days.

This compares to a national average of 35 days in the 2020 NHS Mental Health Benchmarking report with the Trust located in the upper quartile for performance.

There are 9 patients with a length of stay of longer than 60 days and 14 patients with a length of stay longer than 90 days. These are attributed to Ward 1 and PICU respectively.

33

- Average Length of Stay - Older Adult ↘

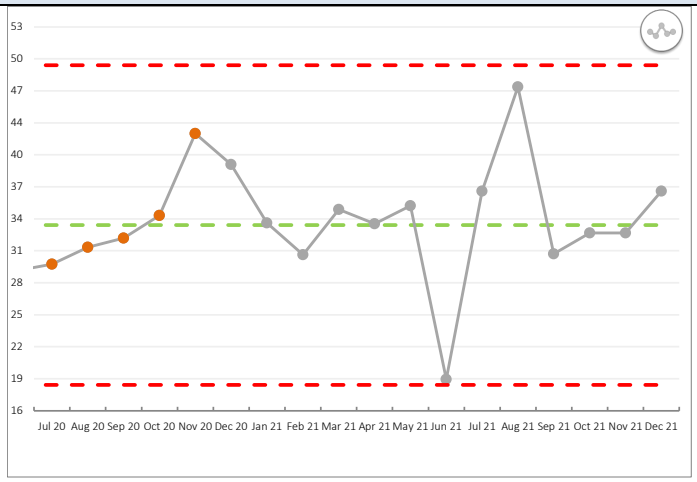
A Lower Value Is Better

Actual 37.00 M9

Target: Monthly

Executive Director of Operations Responsive

Trust Measure



12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
34	31	35	34	36	19	37	47	31	33	33	37

Trust
37.00

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

-- Monthly Narrative (Key Issues and Actions) --
The average length of stay for inpatients on an older adult ward during M9 is 37 days.

This compares to a national average of 74 days in the 2020 NHS Mental Health Benchmarking report with the Trust located in the upper quartile for performance.

There are 10 patients with a length of stay longer than 60 days and 40 patients with a length of stay longer than 90 days, these are attributed to Assessment and Treatment (5 pts), PICU (7 pts), Summers View (21 pts), , Ward 1 (7 pts) respectively. All of these wards had an outbreak of Covid at some point during December.

34

- Incident Reporting ↘

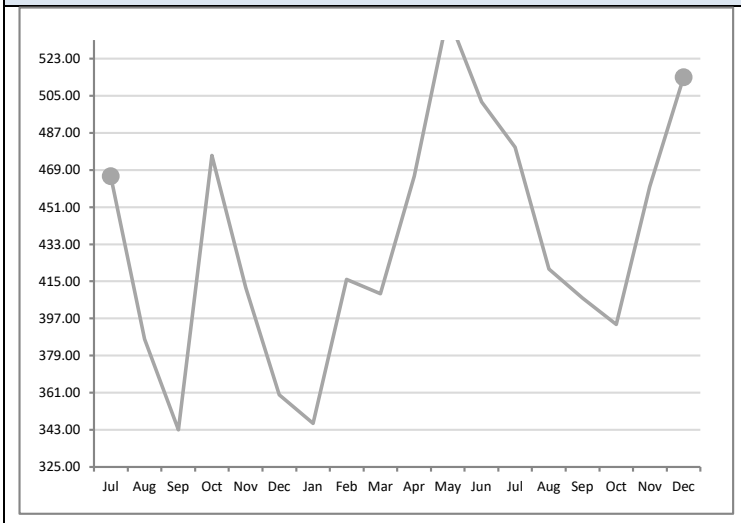
A Lower Value Is Better

Actual 514.00 M9

Target: Monthly

Executive Director of Nursing and Quality Safe

Trust Measure



12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
346	416	409	466	544	502	480	421	407	394	461	514

Trust	North Staffs Community	Stoke Community	Specialist Services	Acute and Urgent Care
514.00	26.00	31.00	187.00	265.00

-- Context --
Incident reporting is vital for improving patient and staff safety through the Trust's ability to learn when things go wrong and identify what, if anything could have been done differently. An incident is any event that has, or may have, impacted upon the safety of patients, staff, delivery of service or health improvement.

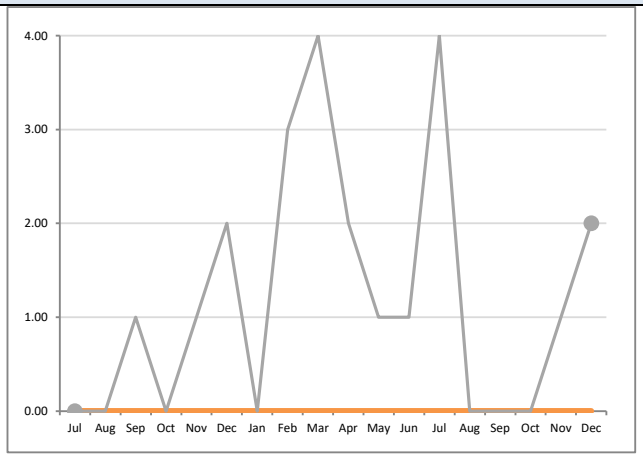
-- Monthly Narrative (Key Issues and Actions) --
The number of incidents Trust wide is 514.

Discussion at weekly incident review group identifies areas for concern/additional review and ensures that opportunities for learning are taken and shared across all directorates. This group also provides an additional platform for analysis of significant increases/reductions in incident reporting.

35

Organisational Health and Workforce

Not Met - Complaints Open Beyond Agreed Timescale ↘	**Actual**	2.00	M9	**Executive Director of Nursing and Quality**	Caring
A Lower Value Is Better	**Target:**	0.00	Monthly	Trust Measure	



12 Month Trend

0	3	4	2	1	1	4	0	0	0	1	2
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec

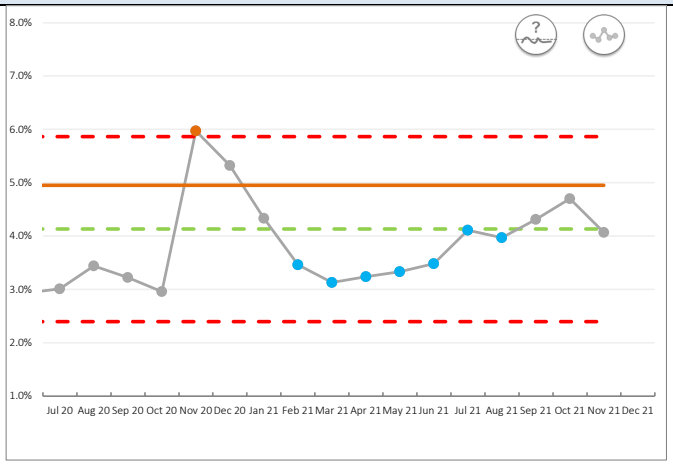
Trust
✖
2.00

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

-- Monthly Narrative (Key Issues and Actions) --
There are two complaint responses outside of the 40 working day deadline during M9, which are in the final review stages.

36

- Sickness Absence	**Actual**	#N/A	M9	**Executive Director of Workforce**	Organisational Health
A Lower Value Is Better	**Target:**	4.95%	Monthly	Trust Measure	



12 Month Trend

4.33%	3.46%	3.13%	3.24%	3.33%	3.48%	4.11%	3.97%	4.31%	4.70%	4.07%	
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec

Trust	North Staffs Community	Stoke Communit	Specialist Services	Acute and Urgen Care	Primary Care	Corporate
#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A

-- 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) --
September sickness figures have been confirmed. December figures are not yet available.

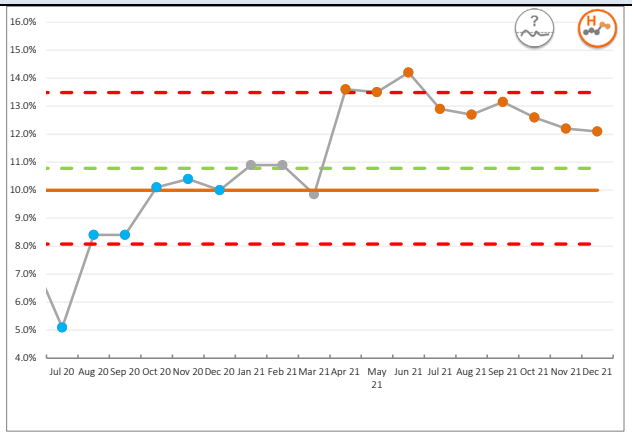
There is a key focus on Health and Wellbeing support to staff, particularly in light of the recent increase in proportion of sickness due to Mental Health. It should be noted that these figures do not contain absences relating to Covid which are not classed as "sickness" e.g. isolation due to symptomatic family member, track and trace, shielding and other associated absences. Such instances are being recorded as other absence codes such as medical suspension (in accordance with the national guidelines).

37

Not Met - Vacancy Rate ↗

A Lower Value Is Better

Actual 12.1% M9	**Executive Director of Workforce**	Organisational Health
Target: 10.0% Monthly	Trust Measure	



12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
10.9%	10.9%	9.9%	13.6%	13.5%	14.2%	12.9%	12.7%	13.2%	12.6%	12.2%	12.1%

Trust	North Staffs Community	Stoke Communit	Specialist Services	Acute and Urgen Care	Primary Care	Corporate
✗	✗	✗	✗	✗	✗	✓
12.1%	14.6%	13.7%	11.4%	14.6%	14.9%	6.9%

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

-- Monthly Narrative (Key Issues and Actions) --
The vacancy rate is 12.1% in M9 and the 10% target remains challenging for all directorates, with the exception of Corporate services.

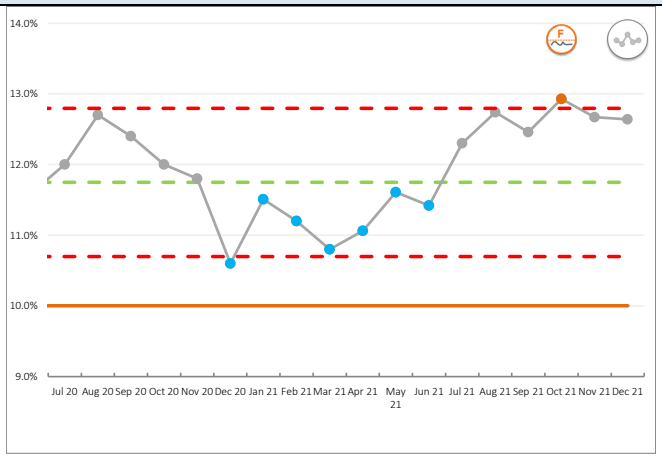
It is noted that a number of service development schemes have adversely affected the vacancy position. In Q3/4, 20/21 there was a 5% growth in workforce and in Q1, 21/22 there was an additional 6% growth in workforce. This is set against a national and local backdrop of workforce supply shortages for Nursing, AHP and Medical professions. A Vacancy Management Plan has been developed which consists of a number of short/medium and long terms initiatives to address the position. Performance against the plan is being actively monitored.

38

Not Met - Staff Turnover ↗

A Lower Value Is Better

Actual 12.6% M9	**Executive Director of Workforce**	Organisational Health
Target: 10.0% Monthly	Trust Measure	



12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
11.5%	11.2%	10.8%	11.1%	11.6%	11.4%	12.3%	12.7%	12.5%	12.9%	12.7%	12.6%

Trust	North Staffs Community	Stoke Communit	Specialist Services	Acute and Urgen Care	Primary Care	Corporate
✗	✗	✗	✗	✗	✗	✓
12.6%	14.6%	11.2%	14.3%	12.9%	18.8%	8.7%

-- 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. This is the mitigated position excluding rotational trainees, fixed term contracts, TUPE's and internal staff movement.

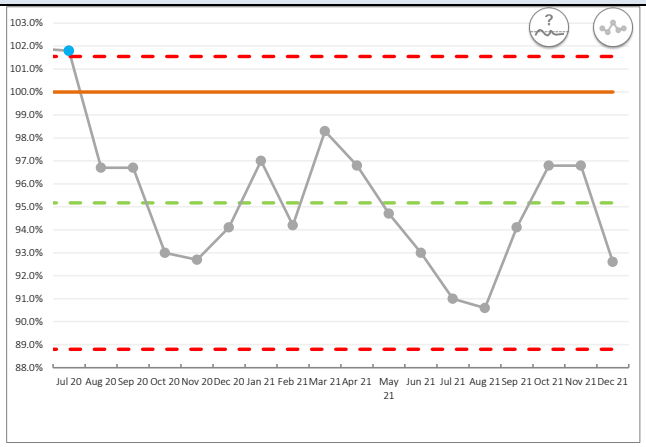
-- Monthly Narrative (Key Issues and Actions) --
Performance is consistently above the 10% threshold at 12.6% and remains challenging for all directorates, with the exception of Corporate services.

The top three reported reasons for leaving the Trust include: Retirement - 55%, Promotion - 29% and Work Life balance - 29%. The Vacancy Management Plan also contains a number of strategies which are expected to improve retention.

NHSE/I measure - All staff turnover (rolling 12 month average) = 13%. This is the position that the Trust is benchmarked against.

39

Not Met - Safe Staffing ↘ A Higher Value Is Better	**Actual** 92.6% M9 **Target:** 100.0% Monthly	**Executive Director of Nursing and Quality** National	Responsive



12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
97.0%	94.2%	98.3%	96.8%	94.7%	93.0%	91.0%	90.6%	94.1%	96.8%	96.8%	92.6%

Trust
✖
92.6%

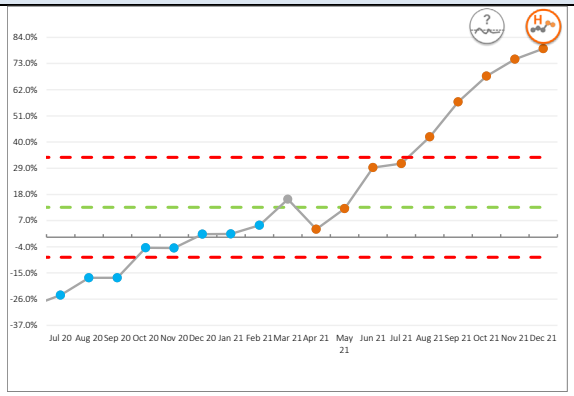
-- Context --
National measure (Trust target) - This measures the total planned hours divided by the actual hours.

-- Monthly Narrative (Key Issues and Actions) --
Safe staffing performance is at 92.6% during M9.

Ward Managers, Service Managers and Quality Improvement Nurses (Matrons) continue to review staffing levels on a daily basis. Bank and Agency staff continue to be used to fill shortfalls. Several short and longer term actions are being undertaken to support recruitment and retention.

40

Not Met - % Year to Date Agency Spend compared to Year to Date Agency Ceiling ↘ A Lower Value Is Better	**Actual** 79.2% M9 **Target:** 0.0% Monthly	**Executive Director of Operations** National	Organisational Health



12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1.4%	5.0%	16.0%	3.4%	12.0%	29.3%	31.0%	42.2%	56.9%	67.7%	74.8%	79.2%

Trust
✖
79.2%

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

-- Monthly Narrative (Key Issues and Actions) --
Agency spend is exceeded the agency threshold by 79.2% and continues to operate outside of the upper control limit.

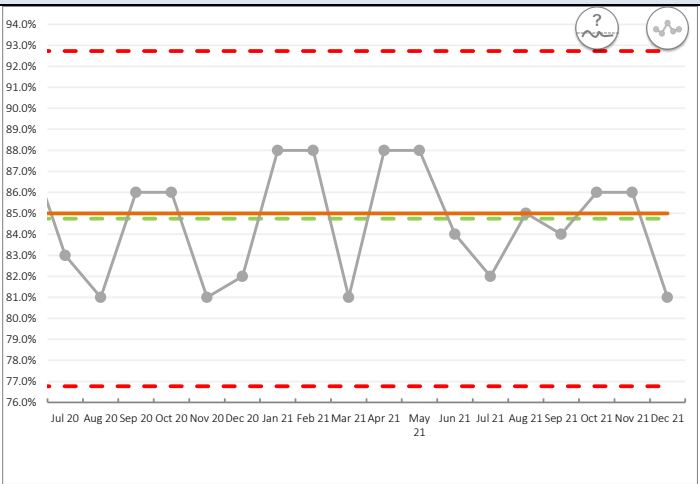
Agency spend in M9 came to £346k, of which £201k relates to Medical and £109k relates to Nursing. Of the £201k medical agency spend, £59k relates to Stoke Community, £47k to Specialist Services & £43k to North Staffordshire Community. Of the £109k Nursing agency spend, £88k relates to Acute & Urgent Care and £20k to Specialist Services. There are ongoing targeted recruitment campaign events held for medics and nursing posts. A fortnightly Task and Finish Group meet to define actions needed to boost recruitment and retention.

41

Not Met - Clinical Supervision ↘

A Higher Value Is Better

Actual	81.0%	M9	**Executive Director of Workforce**	Organisational Health
Target:	85.0%	Monthly	Trust Measure	



12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
88.0%	88.0%	81.0%	88.0%	88.0%	84.0%	82.0%	85.0%	84.0%	86.0%	86.0%	81.0%

Trust	North Staffs Community	Stoke Community	Specialist Services	Acute and Urgen Care	Primary Care	Corporate
✗	✗	✗	✗	✗	✗	✗
81.0%	82.0%	82.0%	82.0%	79.0%	62.0%	79.0%

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

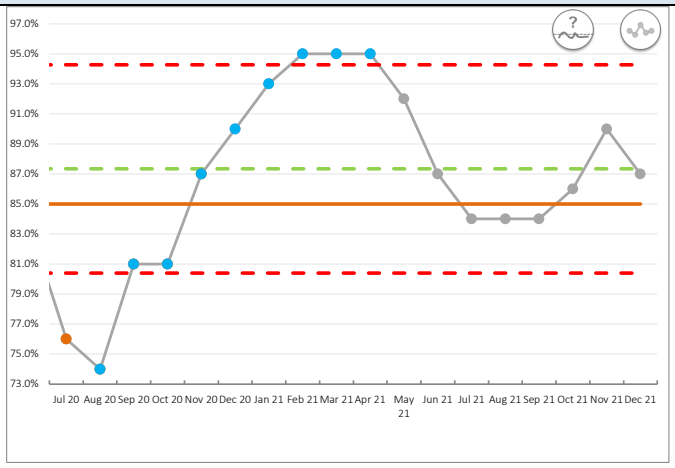
-- Monthly Narrative (Key Issues and Actions) --
Performance is at 81% and although operating with normal control limits for our Trust, is below the required standard for all directorates.

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

Met - Appraisal ↘

A Higher Value Is Better

Actual	87.0%	M9	**Executive Director of Workforce**	Organisational Health
Target:	85.0%	Monthly	Trust Measure	



12 Month Trend

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
93.0%	95.0%	95.0%	95.0%	92.0%	87.0%	84.0%	84.0%	84.0%	86.0%	90.0%	87.0%

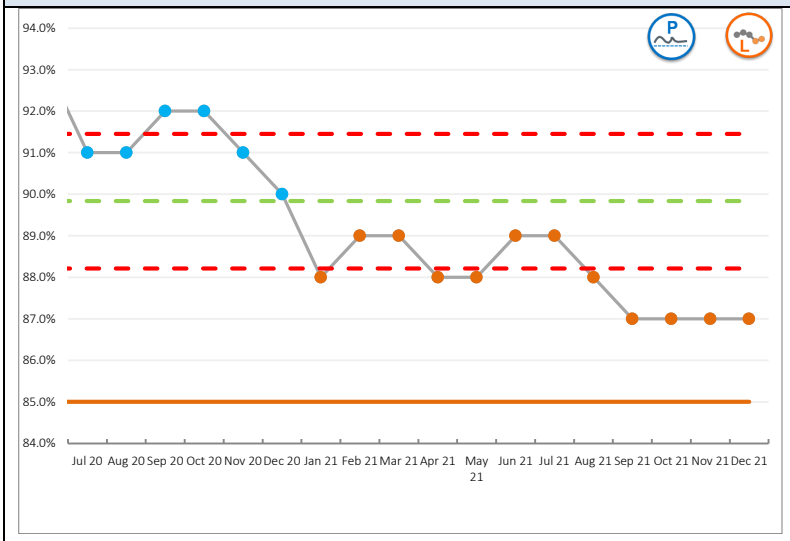
Trust	North Staffs Community	Stoke Community	Specialist Services	Acute and Urgen Care	Primary Care	Corporate
✓	✓	✓	✓	✓	✗	✗
87.0%	90.0%	91.0%	90.0%	87.0%	82.0%	81.0%

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

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 87% and is operating within normal control limits. All directorates, with the exception of Primary Care and Corporate services have met the required standard.

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

Met - Statutory & Mandatory Training ↔	Actual 87.0% M9	Executive Director of Workforce: Organisational Health
A Higher Value Is Better	Target: 85.0% Monthly	Trust Measure



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

-- Monthly Narrative (Key Issues and Actions) --
Performance is at 87% during M9 and all directorates are achieving the required standard. A special cause variation continues as performance is well below the operational average and operating outside of the lower control limits for the Trust.

While the overall percentage is on target, there are areas of Statutory and Mandatory Training that do not reach the target required. These are notably training sessions that are required to be delivered face to face: MAPA, Resuscitation, Safer People Handling, and Safeguarding Level 3 for Children & Young People and Dementia Tier 2. The extra sessions provided at weekends to target the 'at risk' have seen the face-to-face compliance improve in all areas

12 Month Trend

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

Trust	North Staffs Community	Stoke Community	Specialist Services	Acute and Urgen Care	Primary Care	Corporate
✓	✓	✓	✓	✓	✓	✓
87.0%	95.0%	92.0%	90.0%	89.0%	94.0%	91.0%

Statistical Process Control

What is It?

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

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

When to use it

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

How to use it

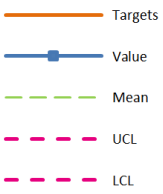
An SPC chart has a mean line and two control lines, both of which allow more statistical interpretation. These control lines are 3σ (3 Sigma) away from the Mean - with recalculation of these lines occurring when significant changes in the process occur.

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

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

Interpreting the Report

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



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

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

Directional Arrows:

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

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

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

REPORT TO PUBLIC TRUST BOARD

Enclosure 9

Date of Meeting:	10th February 2022		
Title of Report:	Finance Position Month 9		
Presented by:	Eric Gardiner – Executive Director of Finance, Performance & Estates		
Author:	Michelle Wild – Financial Controller / Lisa Dodds – Assistant Director of Finance/ Rachel Heath – Project Accountant		
Executive Lead Name:	Eric Gardiner – Executive Director of Finance, Performance & Estates	**Approved by Exec**	☒

Executive Summary:		**Purpose of report**	
The report summarises the finance position at month 9 (December 2021)		**Approval**	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☒ Execs ☐ Performance Review	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. We will attract, develop and retain the best people ☐ 2. We will actively promote partnership and integrated models of working ☐ 3. We will provide the highest quality, safe and effective services ☐ 4. We will increase our efficiency and effectiveness through sustainable development ☒		
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.		
Shadow ICS Alignment / Implications:	Part of the aggregate STP/Shadow ICS reported financial position		
Recommendations:	The Trust Board are asked to: Note: • The reported year to date position of £646k surplus. • Note the 2021/22 agreed capital plan and year to date position.		

	• The cash position of the Trust as at 31st December 2021 with a balance of £25.4m; • Agency expenditure in month 9 of £346k against the agency ceiling of £155k; an adverse variance of £191k to the agency ceiling. • Note the achievement of transacted CIP schemes totalling £1,300k against a target for the year of £1,200k.	
Version	Name/group	Date issued
1.1	N/A	27 January 2022

North Staffordshire Combined Healthcare NHS Trust

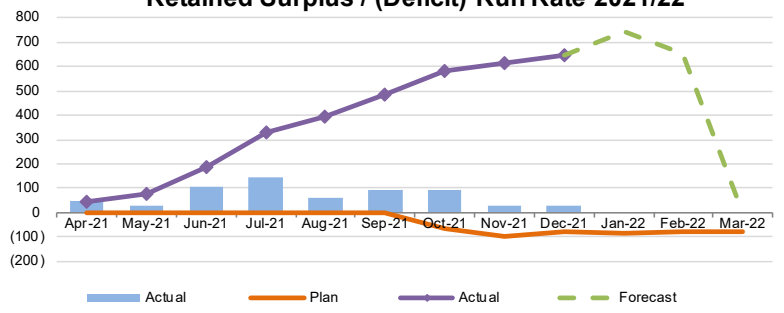
Finance and Resource Committee – 3rd February 2022
Finance Position Month 9

Financial Overview as at 31 December 2021

Key Metrics

		Plan £000	Actual £000	Var £000	%	RAG
Financial Position	YTD	(244)	646	890	364	G
	FOT	(488)	(0)	488	100	G
Charge to CRL	YTD	3,944	967	(2,977)	(75)	R
	FOT	6,621	5,678	(943)	(14)	R
Cash Balances	YTD	24,450	25,442	992	4	R
	FOT	19,799	25,037	5,238	26	G
CIP Programme	YTD	915	984	69	8	G
	FOT	1,200	1,300	100	8	G
Identified Schemes	Full Year		1,300			G

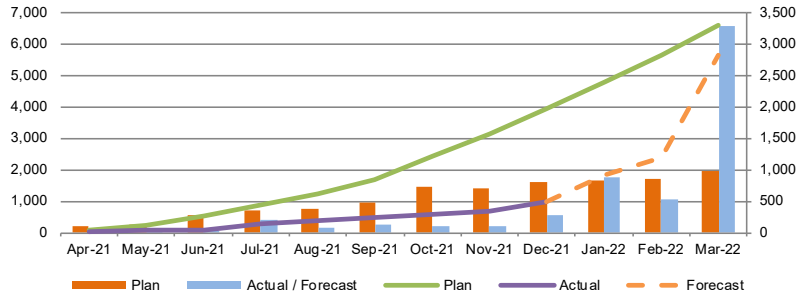
Retained Surplus / (Deficit) Run Rate 2021/22

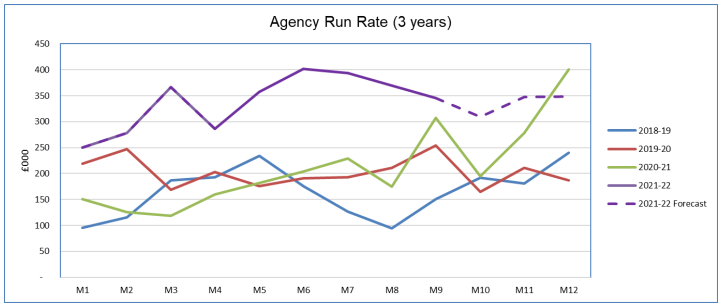


Better Payment Practice Code

	In month		YTD	
	Number	£000	Number	£000
Total trade invoices paid in period	1,213	6,961	10,401	57,408
Total trade invoices paid within target	1,195	6,845	9,993	53,075
% paid within target	99%	98%	96%	92%

Net Capital Expenditure - Plan / Actual 2021/22





Executive Summary

The NHSE/I plan for H2 shows a £488k deficit as the requirement was to match the STP plans, which at the time were based on the Trust moving from a £488k surplus position in H1 to breakeven position at year-end. As at month 9, the Trust is reporting an in month surplus position of £32k for the adjusted financial performance and a £646k surplus year to date which is a £646k variance against the year-to-date budget mainly due to pay underspends as a consequence of vacancies.

The retained surplus year to date is £953k which includes the overage payments made to the Trust relating to the sale of the Bucknall site land in previous years and donated asset income relating to patient monitors received from DHSC. This does not form part of the Trust's financial performance total for reporting purposes nationally.

As a result of the vacancies across the Trust, agency expenditure has exceeded the agency ceiling by £1,348k year-to-date and there has been an under recovery of income due to delays in some service developments. Pay has underspent by £2,088k year-to-date, and non-pay has over spent by £1,188k.

High Level Analysis	YTD Plan	Month 9 Budget	Month 9 Actuals	Variance	Year to Date Budget	Year to Date Actuals	Variance	Forecast Budget	Forecast Actuals	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Income	**104,604**	**11,974**	**12,259**	**286**	**105,241**	**105,183**	**(59)**	**141,675**	**145,043**	**3,368**
Pay Costs	(54,903)	(6,583)	(6,426)	158	(58,393)	(56,305)	2,088	(78,087)	(75,659)	2,428
Non Pay Costs	(46,198)	(4,977)	(5,403)	(425)	(43,132)	(44,321)	(1,188)	(58,633)	(64,257)	(5,625)
Finance & Other Non Operating Costs	(3,747)	(413)	(399)	14	(3,716)	(3,604)	112	(4,955)	(4,820)	135
Expenditure	**(104,848)**	**(11,974)**	**(12,227)**	**(254)**	**(105,241)**	**(104,230)**	**1,012**	**(141,675)**	**(144,736)**	**(3,062)**
Retained Surplus / (Deficit)	**(244)**	**0**	**32**	**32**	**0**	**953**	**953**	**0**	**307**	**307**
Less Gains on Disposal of Assets	0	0	0	0	0	(243)	(243)	0	(243)	(243)
Less DHSC Donated Assets Income	0	0	0	0	0	(64)	(64)	0	(64)	(64)
Adjusted Financial Performance	**(244)**	**0**	**32**	**32**	**0**	**646**	**646**	**0**	**(0)**	**(0)**

CIP schemes identified as at month 9 total £1,300k against the revised required level of CIP included in the update to the plan at H2 of £1,200k. Therefore, the Trust has overachieved on recurrent CIP for 21/22 by £0.1m. Directorates will now focus on identifying schemes for 2022/23 onwards.

Trade payables are higher in 2021/22 due to patient placements costs for TCP and Community Rehab Placements (formally known as Project 86) and also includes deferred income at £5.5m. Trade receivables are also high due to TCP/P86 recharges to CCGs having not been settled although full payment is expected during January.

The cash position at month 9 is £1.0m higher than plan due to lower payment runs than plan year to date and slippage on the capital plan, partly offset by a delay in the CCG settling TCP/Project 86 invoices.

In month 9, the Trust achieved the Better Payment Practice Code target of 95% on both the total number of invoices paid and value of invoices paid, with a total of 99% paid within the target on count and 98% within target on value. Year to date the trust has achieved 96% on the number of invoices received and 92% on the value of invoices received.

The Trust's capital expenditure to month 9 was £2,977k below plan with slippage across most schemes due to delayed starts. Colleagues are working through alternative options to utilise slippage and contingency including schemes brought forward from the 2022/23 capital plan. A number of these are planned to start in Q4.

1. Income

The table below shows the Trust's 2021/22 income position at 31st December 2021.

- The majority of CCG/NHSE block income is fixed for 2021/22 under the block payments arrangements. In month 9 block contract income includes £6,977k received from Staffordshire CCGs, £31k from Cheshire CCGs and £296k from NHSE. Income from CCGs is underperforming due to delayed starts for some service developments.

- Patient Placements income relates to TCP and Community Rehab Placements income from the CCGs and Local Authorities, this is separate from the CCG block. The forecast over performance relates to the current forecast assumption on growth in costs over the agreed baseline which the CCG have committed to cover via a fully signed MOU and is offset by an equal amount of expenditure.

- Non-patient care services to other bodies is under recovered year to date due to the delays in the recruitment of the ARRS (Additional Roles Reimbursement Scheme) posts. These posts are funded 50% direct from CCGs and 50% from PCNs, this income relates to the element to be received from the PCN. This is offset by pay underspends.

Income	YTD Plan	Month 9 Budget	Month 9 Actuals	Variance	Year to Date Budget	Year to Date Actuals	Variance	Forecast Budget	Forecast Actuals	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Income From CCGs and NHSE / Block Contract Income	63,703	7,173	7,305	131	64,453	62,465	(1,987)	85,975	85,706	(268)
Local authorities	4,722	323	323	(0)	2,712	2,712	0	3,978	3,877	(101)
Patient Placements Income	24,043	2,880	3,116	236	25,918	27,654	1,736	34,558	37,127	2,570
Non-NHS: Private Patients	0	0	0	0	0	37	37	0	49	49
Non-NHS: other	2,141	276	266	(11)	2,487	2,312	(175)	3,316	3,143	(173)
Total Income From Patient Care Activities	**94,610**	**10,652**	**11,009**	**357**	**95,570**	**95,181**	**(389)**	**127,826**	**129,902**	**2,076**
Research and development	73	8	9	1	74	82	8	98	107	9
Education and training	1,903	381	379	(2)	2,278	2,646	368	3,039	3,854	816
Non-patient care services to other bodies	5,947	675	688	13	6,075	5,990	(85)	8,100	8,038	(61)
Other Income	2,071	257	174	(83)	1,245	1,284	40	2,612	3,141	529
Total Income from Other Operating Activities	**9,994**	**1,321**	**1,250**	**(71)**	**9,671**	**10,002**	**331**	**13,848**	**15,140**	**1,292**
Total Income	**104,604**	**11,974**	**12,259**	**286**	**105,241**	**105,183**	**(59)**	**141,675**	**145,043**	**3,368**

2. Expenditure

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

- Pay costs in month 9 are £6,426k, £158k below the budget for month 9 due to vacancies. Year-to-date pay is £2,088k below budget as a consequence of vacancies across all areas. In month 9 there were 209.34wte vacancies (budgeted wte less contracted wte, the figures in the table below show budgeted wte and worked wte to show the inclusion of overtime, bank and agency). 91.15 wte of these vacancies are in nursing and 70.25 wte are in other clinical. This is partly offset by the cost of agency at £346k.

- Non-Pay over spend of £1,188k year to date relates to over spends on premises, patient placements and consultancy, partly offset by underspends on other non-pay.

Expenditure	YTD Plan	Month 9 Budget	Month 9 Worked	Month 9 Budget	Month 9 Actuals	Variance	Year to Date Budget	Year to Date Actuals	Variance	Forecast Budget	Forecast Actuals	Variance
	£000	WTE	WTE	£000	£000	£000	£000	£000	£000	£000	£000	£000
Medical	(5,350)	(79.96)	(54.07)	(775)	(637)	139	(7,001)	(5,494)	1,506	(9,484)	(7,537)	1,946
Nursing	(18,556)	(578.19)	(503.98)	(2,299)	(2,041)	258	(20,442)	(17,614)	2,828	(27,296)	(23,516)	3,779
Other Clinical	(18,925)	(689.57)	(677.83)	(2,217)	(2,135)	82	(19,352)	(19,223)	129	(25,877)	(25,901)	(25)
Non-Clinical	(10,365)	(382.32)	(358.02)	(1,292)	(1,256)	37	(11,377)	(10,711)	666	(15,210)	(14,395)	815
Agency	0	0.00	42.48	0	(346)	(346)	0	(3,012)	(3,012)	0	(4,018)	(4,018)
COVID-19 Pay Costs	(1,707)	0.00	(4.10)	0	(11)	(11)	(221)	(250)	(29)	(221)	(291)	(71)
Total Pay	**(54,903)**	**(1,730.04)**	**(1,555.52)**	**(6,583)**	**(6,426)**	**158**	**(58,393)**	**(56,305)**	**2,088**	**(78,087)**	**(75,659)**	**2,428**
Drugs & Clinical Supplies	(1,726)			(203)	(241)	(39)	(1,802)	(2,060)	(259)	(2,452)	(2,790)	(338)
Establishment Costs	(489)			(77)	(86)	(9)	(693)	(620)	73	(923)	(855)	69
Premises Costs	(2,485)			(501)	(548)	(47)	(3,333)	(3,711)	(378)	(6,149)	(7,079)	(930)
Private Finance Initiative	(2,469)			(263)	(258)	5	(2,368)	(2,295)	73	(3,157)	(3,080)	77
Services Received	(5,352)			(515)	(603)	(88)	(4,699)	(4,581)	118	(6,572)	(7,045)	(472)
Patient Placements	(25,167)			(2,881)	(3,116)	(234)	(25,933)	(27,654)	(1,721)	(34,577)	(37,127)	(2,550)
Consultancy & Prof Fees	(1,292)			(6)	(78)	(72)	(45)	(464)	(420)	736	(525)	(1,261)
External Audit Fees	(63)			(7)	(9)	(2)	(64)	(66)	(2)	(86)	(87)	(2)
COVID-19 Non Pay Costs	0			0	5	5	(78)	(68)	10	(78)	(78)	0
Other	(7,153)			(525)	(469)	55	(4,119)	(2,801)	1,318	(5,373)	(5,592)	(218)
Total Non-Pay	**(46,198)**			**(4,977)**	**(5,403)**	**(425)**	**(43,132)**	**(44,321)**	**(1,188)**	**(58,633)**	**(64,257)**	**(5,625)**
Finance Costs	(2,031)			(223)	(223)	(0)	(2,007)	(2,007)	(0)	(2,676)	(2,676)	(0)
Dividends Payable on PDC	(423)			(49)	(33)	15	(437)	(292)	145	(583)	(392)	191
Investment Revenue	36			6	0	(6)	56	0	(56)	74	0	(74)
Depreciation (excludes IFRIC	(1,329)			(148)	(143)	5	(1,328)	(1,305)	22	(1,770)	(1,752)	18
Total Non-operating Costs	**(3,747)**			**(413)**	**(399)**	**14**	**(3,716)**	**(3,604)**	**112**	**(4,955)**	**(4,820)**	**135**
Total Expenditure	**(104,848)**	**(1,730.04)**	**(1,555.52)**	**(11,974)**	**(12,227)**	**(254)**	**(105,241)**	**(104,230)**	**1,012**	**(141,675)**	**(144,736)**	**(3,062)**

3. Agency Utilisation

Headlines - Trust Agency Use

For 2021/22 the Trust will be monitored against the agency ceiling at £2,167k for the year, however, NHSEI have confirmed that the agency cap does not directly contribute to the Use of Resources score for 2021/22. The agency costs to month 9 are shown below.

Month 9 expenditure on agency is £346k; **which is over the in-month agency ceiling by £191k.** This is 5.4% of total pay costs in month 9. Total agency costs to month 9 are £3,050k; **£1,348k over the agency ceiling.** This is 5.4% of total pay costs year to date.

Of the £3,050k agency costs to date, 44% of this is was incurred in the two community directorates, with 19% in Specialised and 27% in Acute and Urgent Care, the remainder related to Primary Care and Corporate areas.

The table below shows total agency expenditure by staffing group.

Total Agency	Actual											Forecast				
	Apr-21 £000	May-21 £000	Jun-21 £000	Jul-21 £000	Aug-21 £000	Sep-21 £000	H1 Total £000	Oct-21 £000	Nov-21 £000	Dec-21 £000	YTD £000	Jan-22 £000	Feb-22 £000	Mar-22 £000	H2 Total £000	Total £000
Medical	(181)	(198)	(222)	(155)	(211)	(240)	(1,208)	(238)	(201)	(186)	(1,832)	(188)	(222)	(222)	(1,255)	(2,463)
Nursing	(49)	(45)	(96)	(92)	(99)	2	(379)	(74)	(93)	(74)	(620)	(35)	(35)	(35)	(347)	(726)
Other Clinical	0	(6)	(15)	(11)	(19)	(135)	(187)	(52)	(47)	(59)	(345)	(44)	(44)	(44)	(289)	(476)
Non Clinical	(5)	(5)	(5)	(6)	(7)	(8)	(35)	(10)	(11)	(6)	(62)	(13)	(13)	(13)	(67)	(102)
Sub Total	**(235)**	**(255)**	**(338)**	**(264)**	**(337)**	**(381)**	**(1,809)**	**(374)**	**(351)**	**(325)**	**(2,859)**	**(280)**	**(314)**	**(314)**	**(1,958)**	**(3,767)**
Primary Care	(15)	(23)	(28)	(22)	(21)	(21)	(132)	(20)	(18)	(21)	(191)	(30)	(34)	(34)	(157)	(289)
Total Agency	**(250)**	**(278)**	**(366)**	**(286)**	**(358)**	**(402)**	**(1,940)**	**(394)**	**(370)**	**(346)**	**(3,050)**	**(310)**	**(348)**	**(348)**	**(2,115)**	**(4,056)**
Agency Ceiling	(242)	(230)	(220)	(210)	(180)	(155)	(1,237)	(155)	(155)	(155)	(1,702)	(155)	(155)	(155)	(930)	(2,167)
Surplus / (Deficit)	**(8)**	**(48)**	**(146)**	**(76)**	**(178)**	**(247)**	**(703)**	**(239)**	**(215)**	**(191)**	**(1,348)**	**(155)**	**(193)**	**(193)**	**(1,185)**	**(1,889)**

The table below shows total agency expenditure by Directorate.

Total Agency	Actual											Forecast				
	Apr-21 £000	May-21 £000	Jun-21 £000	Jul-21 £000	Aug-21 £000	Sep-21 £000	H1 Total £000	Oct-21 £000	Nov-21 £000	Dec-21 £000	YTD £000	Jan-22 £000	Feb-22 £000	Mar-22 £000	H2 Total £000	Total £000
Acute Services & Urgent Care	(26)	(29)	(70)	(76)	(95)	(131)	(428)	(123)	(157)	(124)	(832)	(64)	(90)	(90)	(648)	(1,076)
North Staffordshire Community	(29)	(80)	(94)	(53)	(63)	(78)	(397)	(81)	(57)	(45)	(581)	(62)	(70)	(70)	(384)	(781)
Specialist Care	(72)	(45)	(65)	(62)	(57)	(80)	(380)	(81)	(42)	(68)	(571)	(60)	(60)	(60)	(371)	(751)
Stoke Community	(88)	(61)	(91)	(64)	(116)	(86)	(507)	(81)	(84)	(85)	(757)	(83)	(83)	(83)	(500)	(1,007)
Workforce & OD	0	0	0	0	0	0	0	0	(2)	(0)	(3)	0	0	0	(3)	(3)
Central Services (Non-recurring schemes)	4	(10)	(18)	(3)	(2)	0	(29)	0	0	0	(29)	0	0	0	0	(29)
Covid-19	(19)	(24)	5	0	0	0	(38)	0	0	0	(38)	0	0	0	0	(38)
Quality & Nursing	(1)	(2)	(2)	(3)	(2)	(2)	(11)	(5)	(3)	(3)	(22)	(3)	(3)	(3)	(18)	(29)
Finance, Performance & Estates	(4)	(4)	(3)	(3)	(2)	(4)	(19)	(2)	(5)	(1)	(27)	(9)	(9)	(9)	(35)	(53)
Total Agency	**(235)**	**(255)**	**(338)**	**(264)**	**(337)**	**(381)**	**(1,809)**	**(374)**	**(351)**	**(325)**	**(2,859)**	**(280)**	**(314)**	**(314)**	**(1,958)**	**(3,767)**
Primary Care	(15)	(23)	(28)	(22)	(21)	(21)	(132)	(20)	(18)	(21)	(191)	(30)	(34)	(34)	(157)	(289)
Total Agency	**(250)**	**(278)**	**(366)**	**(286)**	**(358)**	**(402)**	**(1,940)**	**(394)**	**(370)**	**(346)**	**(3,050)**	**(310)**	**(348)**	**(348)**	**(2,115)**	**(4,056)**
Agency Ceiling	(242)	(230)	(220)	(210)	(180)	(155)	(1,237)	(155)	(155)	(155)	(1,702)	(155)	(155)	(155)	(930)	(2,167)
Surplus / (Deficit)	**(8)**	**(48)**	**(146)**	**(76)**	**(178)**	**(247)**	**(703)**	**(239)**	**(215)**	**(191)**	**(1,348)**	**(155)**	**(193)**	**(193)**	**(1,185)**	**(1,889)**

The table below shows the percentage of agency usage that has been provided by off framework agency providers.

% Agency off framework	Dec-21 %	YTD %
Medical	34%	12%
Nursing	0%	1%
Other Clinical	0%	0%
Non Clinical	11%	8%
Total	**19%**	**7%**

6. CIP

Following the release of the H2 planning guidance the Trust CIP target has been reduced from £2.9m to £1.2m reflecting 1.1% efficiency for the full year which is in line with system partners. Therefore the focus can now move on to delivering CIP from 22/23 onwards, the below table shows the identified schemes to date against the internal draft target of £2.8m for 2022/23. The 2022/23 target will be finalised following the release of planning guidance and preparation of the system and organisational level plans for next year.

		2022-23					
22/23 CIP Scheme Development Tracker		**In development**	**Oversight Group review**	**Further action required for QIA approval**	**QIA**	**Ready for Transacting in 22/23**	**22-23 Forecast**
ASUC	Non Pay review					19	19
ASUC Sub-total		**0**	**0**	**0**	**0**	**19**	**19**
Stoke Community	Transformation skill mix review (N Staffs & Stoke)			19			19
Stoke Community	HSCW establishment review (N Staffs & Stoke)					26	26
Stoke Community	Homeless CIP					111	111
Stoke Community	Mental Health Support Teams Structure Review				44		44
Stoke Community	CYP Eating Disorder					11	11
Stoke Community Sub-total		**0**	**0**	**19**	**44**	**148**	**211**
North Staffordshire	Transformation skill mix review (N Staffs & Stoke)			19			19
North Staffordshire	HSCW establishment review (N Staffs & Stoke)					26	26
North Staffordshire	Mental Health Support Teams Structure Review				44		44
North Staffordshire	CYP Eating Disorder					11	11
North Staffordshire Community Sub-total		**0**	**0**	**19**	**44**	**37**	**100**
Specialist Services	CYP ISH					0	0
Specialist Service Sub-total		**0**	**0**	**0**	**0**	**0**	**0**
Total Clinical schemes in development		**0**	**0**	**38**	**88**	**205**	**331**
Corporate	Trust Board Diligent					10	10
Corporate Sub-total		**0**	**0**	**0**	**0**	**10**	**10**
Total Identified CIP Schemes		**0**	**0**	**38**	**88**	**215**	**341**

7. Statement of Financial Position

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

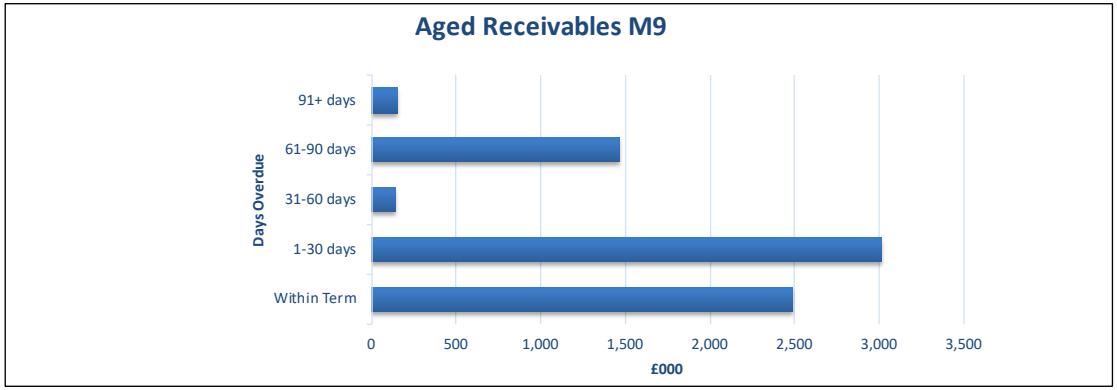
SOFP	Sep-21 £000	Oct-21 £000	Nov-21 £000	Dec-21 £000
Non-Current Assets				
Property, Plant and Equipment - PFI	13,183	13,229	13,271	13,265
Property, Plant and Equipment	16,008	15,980	15,895	16,019
Intangible Assets	413	412	421	424
NCA Trade and Other Receivables	114	114	114	114
Other Financial Assets	0	0	0	0
Total Non-Current Assets	**29,718**	**29,734**	**29,700**	**29,823**
Current Assets				
Inventories	200	206	200	204
Trade and Other Receivables	10,132	11,605	11,769	10,990
Cash and Cash Equivalents	23,705	21,497	23,587	25,443
Non-Current Assets Held For Sale	0	0	0	0
Total Current Assets	**34,037**	**33,308**	**35,556**	**36,637**
Current Liabilities				
Trade and Other Payables	(21,778)	(20,958)	(23,190)	(24,412)
Provisions	(275)	(273)	(272)	(272)
Borrowings	(633)	(633)	(633)	(633)
Total Current Liabilities	**(22,687)**	**(21,865)**	**(24,096)**	**(25,316)**
Net Current Assets / (Liabilities)	**11,350**	**11,444**	**11,460**	**11,321**
Total Assets less Current Liabilities	**41,068**	**41,178**	**41,160**	**41,143**
Non Current Liabilities				
Provisions	(1,281)	(1,281)	(1,281)	(1,281)
Borrowings	(9,068)	(9,019)	(8,969)	(8,920)
Total Non-Current Liabilities	**(10,349)**	**(10,300)**	**(10,250)**	**(10,201)**
Total Assets Employed	**30,720**	**30,878**	**30,910**	**30,942**
Financed by Taxpayers' Equity				
Public Dividend Capital	8,846	8,846	8,846	8,846
Retained Earnings reserve	15,730	15,888	15,920	15,952
Other Reserves (LGPS)	0	0	0	0
Revaluation Reserve	6,144	6,144	6,144	6,144
Total Taxpayers' Equity	**30,720**	**30,878**	**30,910**	**30,942**

Current receivables are £10,990k of which:

- £3,734k is based on accruals (not yet invoiced) relating to income accruals for services invoiced retrospectively at the end of every quarter.
- £7,256k is trade receivables; based on invoices raised and awaiting payment of invoice. (£2,487k within terms).
- Invoices overdue by more than 31 days are subject to routine credit control processes.

Trade and Other payables remain higher as a result of patient placement invoices and accruals.

		Days Overdue				
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	401	1,874	38	852	68	**3,233**
Receivables NHS	2,086	1,139	103	615	80	**4,023**
Payables Non NHS	(3,263)	(406)	(128)	(122)	(123)	**(4,042)**
Payables NHS	(405)	(17)	0	0	(11)	**(433)**



8. Cash Flow Statement

The Trust's cash balance at 31st December 2021 is £25.4m. This is above plan by £1.0m due to lower pay costs and payment runs to date and capital slippage. As service developments commence throughout the rest of the year, payment runs are expected to increase.

A cash forecast was prepared for 2021/22 based on the H1 plan and budget setting assumptions which has then been updated for H2 plans as more information became available on H2 income. This gave a revised plan as at 31st March 2022 of £19.8m against which the Trust is forecasting a £25m year-end balance due to slippage on Project Chrysalis and an increase in patient placements income and other income compared to plan.

	Cashflow summary - Apr 21 - Mar 22											
	Actuals									Forecast		
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Balance b/fwd	**17,803**	**16,152**	**16,034**	**13,743**	**20,596**	**20,684**	**23,717**	**21,489**	**23,578**	**25,442**	**30,705**	**29,122**
Patient Income CCG & NHSE	6,622	7,986	7,685	14,720	10,996	9,096	9,303	8,997	12,582	15,807	9,896	7,781
Local Authority Income	14	0	0	1,401	0	907	0	1,069	3	938	0	300
Other income	1,339	710	1,405	1,450	183	3,062	1,533	3,418	934	2,503	1,284	1,764
PDC Funding												1,668
Total Receipts	**7,975**	**8,696**	**9,089**	**17,571**	**11,180**	**13,064**	**10,836**	**13,484**	**13,519**	**19,247**	**11,179**	**11,512**
Monthly Pay	(5,489)	(5,584)	(5,598)	(5,592)	(5,627)	(6,237)	(6,418)	(6,044)	(6,105)	(6,154)	(6,154)	(6,154)
Non Pay	(3,248)	(3,221)	(5,769)	(5,115)	(5,261)	(3,389)	(6,587)	(5,328)	(5,426)	(7,150)	(6,548)	(7,188)
Capital	(889)	(9)	(14)	(11)	(203)	(120)	(60)	(22)	(125)	(679)	(61)	(2,170)
PDC	0	0	0	0	0	(286)	0	0	0	0	0	(94)
Total Payments	**(9,626)**	**(8,814)**	**(11,381)**	**(10,718)**	**(11,091)**	**(10,031)**	**(13,065)**	**(11,394)**	**(11,656)**	**(13,983)**	**(12,763)**	**(15,606)**
Closing Cash Balance - Main Accounts	**16,152**	**16,034**	**13,743**	**20,596**	**20,684**	**23,717**	**21,489**	**23,578**	**25,442**	**30,705**	**29,122**	**25,028**
Unpresented cheques/uncleared deposits		**(69)**	**(172)**	**(0)**	**(121)**	**(21)**	**(1)**	**(1)**	**(9)**			
Cash in Hand (Petty Cash)	**8**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**
Total Reported Cash Book Balance	**16,160**	**15,974**	**13,580**	**20,604**	**20,572**	**23,705**	**21,497**	**23,587**	**25,442**	**30,714**	**29,131**	**25,037**
Plan	**16,160**	**17,182**	**17,322**	**17,287**	**17,694**	**16,705**	**21,471**	**25,415**	**24,450**	**25,328**	**22,630**	**19,799**
Variance to Plan	**0**	**(1,208)**	**(3,742)**	**3,317**	**2,878**	**7,000**	**26**	**(1,828)**	**992**	**5,386**	**6,501**	**5,238**

9. Capital Expenditure

The Trust's gross capital expenditure plan for 2021/22 has been agreed at £6,621k, including £250k PFI Capital Lifecycle. Capital expenditure at month 9 is £967k compared to a plan of £3,944k, giving a variance of £2,977k year to date. This is as a result of some schemes starting more slowly than anticipated and where slippage has been identified, a mixture of new schemes and schemes brought forward from 2022/23 that are deliverable this year have been brought into this year's capital plan and forecast.

Following the tender response for Project Chrysalis and discussions with Town Hospitals the forecast for the Learning Disabilities, Dormitories Conversion and Alternative Space Provision schemes has been revised to a forecast of £2,000k on the dormitories scheme for 2021/22, with the Learning Disabilities scheme being deferred to later years due to the increased costs against the funding available. The Trust is forecasting total capital spend in 21/22 of £5,678k resulting in an under spend of £943k.

The table below shows the original annual plan and revised plan and forecast which includes recently approved additional schemes. This revised plan will be updated as more is known on the outcome of the review of the Project Chrysalis tender response. Further updates will be reflected as received.

Capital Expenditure	Annual Plan £000	Year to Date			Forecast Outturn		
		YTD Plan £000	Actual £000	Variance £000	Revised Plan £000	Outturn £000	Variance to Plan £000
Strategic Schemes							
Learning Disabilities Facilities	2,381	1,351	0	(1,336)	119	0	119
Operational Schemes							
Environmental Improvements (Backlog Maintenance)	120	80	5	(75)	120	120	0
Environmental Improvements (Incl. Reduced Ligature Risk)	170	120	0	(120)	170	170	0
Medical Equipment	60	0	0	0	13	13	0
Energy Efficiency Programme	75	25	0	(25)	50	130	(80)
Hazelhurst Entrance & Child Place of Safety	0	0	8	8	125	125	0
Capitalised Salaries - Project Chrysalis	100	75	0	(75)	0	0	0
Digital							
Digital Innovations	50	50	0	(50)	50	30	20
Digital Infrasture	235	235	0	(235)	235	235	0
Network Refresh	90	90	67	(23)	96	96	0
EPMA System Implementation	200	141	71	(70)	112	112	0
Capitalised Salaries - IT rolling replacement	40	30	30	(0)	40	40	0
Contingency / Reactive							
Contingency	100	0	(73)	(73)	0	(73)	73
Trust Wide Estates Fleet replacement	0	0	91	91	91	91	0
Summers View Garden Buildings & Courtyard Upgrades	0	0	0	0	100	40	60
Greenfield Centre Entrance Remodelling	0	0	0	0	60	60	0
Additional inpatient devices	0	0	0	0	88	88	0
WIFI point replacement (with HIS for costing)	0	0	0	0	227	227	0
Small Form Factor PC's	0	0	0	0	237	237	0
IT Device Replacement	0	0	175	175	497	497	0
Alternative Space Provision EMU 1st Floor	0	0	14	14	14	14	0
Harplands New Air Conditioning Units	0	0	0	0	40	40	0
Digital signage	0	0	0	0	100	100	0
Additional IPADs	0	0	0	0	100	100	0
Ashcombe First Floor works	0	0	0	0	0	0	0
Purchase mobile unit	0	0	0	0	15	15	0
Data Warehouse	0	0	0	0	644	644	0
Total Trust Funded Capital Expenditure	**3,621**	**2,197**	**388**	**(1,795)**	**3,343**	**3,151**	**192**
Dormitory Conversion	2,750	1,559	391	(1,182)	2,750	2,000	750
WIFI Improvement Programme	0	0	0	0	340	340	0
Total PDC Funded Capital Expenditure	**2,750**	**1,559**	**391**	**(1,182)**	**3,090**	**2,340**	**750**
PFI Lifecycling	250	188	187	(1)	188	187	1
Total Gross Capital Expenditure	**6,621**	**3,944**	**967**	**(2,977)**	**6,621**	**5,678**	**943**

10. Better Payment Practice Code

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

During month 9, the Trust has achieved the 95% target in terms of both the total number of invoices paid within 30 days, and the value of invoices paid within 30 days. NHS invoices in month 9 achieved the 100% on value and 98% on the number of invoices. Non-NHS achieved 98% on value against the target of 95%, and 99% on the number paid in the target in month. Year to date overall the Trust is achieving 96% on the number of invoices paid but falling below target on the value at 92%.

It is expected that as the backlog of invoices is cleared, the monthly performance against target will improve and bring the Trust back in line with the target.

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

	2020/21 Total			2021/22 Month 9			2021/22 Total		
Better Payment Practice Code	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**
Number of Invoices									
Total Paid	430	9,453	9,883	51	1,162	1,213	340	10,061	10,401
Total Paid within Target	406	9,206	9,612	50	1,145	1,195	319	9,674	9,993
% Number of Invoices Paid	94%	97%	97%	98%	99%	99%	94%	96%	96%
% Target	95%	95%	95%	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**-1%**	**2%**	**2%**	**3%**	**4%**	**4%**	**-1%**	**1%**	**1%**
Value of Invoices									
Total Value Paid (£000s)	7,998	45,262	53,260	457	6,504	6,961	4,754	52,654	57,408
Total Value Paid within Target (£000s)	7,406	44,299	51,705	456	6,389	6,845	4,577	48,498	53,075
% Value of Invoices Paid	93%	98%	97%	100%	98%	98%	96%	92%	92%
% Target	95%	95%	95%	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**-2%**	**3%**	**2%**	**5%**	**3%**	**3%**	**1%**	**-3%**	**-3%**

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.

11. Recommendations

The Finance and Resource Committee are asked to:

Receive the Month 9 position noting:

- The reported year to date position of £646k surplus.
- Note the 2021/22 agreed capital plan and year to date position.
- The cash position of the Trust as at 31st December 2021 with a balance of £25.4m.
- Agency expenditure of £346k in month against the agency ceiling of £155k; **an adverse variance of £191k to the agency ceiling.**
- Note the achievement of transacted CIP schemes totalling £1,300k against a target for the year of £1,200k.

REPORT TO PUBLIC TRUST BOARD

Enclosure 10

Date of Meeting:	10th February 2022		
Title of Report:	Finance & Resource Committee Assurance Reports		
Presented by:	Russell Andrews Chair/Non-Executive Director		
Author:	Kimberli McKinlay –Interim Director of Finance		
Executive Lead Name:	Eric Gardiner, Executive Director of Finance, Performance and Estates	**Approved by Exec**	☒

Executive Summary:		**Purpose of report**	
This paper details the items discussed at the Finance & Resource Committee meeting on the 3 February 2022		**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. We will attract, develop and retain the best people ☐ 2. We will actively promote partnership and integrated models of working ☐ 3. We will provide the highest quality, safe and effective services ☐ 4. We will increase our efficiency and effectiveness through sustainable development ☒		
Risk / legal implications: Risk Register Reference	Oversees the risk relevant to the Finance & Resource 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		
Shadow ICS Alignment / Implications:	The Trust Financial performance feed into the overall STP Financial Position.		
Recommendations:	The Trust Board is asked to receive the contents of this report for information and assurance.		

Version	Name/group	Date issued

Finance and Resource Committee
Assurance Report to the Trust Board
3rd February 2022

Finance and Resource Committee Report to the Trust Board – 10th February 2022.

This paper details the items discussed at the Finance and Resource Committee meeting held on the 3rd February 2022. The meeting was held as a MS Teams conference meetings and were quorate with minutes reviewed and approved from the previous meeting on the 6th January. Progress was reviewed and actions confirmed from previous meetings. Declarations of interest were noted.

Chairs Actions

None noted.

Performance

- **IQPR**

The Committee received the IQPR report. In month 9 performance was reported as good with access and waiting times performing well despite workforce pressures in M9 in sickness, turnover, vacancy and agency rate. No new PIPs were issued in month 9 and 2 PIPs remain in place. It was noted that 48 hour and 7 day follow up was below standard but these were small numbers and breach rectification forms provided assurance that there is no risk as a consequence. There are 4 special cause variations (orange variation flags - signifying concern) a reduction from that seen in month 8. The Committee were assured that detailed performance data relating to learning disability was reviewed at directorate level and formed part of the overall Specialised Services directorate data for Committee.

The Committee noted the contents of the report.

Capital and Estates

- **Project Chrysalis Update**

The Associate Director of Estates updated the Committee on the current position of the project both in terms of the timeline of events and an overview of the latest financial position. The Committee were assured that there had been partial resolution relating to the Letter of Indemnity with the remainder expected to be resolved before the end of the month. It was noted that a Letter of Intent had been issued to the contractor which had enabled the commencement of long lead procurement items. A thorough discussion took place regarding the implications, risks and mitigations in place as a result of the issuing of the Letter of Intent. The Committee thanked the Associate Director of Finance and the Head of Estates for progressing these issues.

Finance

- **Finance Update**

Month 9 Position - The Committee took the paper as read. The month 9 position shows a small surplus against plan for the month. Following a deep dive during month 9 the year end position is forecast to breakeven however there continues to be the risk of slippage against some non-recurrent spend schemes and the receipt of further non recurrent income from the centre. Capital spend continues to be materially behind plan in M9 however further schemes have been approved for delivery during Q4 and is forecasting a small under spend at year end however the Committee noted this was dependant on Project Chrysalis. The cash balance is slightly higher than plan at M9 mainly due to delays in the receipt of some commissioner funding offset by capital slippage and vacancies. Agency costs continued to be materially higher than the ceiling in M9 if it were in place for monitoring purposes. The Committee noted that the Better Payment Policy was achieved in month and thanked the team for a high-quality finance report.

The Committee noted the month 9 position.

- **22/23 Financial Planning Update**

The Deputy Director of Finance updated the Committee that the draft finance plan for 2022/23 was currently being worked through following receipt of the initial funding envelope from the ICS. The Committee were informed that system allocations for next year were returning to the ICS for distribution and were to be agreed locally, rather than national mandated blocks. System partners intended to return to the distribution of local resource based on the IFP principles which were being refreshed and amendments agreed in the coming weeks. The Committee were assured that the underlying system position was based on pre-pandemic business as usual activity and not representative of current run rates which would be fed into planning assumptions over the coming weeks. The Committee noted that the draft plan is due to be submitted in mid-March with an initial view and discussion to allow finalisation of the IFP income at the next System DoF's meeting in a week's time.

The Committee noted the update and looked forward to receiving the draft 2022/23 plan at the March meeting.

- **Draft 5 Year Capital Plan**

The Deputy Director of Finance presented to the Committee the latest draft 5 year capital plan. Capital allocations for the system had been confirmed for the next 3 years as part of planning guidance released and therefore discussions with system partners were commencing shortly regarding the split of the system capital resource limit (CRL) for each organisation. The Committee were made aware that due to commitments relating to Project Chrysalis and the potential impact of IFRS16 the Trust would be requesting from the system a level of CRL which would be more than a calculated "fair share" across the system. The Committee agreed to revisit risk 1403 relating to the risk regarding sufficient levels of CRL to deliver the Trust capital plan, noting discussions at DoF level had commenced to mitigate against this. A discussion took place regarding including the intention to complete phase 2 (inc Learning Disabilities) of Project Chrysalis in 2024/25 and including a placeholder in the capital plan.

The Committee noted the update.

- **Data Warehouse Business Case**

The Associate Director of Performance presented a business case detailing the proposal for a

new data warehouse and moving away from the current arrangements given they were not deemed fit for purpose. The Committee noted that notice had been given in November 2021 to the current supplier and if approved there would be an extended period of double running. A detailed discussion followed, and the Committee approved the proposal subject to ongoing revenue funding being affordable in the 2022/23 financial plan which would be prioritised in the coming weeks along with other cost pressures as part of the finalisation of budget setting.

The Committee supported the proposal for review at Trust Board.

- **Recruitment and Retention Premia**

The Associate Director of Transformation presented a business case detailing the proposal for a recruitment and retention premia to be introduced on a number of the Trust's inpatient areas. It was explained that the impact of the pandemic on the wellbeing of staff especially in Acute area's was making recruitment and retention very difficult. This proposal was intended to develop the Trust's ability to be the employer of choice and aid towards reducing the levels of vacancy in these areas over the next 18 months to 2 years. Upon querying the exit strategy for the scheme the Committee were assured that this was not intended to be a long-term solution, more an interim proposal until a number of apprentices that the Trust is currently supporting are able to qualify.

The Committee supported the proposal.

Strategy, Partnerships and Digital

- **Digital Update**

The Committee took the paper as read which included an update across all live projects. The main points highlighted to the Committee were:

- Discussions are underway with Dedalus to move the contractual arrangement from NHS Digital to the Trust which was defined as part of the original case.
- Work is progressing to coordinate the procurement of video consultation software following the cessation of national funding in the current financial year. The Trust is continuing to participate in a regional consortium of NHS providers but is required to undertake its own procurement arrangement. The business case was approved by the SLT Committee in principle and is currently being included in the financial prioritisation process.
- The Trust were successful in a capital funding bid relating to digital infrastructure for £340k related to additional wireless access points which this was already part of the Trusts capital programme.

The Committee received an update report on the work of the Digital Aspirants Programme and focussed in particular on the extension of the timeline of the programme and upcoming EPMA deployment.

Risk Register:

The Committee received the report as read noting and approving an increase in risk 1540 to acknowledge pressures on the Digital Aspirant capacity due to the pandemic. The Associate Director of Governance assured the Committee that risk 1403 relating to capital resource limit would be reviewed and updated for the March meeting following the discussions regarding the 5 year capital plan.

Other Reports received:

- Estates Update Report
- STP Month 9 Finance Report
- Q3 BAF

Recommendation

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

On Behalf of Russell Andrews
Chair of Finance and Resource Committee

REPORT TO PUBLIC TRUST BOARD

Enclosure 11

Date of Meeting:	10th February 2022		
Title of Report:	Board Assurance Framework Report Q3		
Presented by:	Laurie Wrench, Associate Director of Governance		
Author:	Laurie Wrench, Associate Director of Governance		
Executive Lead Name:	Dr Buki Adeyemo, Interim CEO	**Approved by Exec**	☒

Executive Summary:	**Purpose of report**	
The Board Assurance Framework (BAF) for 2021/22 aligns the Trusts strategic objectives to our quality priorities and key risks. The BAF provides oversight of the key control and assurances to be introduced and mapped against our four strategic objectives. This is the Q3 report for 2021/22.	**Approval**	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☒ Execs ☐ Date: 1st February 2022	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. We will attract, develop and retain the best people X 2. We will actively promote partnership and integrated models of working X 3. We will provide the highest quality, safe and effective services X 4. We will increase our efficiency and effectiveness through sustainable development X		
Risk / legal implications: Risk Register Reference	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). See wider D&I Guidance	The BAF describes the ongoing work regarding diversity and inclusion		
Shadow ICS Alignment / Implications:	N/A		
Recommendations:	Members are asked to receive the BAF for information and assurance purposes noting the mapping of controls and assurances against the four new strategic objectives and Q3 update against progress.		

Version	Name/group	Date issued
1	L Wrench	27.01.2022

Board Assurance Framework (BAF) 2021/2022- Quarter 3 Update – February 2022

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

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

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

Those key risks, mapped against our current new four strategic ambitions are set out in the following pages. We have also categorised each objective against our quality priorities – SPAR. A full refresh of the BAF will be undertaken following the publication of pending national guidance and the formal agreement of the new Trust strategic objectives to fully reflect the deliverables of the Trust's enabling strategies; Quality, People, Partnerships, and, Sustainability.

Objective 1: Quality	We will 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		Quality (Innovation)		Regulation		Reputation			

	Gross Risk (no mitigation)			Residual Risk (with mitigation)			Target Risk (31/03/22)		
	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE
RISK: *The Trust fails to collaborate with service user and carer involvement resulting in an inability to deliver responsive services.* *Risk Trend Arrow*	4	3	12	3	3	9	2	3	6
RISK: *The Trust fails to deliver safe and effective services, resulting poor care, reputational harm and regulatory restrictions* *Risk Trend Arrow*	4	4	16	3	4	12	2	4	8
RISK: *The Trust fails to exploit its potential in research and innovation, resulting in a loss of credibility and a failure to improve services.*	4	3	12	3	3	9	2	3	6

Risk Trend Arrow 									
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 • 423 – Compliance with MHA/MCA • 1112 – Ligature anchor points • 1344 – Non anchored ligature self-harm • 1113 – Community pathway for personality disorder • 1383 – Covid-19 pandemic (quality of services) • 440 – 3 hour assessment timescale (section 136) • 1446 – Covid-19 pandemic (increasing demand) • 1218 – LA funding for substance misuse services • 1139 – Continuity of prescribing								

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**

SPAR Reference	CONTROLS to Mitigate Strategic Risk	Level of Assurance	Description of Assurance	Exec Owner	Year Start RAG	Qtr Due	Forward Plan/Progress	Q3 RAG	On Target RAG	Year End RAG
R	Enhance Service User & Carer Collaboration - Focus on Service Users Recovery.	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		Q3	Business Case for the development of the Wellbeing Academy has received Executive approval and recruitment has commenced. Recruitment will have a strong focus on ensuring co-production and co-facilitation to maintain fidelity to the model. The Trust is working in partnership with ImROC to support embedding co-production across our services. Board session took place in Q3 with sessions plans in operational teams during Q4. Wellbeing college model agreed with service users and carers, however delivery slightly delayed due to recruitment and impact of COVID. Full implementation will now be in 2022/23			
AR		2	Further embed Peer Support Workers and Peer Support Mentor roles, as a key component of our workforce having lived experience.	DON		Q3	LD and CAMHS workers in post and working within teams An accredited training programme for Peer Support Workers has been secured.			

			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.				Volunteers now returned to workforce and peer support pathway being formalised as part of work with ImROC			
SPAR	CQC Rating of 'Outstanding' is maintained.	3	A rating of 'good' for all core services in the Safe domain (Adult Inpatient Wards).	CEO		Q4	Inspection preparation well underway pre-covid now reinstated with amongst other things well led session with Board having occurred. Face to face inspections now in place nationally. Primary Care inspection has occurred with positive outcome			
SPAR		3	An increase in the number of core services rated as 'outstanding' currently 3/11).	CEO		Q4	Awaiting confirmation of new inspection regime and requirements from CQC. Likely to carry over to 2022/23. Ongoing engagement with new inspectorate team			

SPAR	Continue work to strengthen approach to risk management including:	1	Risk appetite analysis is undertaken for strategic risks.	ADG		Q4	Focus on key areas of risk e.g. TCP and P86			
		2	Undertake residual and target score gap analysis 6 monthly.	ADG		Ongoing	Deep dive undertaken for Trust wide risks – to continue. Risk registers reviewed monthly and reported through			

		2	Undertake deep dive for long standing risks 6 monthly.	ADG		Ongoing	Directorate, SLT and Committees and mapped to BAF			
SPAR	Develop a Trust wide systematic approach to quality improvement.	1	Continue to strengthen relationship with the CQC via regular engagement meetings and new inspection team	DON		Ongoing	Regular engagement meetings with the CQC have taken place through the COVID period. Including a successful TMA New CQC team now in place, plans for engagement continue and CQC preparedness has commenced.			
		2	Develop and implement Combined Quality Improvement (QI) strategy	DON		Q1	QI lead working with UHNM QI lead to embed QI tools into System Connects programme reaching 40 additional B7& B8 leaders.			
		3	Embed SPAR accreditation across all inpatient wards (pilot completed 18/19).	DON		Q4	There have been further wards under taking the process, but at a reduced schedule due to COVID.			
S	People with complex needs are supported.	2	PD Pathway will be established.	DO		Q1	PD service started taking referrals. Service now fully established.			
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.	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		Q1	A new Suicide Awareness scorm package sourced from the Zero Suicide Alliance (ZSA) and will be available in Q4 for all Combined Healthcare.			

S		2	Investment in environmental ligature improvements as per the capital plan.	DO		Q4 and beyond	National funding approved for Dormitory eradication. Inpatient Reconfiguration Programme established to oversee all inpatient investments and improvements.			
S		2	Complete PDSA cycle into panel review methodology to improve learning from serious incidents.	MD		Q3	Findings of review to inform the Trust's approach to structuring 'Panel Reviews' throughout the Trust. Staff surveys undertaken by the Trust audit team; a summary report of these audits has been submitted to SLT. Consultant Psychiatrist Dr Chubb is also reviewing in order to prepare a report for the HSJ with any learning disseminated trust wide accordingly. CPD session held with Medics to share learning from this approach.			
SPAR	Every patient can expect Mental Health Law compliance.	1	Zero tolerance for failure to comply with the MHA:	MD						
			Two LiA workshops (informed by QI methodology) to be held for section 17 leave and consent.	MD		Q4	The Section 17 steering group which has two work streams: Digital Group and Practice/Process Group had to be postponed due to COVID19. Work is set to commence again in Q1.			

		1	100% compliance with requirements for Section 17 leave.	MD		Ongoing	COVID has led to further delays - to provide assurance of improvement in compliance with Section 17. The Trust re-introduced the quarterly mental health law audit Trust wide during Q4. Initial findings have been shared with the individual teams with a request for feedback on any issues with completing the audit. Before we can provide assurance, it has been recognised that there is still some work to be done with the performance department in readiness for when the Q1 2021-2022 audit is requested. Awaiting Q3 compliance figures			
		1	100% compliance with requirements for consent.	MD		Ongoing	COVID has led to further delays - to provide assurance of improvement in compliance with the requirements for Consent. The Trust re-introduced the quarterly mental health law audit Trust wide during Q4. Initial findings have been shared with the individual teams with a request for feedback on any issues with completing the audit. Awaiting Q3 compliance figures			
AR	Dual Diagnosis is in the third year for this programme of work.	2	Integrate DD strategy by disseminating and publicising.	MD		Q1	Training continues to be delivered online as part of the Trusts training programme, available through LMS.			

	Delivery of the Trust wide Strategy for service users with Dual Diagnosis.						Work has begun to integrate the dual diagnosis strategy into each of the clinical pathways, with the psychosis pathway being the first to complete. A clinical audit has begun within the Stoke directorate assessing practice against NICE guidance [QS188]. The findings will be shared through CEG. A review of the existing service provision and design commenced in Q3 with the support of a Project. Support Manager. .They will work with the Clinical Lead (medic) appointed to oversee project to identify current gaps in provision and work collaboratively with colleagues to develop the service offering based on best practice. Ongoing scoping of documents and literature with a short survey agreed with a view to cascade to all staff in dual diagnosis services, to identify what is going well and areas for improvement. Meeting planned for the 14/01/2021 to discuss the improvement of uptake of IAPT services in those with co-occurring mental health and substance use needs.			

AR		1	Establish joint case review processes in all Directorates for all service users with DD.	MD		Q2	Joint case reviews is being established in all four CMHT settings on a monthly basis. A similar process has commenced within the early intervention team, however this is still at an early stage at present. Acute Psychiatric services, Liaison psychiatry and Substance Misuse services have established a working group to consider effective pathways for those with dual diagnosis in acute psychiatric wards. Medical Consultant leadership from both substance misuse and adult psychiatry are in attendance. An outline pathway has been agreed and specific work around alcohol detox has been progressed. A review commenced in Q3with support from a dedicated project manager to support.			
S	Revise Pharmacy strategy to ensure delivery of integrated working within the community teams.	1	Each Pharmacist to complete an innovation project within their Directorate.	MD		Q3	Due to the impact of COVID-19 project work has had to be delayed. Likely to carry over to 2022/23			
A	Services are responsive to the needs of service users.	1	92% compliance for referral to treatment (2nd contact) in 18 weeks.	DO		Quarterly	97.6% in Q3			

SA		1	100% compliance with 3 hour assessment target for service users entering the Place of Safety (where clinically appropriate).	DO		Quarterly	82% in Q3			
A		1	95% compliance referral to assessment within 4 weeks (CAMHS).	DO		Quarterly	Aspirational target set by the Trust. 95.3% in Q3.			
A		1	There are zero acute adult mental health out of area placements.	DO		Quarterly	There has been no inappropriate out of area placement during Quarter 3.			
SPAR	Ensure delivery of the Research Strategy.	1	Launch mandatory GCP training for clinical professionals – 85% medics achieving compliance.	MD		Q3	There are 34 clinicians recorded on EDGE with an in date GCP certificate across the Trust, a 24% decrease from Q2. GCP continues to be closely monitored and reported on through the Performance reporting framework with regular updates to, CEG and, R&D steering group. Senior Lecturer and Honorary Clinical Lecturer post are now in place.			

SPAR		1	Support and develop roles within the Trust structure. Identify one Principal Investigator (PI) within each specialty to ensure research delivery.	MD		Q1	• One PI identified in all six clinical specialties; AMHI, AMHC, OP, LD, CYP, NP. • Not all PI's are presently active due to the lack of open studies within some specialties due to COVID-19, the teams will consider how best to maintain their skills during this time.			
SPAR	Implement a Trust wide innovation Strategy to support widespread engagement and to celebrate the successes achieved.	1	Establish an Innovation Group incorporating expertise from across the Trust • 10% increase of ideas presented at Innovation Nation	MD		Q3	Dragons Den platform being explored with a potential date for Spring 2022. R&I working with Talent & Leadership Manager to align and integrate Innovation into Leadership development activities e.g. Leadership Academy & System Connects			
SPAR		2	Develop and implement an 'Innovation Strategy' with support from MIDTECH and AHSN – to be approved by QC.	MD			Innovation Collaborative group established to support the innovation agenda within the Trust. R&I strategy progress continues to be reviewed and monitored as part of Research and Development Steering Group and Innovation Collaborative meetings. Presented to Board 2021. R&D Away day held November 2021.			

Objective 2: People	We will attract, develop and retain the best people									
SPAR PRIORITY										
Exec owner:	Director of People, 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 (31/03/22)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	3	4	12	2	4	8	2	4	8
RISK: *The Trust fails to attract, develop and retain talented people resulting in reduced quality and increased cost of services* *Risk Trend Arrow* 	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	4	5	20	3	5	15	2	5	10

which will impact on the safety, wellbeing and capacity of staff and patients									

Links to 12+ Trust Risks	**Description of linked 12+ Trust Risks** • 12 – Staffing. • 1011 – Exec capacity and STP • 900 – Diverse and Inclusive services. • 901 – Diverse and inclusive workforce. • 868 – Agency spend. • 1313 – Psychological services. • 992 – Lorenzo training.

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		

			Description of Assurance			**Qtr Due**	**Forward Plan/Progress**	**Q3**		

SPAR Reference	CONTROLS to Mitigate Strategic Risk	Level of Assurance		Exec Owner	Year Start RAG			RAG	On Target RAG	Year End RAG
	Develop and deliver a strategy for the Psychology workforce with the key objectives of research, recruitment and retention.									
SPAR		1	Deliver psychology led conference in partnership with Staffordshire University to Launch new Psychology Strategy.	MD		Q1	Strategy group have decided to refocus on a face to face or hybrid conference event in late spring/early summer 2022			
SPAR	Upskilling our workforce (new, existing and those returning).	2	Maximise the apprenticeship levy to meet the future needs of the workforce based on the care pathways and business plan.	DPO DI		Q4	We are in a strong position in that we continue to exceed our monthly contributions and are utilising the underspend, which means we currently do not have funds expiring from the levy account. We have had 24 new starters in Quarters 1 - 3 and expect to meet/exceed our public sector target again in year.			
SPAR	Maximise collaborative working across the STP to build skills and capacity in the local health economy.	1	Continue to develop programmes in collaboration with delivery partners and other NHS Trusts and stakeholders. Cohorts of staff from local	DPO DI		Q4	The Trust has procured and delivered a suicide training course for GPs across the STP. Additionally, we have developed and trained two Train the Trainer Dementia Level 2 courses and two Dementia Tier 2 courses. With further planned in quarter 4.			

			health economy learning together.				The System Connects Leadership Development programme designed & delivered with colleagues from UHNM launched in July 2021 is now mid-way through. With 2 cohorts at Platinum and 2 cohorts at Gold level with 20 NSCHT staff on each programme. High Potential Scheme – system wide leadership programme. First pilot site for NHS. 1st cohort finishes in March 2022. 2nd cohort trialling buddy model approach in conjunction with Shropshire, Telford and Wrekin ICS planned to begin in Q1. Successful delivery of 3 Inclusion Summer School Masterclasses across the system (May to July 2021) Delivery of an education programme for very senior leaders across the system on race inclusion (54 system attendances in Q2 and a further 159 system attendances in Q3. Ongoing rollout in planning for Q4. Development with our partners of a system wide virtual work experience platform, utilising our people to deliver role model video of different			

							professionals. Planned attendance of our professionals at a Virtual Work Experience Conference to be delivered in Q4. An ICS-wide health and wellbeing festival is in the planning and co-design stages ready for delivery in Q4 (week commencing 28/02/22). International guest speaker confirmed, project team meeting weekly. Following advice from AA and Samaritans of running our alcohol awareness event in Jan/Feb System-wide Coaching and Mentoring offer for staff in place since Q1. Partnerships and working groups established with local education providers including Keele Uni, Stoke College, local schools & Careers Enterprise Company to raise the profile of Combined Healthcare as a local employer of choice.			
SPAR	Learning and development options reflect the demands of our sector and the investment in Mental Health through the 10 year Plan.	1	Develop a suite of learning and development options that reflect the demands of our sector.	DPO DI		Q4	New Chapter on LMS: Bitesize sessions covering subjects as requested by our people: coaching, apprenticeships, TNA, Leadership, Developing Diversity etc			

							Mandatory Trainer post advertised and to be recruited to Q4 Physical Health training preparation and planning underway and to be implemented in Q4 Development of a Development programme for Support Staff to be delivered in Q4. A Leadership and Quality Improvement Virtual Development Programme was developed between Nursing and OD 2 cohorts planned which commenced in March and September 2021 and aimed at Band 5/6 nurses and AHPs. The 8 month programme will support staff to become excellent leaders who understand the values of patient-centred care; become aware of their own leadership style; explore resilience and how it influences own personal effectiveness and relationships with others; enable staff to develop and lead a sustainable and compassionate culture and understand and implement quality improvement tools and techniques. Plans to continue this programme with modules & psychometrics delivery			

							supported by OD with a further 2 cohorts planned for 22/23				
SPAR	**Equality Delivery System (EDS)** The care that services users and carers receive respects (reflects) the diverse requirements of our local population	2	The workforce more accurately represents the community it serves through themes identified within the: • Staff Survey • WRES • WDES • Annual D&I report	DPOD I		Q4	• WDESEnd of Q3 WF :- - Ethnicity: **– 9.04% (156 people)** stating ethnic diverse heritage [up from 8.8% (150 people) at end Q2] • Disability **– 5.85%** of workforce (101 people) declaring disability [up from 5.4% (92 people) at end Q2] 'Mind the Gap' exercise undertaken in Q3 by Workforce Information team to support further closing of our WF equality data gaps. Inclusive recruitment programme ongoing with focus on recruiting for greater diversity and inclusion (including flexible working) Trust EDS for 2021 in development and due for publication (in line with system colleagues) by end March 2022. Learning Disabilities services being reviewed as part of this. November 2021 – Finalist in HSJ Awards for Staff Engagement Award for Trust work on engagement, inclusion and staff health and wellbeing			

							December 2021 – Finalist in 3 categories at the Recruitment Industry Disability Initiative Awards for Expert by Experience roles in Learning Disabilities. Work commenced with Recruitment to determine application levels over a rolling 12 months of those from underrepresented groups compared to other groups as part of understanding existing development gap analysis.			
SPAR	Deliver Talent Management Strategy linking Trust People & OD strategy and the Regional Talent Review									
		1	Hold staff engagement sessions.	DPO DI		Q3	A series of early engagement sessions held with key stakeholders on Inclusive Talent Management approach following Nov 21 Talent & Leadership Managers appointment. Delayed NHSI/E progression of a supporting Leadership Compact and system co-design group for regional Talent processes delayed due to national ongoing Covid pressures. Talent & Leadership Manager has monthly updates with other system leads & subject matter experts to progress the shaping of internal approaches in the interim.			

							Scope for Growth development & early engagement commenced with approach being aligned to updated Combined Healthcare's internal appraisal processes. Pilot groups of our current and future HPS cohorts, Stepping up Alumni, New Futures participants all identified as part of the initial pilot. Train the trainer booked for Q4, ready for launch Q1.			
		1	Launch Talent Management Steering Group.	DPO DI			Plans to review & update TOR's for the HPS steering group to encompass a "system talent steering group" (working title) to progress Inclusive & System Wide Talent Management. Inclusive Talent Management will also link into the Trusts existing Development Group & Inclusion Council to ensure co-creation is central to our approach			
		1	Approve Inclusive Talent Management approach & action plan.	DPO DI			Staff engagement has taken place and draft priorities & action plans developed. Early engagement has identified 3 key work streams mapped to NHS and Trust people plan including; 1) Quality Development Conversations, 2) Our Combined Leadership Journey & 3) Growing the			

							Future Workforce. Further engagement sessions planned for Jan 2022 to further shape the action plan Papers under development for Feb & March Exec/SLT's on work streams 1 & 2 with ongoing work with Workforce BP's, recruitment & wider teams to determine and prioritise the needs for aspect 3.			
SPAR	Establish the Trusts employment offer.	1	Develop comprehensive and competitive attraction and retention offer	DPO DI		Q1	Both the Trust's Vacancy and Turnover position have significantly improved in year. A vacancy task and finished group has been initiated with key internal stakeholders to identify robust workforce supply opportunities for hard to fill roles (chaired by DDoO). Launch in May 2021 of workforce planning methodology 'Planning for our Future Service and People needs – Combined's Workforce Planning Cycle', to support longer-term planning and mitigate risks associated with future workforce supply challenges. Operating Plan submitted to direct future workforce demands aligned to service transformation. Workforce planning response to H2 2021/22 NHSE/I request is currently being			

							drafted, again outlining workforce demand required to meet future needs aligned to service transformation. Trust wide Vacancy Management Plan launched in July 2021 with 36 schemes (as of 26/10/21). Scope is to address recruitment and retention issues, particularly reflected by high turnover and vacancy rates in inpatient settings and hard to fill posts, such as nursing and consultants linked to national and local supply shortages. Collaborative working with System Partners to identify System wide recruitment and retention opportunities. Developing widening participation with local communities with a virtual work experience platform to attract younger people towards careers with NSCHT. With the first Mental Health (system) Virtual work experience launch in Q4.			
SPAR	Enhance our staff and wellbeing activities and initiatives to ensure that our working environment is supportive and encourages self-care.	1	Refresh workforce Health and Wellbeing Strategy – focused work streams regarding: • Musculoskeletal • Stress, Anxiety and Depression	DPO DI		Q3	Business case for introducing Wellbeing Ambassadors signed off at Execs and shared at SLT, ready for final sign-off at PCDC on 7th Feb.			

		1	Enhanced presence of H&W via CAT and supporting communications	DPO DI		Q1	Health and wellbeing package and support/advice available Working with Comms colleagues to increase profile of Staff HWB support and improve access to support. Monthly HWB staff newsletter started week commencing 25th October.			
SPAR	Deliver OD interventions to support staff engagement aligned to staff survey trends	2	Ensure the Staff Survey results (2020) are promoted and celebrated Development of an annual cycle of activity using a cross sectional approach and regular engagement, ensuring action plans reflect Directorate ownership	DPO DI		Q2	National Staff Survey launched Sept – Nov 2021 and achieved the highest response rates ever with a 64% response rate. Results expected March 2022. Mandated Quarterly People Pulse Survey approved for implementation by senior executive team.			
SPAR	Encouraging an open, fair, inclusive, transparent and just culture.	1	Widen the focus of the Inclusion Council to include other protected characteristics.	DPO DI		Q3	Continued development of FTSU Champions role, engagement of FTSU Guardian with Trust Staff Networks and development of a more diverse pool of Champions Our proposed Talent Management approach & priorities will encompass inclusion & equality as a core principle. Working closely with Inclusion lead to align activity & conduct equality impact assessments throughout.			

A	Co-create with staff and service users relevant and appropriate communication and engagement opportunities.	2	Build and extend Awareness Days calendar by liaison with staff groups and service users.	DPO DI		Q4	Ongoing delivery against a diverse range of awareness days / weeks ongoing in conjunction with OD/Inclusion and Comms teams. Eg celebrating World Religions Day in January, LGBT+ History Month in February, International Womens' Day in March, and much more. We participated in sharing a programme of events, information and webinars for Black History Month (October) along with system colleagues. Our Disability History Month activities included our Autumn Inclusion School (23rd November) as well of sharing of relevant information and a number of free online education events and webinars. Refreshed opportunity to align and signpost to wider engagement & learning opportunities embedded into new standard templates for Leadership Academy	GREEN		
SPAR	Embed Values and Behaviour framework.	2	Evidenced in all development programmes e.g. In Place Systems Leadership Programme	DPO DI		Ongoing	Successful delivery of all 3 Winter Inclusion School and 3 Summer Masterclass inclusion school events in 2020-21 and 2021-22.			

		2	Develop a Values recognition scheme in addition to the current compassion scheme.			Q1	REACH 2021, record applications, compassion scheme ongoing through the pandemic			
SPAR	Leadership framework is visible throughout our documentation	2	Leadership framework evidenced in all development programmes.	DPO DI		Q1	Our current leadership development opportunities mapped to our talent pipeline utilising the Combined Leadership, Talent & Improvement Journey. Paper goes to SLT in Feb for approval. Underpinning leadership framework with mapping to existing and scoping of future programmes commenced for Exec approval by year end.			
		2	Leadership development available at all stages of the talent pipeline in preparation for the link to the Regional Talent Board.	DPO DI		Q4	All current leadership development opportunities mapped against our talent pipeline. Ongoing work with system partners and signposting to existing and quality assured offers will further deepen the reach of our leadership development offer. Further refinements to our appraisal process will seek to capture greater level of aspirations, development needs & readiness for our workforce System Connects Leadership programme has reached mid-point			

							and delivery has continued throughout the ongoing covid pressures. Further discussions scheduled for expanding the offer to include Silver Connects for Bands 5 & 6 considered providing early leadership development offerings for our talent pipeline. Ongoing engagement with our system and Trust Stepping up alumni in Q3 including encouragement to participate in coaching and also to seek to develop skills in becoming an accredited coach. Fully funded training places shared December 2021 for commencement in Q4 (positive action, open to BAME applicants only). External supplier commissioned for a new cohort of a Stepping Up (equivalent) programme in Q4 called 'New Futures'. Open to applications December 2021 for Feb-March 2022 commencement. 30 places available New system-wide reciprocal mentoring programme in development for launch Q4 Comfortable being uncomfortable with race and difference programme delivered to 213 system leaders in Q2 and Q3 as above. Feedback excellent.			

							Wider roll-out in development. Feedback excellent.			
SPAR	Promote and extend our reach into all communities within our localities.	1	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.	DPO DI		Q3	LEAP programme launched and initial sign-ups secured. Stakeholder Map and Listening Landscape under construction.			

Objective 3: Partnerships	We will actively promote partnership and integrated models of working								
SPAR PRIORITY									
Exec owner:	Director of Partnerships, Strategy and Digital								
Assurance Committee:	Finance and Resource 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.*	**Gross Risk (no mitigation)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/22)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
Risk Trend Arrow	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** • 1010- Scale and scope of STP plans. • 1103 – Primary care integration. • 1113 - Community pathway for Personality Disorder • 1139 – GP prescribing.								

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	Q3 RAG	On Target RAG	Year End RAG
ARP	Ensure we are constantly pushing channel development to ensure the Trust is at the forefront of digitalisation that will enhance service user engagement.	2	Embed digital channels across all service areas including the use of Combined Podcast. Create subtitled versions on Youtube to ensure inclusive as possible.	DSPD		Q1	Combined Podcast established Trust has active presence on YouTube & other social media platforms			

			Implement Social Media Optimisation Plan.							
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.	1	Work with partners to deliver Suicide Charter:	MD		Q4	Following the cancellation of several speakers, it was collectively agreed that the conference for 2020 would not be held this year. Despite the prevailing challenges of COVID the Trust successfully co-hosted a virtual conference on the 7th October 2021. Work with partners continues to promote the Zero Suicide Ambition.	NO RAG AS POSTPONED		
SPAR	Improve the accessibility of data across multiple providers - ICR Procurement.	2	Mobilisation from Q2 onwards.	DPSD		Q2	ICR – now called 'One Health and Care' record went fully live across the Trust as of 19th October following a four week pilot period with a small number of teams.			
SPAR	Embed the Research Strategy	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	MD		Q1	Work remains on-going to strengthen relationships to build on the 4 medical Honorary Lecturer roles in place. In April we saw the successful joint appointment to a honorary lecturer post In addition research team continue to explore University opportunities and enhance partnership working with Keele University A NED has been appointed from Keele University which strengthens board oversight and engagement. A series of meetings have been scheduled with Staffordshire University to enhance partnership working for the clinical psychology professional			

			from academia.				doctorate programme, and to explore effective joint research governance arrangements. Board Development session, with Keele, held in August 2021.			
SPAR	Encouraging an open, fair, inclusive, transparent and just culture	1	Explore Merseycare approach to Just Culture and how it can be applied here.	MD		Q3	The MD is working with advisors from Lockton to develop survey tools to aid reflection of existing processes and culture. The data gathered from these surveys will inform the next stages. The Report has been received following workshops sessions which took place earlier this year. The findings of this will used to develop next steps. The move to a Just Culture is now embedded in the principle of incident and SI investigations, whereby the Trust attempts to always be a learning organisation, sharing reports, action plans and learning across the organisation in order to minimise future adverse incidents and to promote staff support and engagement . A review of the panel review process is currently being scoped out to gain feedback and insights into the panel reviews and journey. Serious Incident Workshops booked and to be hosted during 2021. People Directorate implemented NHSE/I improving people practices requirements based on a restorative just culture, updating disciplinary policy and introducing a manager decision making triage checklist with just culture considerations. This helps to mitigate against unconscious bias			

							when informing appropriate action for alleged misconduct actions, taking into account the wider systemic context and a learning culture focusing on what has happened rather than who is responsible. Results showed improvements with regards to employee relations activity, evidenced by 0 live disciplinary investigation cases reported between November 2020 to August 2021.			
SPAR	Commitment to the ICS as a willing partner in deploying the skills and expertise of our workforce outside of our immediate organisational boundaries.	3	CEO is the lead for the Mental Health work stream.	CEO		Ongoing	Continues – transition for Executive lead (following resignation of DO) in train.			
		3	Trust is the lead for the OD work stream.	CEO (DPO DI)		Ongoing	Achieved and ongoing			
		3	Trust is Programme Director lead for the Mental Health work stream.	CEO (DO)		Ongoing	Achieved and ongoing			
SPAR	Continue to identify and develop further primary care service offerings.	2	Continued dialogue with GP Practices who have shown an interest in NSCHT service menu.	DPS		Q3	Trust Board approved integration at their meeting 14th October 2021 – mobilisation now underway with integration due 1st December 2021			

Objective 4: Sustainability	We will increase our efficiency and effectiveness through sustainable development								
SPAR PRIORITY									
Exec owner:	Director of Partnerships, Strategy and Digital and Director of Finance, Performance and Estates								
Assurance Committee:	Finance and Resource								
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 (31/03/22)**		
	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 • 868 – Agency spend								

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	Q3 RAG	On Target RAG	Year End RAG
A	Services are responsive to the needs of service users.	1	Deliver substantial compliance against EPRR core standards in annual declaration.	DO		Q2	This has been achieved in 2019/20 and the Trust complied with requirements for 2020/21 to continue with current rating. Plans for 21/22 in place			

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.	1	Pilot video conferencing across inpatient and community site to assess compatibility with services design.	MD		Q1	Due to COVID19 pandemic video consultation was rapidly rolled out across the Trust utilising Attend Anywhere for patient/carer consultations and MS Teams for staff/team discussions/meeting. Attend Anywhere review incorporating feedback from service users and staff was presented to the Innovation Collaborative in September 2020, and was positively received. Final Attend Anywhere review to be presented at November SLT and QC and will be discussed at Innovation Collaborative (3rd Nov) for next steps. The Attend Anywhere review was selected for an abstract at the Leaders in Healthcare conference in November 2020. Ongoing re-procurement and evaluation planned.			

S	Protect the Trust from Cyber Threats.	1	Work in partnership with UHNM & MPFT to deliver Cyber Security project.	DPSD		Ongoing	New service delivered through SSHIS to proactively scan for Cyber Security threats and alert infrastructure engineers to areas of concern for review/action as appropriate.			
S		1	• Project mobilisation from Q2.	DPSD		Q2	See above			
A	Increase Digital profile as national exemplar improving access to services within CYP through the use of digital technology.	2	Delivery of the Lorenzo digital exemplar pilot within the CYP Directorate.	DPS		Ongoing	Digital Aspirant programme confirmed with £4m of national funding, DXC support in place with purchase orders approved. DA programme content has been shared and approved via SLT and individual 'spotlight' sessions with key internal stakeholders.			
-	Delivery of CIP targets.	1	CIP targets for 2021/22 are achieved	EXEC		Q4	The CIP target for the year has been achieved recurrently.			
SPAR	Five year financial model aligned to organisational and STP strategy (year 1 of 5).		Five year plan is developed which describes plans for sustainability.	DOF		Q1	Sustainability now an enabling strategy for the Trust. 5 year financial plan has recently been updated and will be further updated when the 2022/23 planning guidance is finalised.			

	SOME ITEMS ON HOLD PENDING NATIONAL GUIDANCE FOR H2		Delivery of the control total.	DOF		Q4	Target is to breakeven, although the Trust is likely to make a small suplus.			
			Use of resources level 1.	DOF		Q4	Agency caps are not included in UoR metrics which have been announced, there is a focus on systems managing within their financial envelope. The system is in balance in 21/22 but maintains an underlying deficit. As a consequence, the Trust has been awarded a UoR score of 2 and this will not change.			
			Agency spend contained within the agency cap throughout the year.	DO		Q4	Been suspended in year, but spend is not within the cap.			
SPAR	Delivery of STP Financial Plan.	3	Work with the STP long-term financial plan for system solutions to resolve the deficit.	DOF		Q4	System financial strategy being discussed, dependent on the national funding framework for 21/22 and beyond. Agreed plan is in place with regular discussions with NHSE/I who provide scrutiny and oversight. Savings plans in place to support the eradication of the underlying deficit.			

SPAR	Rationalisation of the Trust Estate ensuring value for money.	2	Development of a five year Estates Strategy aligning the estate to operational delivery, locality working and strategic direction.	DOF		Q3	Preliminary work has taken place focused on working arrangements after COVID. Inpatient reconfiguration is underway with the Dormitory scheme. An external company has been commissioned to help support the development of a 5five year estates strategy Estates Strategy. This should be finalised and should be available for Q4 2021/22.			
SPAR	Capital Plan	2	Implement 20/21 capital plan:	DOF		Q4	Capital plan implementation overseen by Capital Investment Group. Revised plan in place following system capital envelopes. Expenditure is currently behind the plan but is forecast to catch up by the year end with contingency plans in place.			
SPAR	Enhance approach to Sustainability Development Goals.	2	DPS will bring forward an assessment of the Trust's position against the SDGs with a plan for further development	DPSD		Q3	NSCHT Sustainability Group now established. Will be used as forum for development of Trust Green Plan and is on schedule for publication to Trust Board for Jan 2022 deadline NSCHT included 'Corporate Social Responsibility Statement' within their Trust Strategy as a			

							statement of intent for the future. Sustainability is one of four key strategic themes for the organisation articulated through the Trust Strategy and will provide the backdrop for our efforts to actively consider the SDG's in our services going forward. NHS has appointed first-ever Chief Officer for Sustainability and expectation is that this will provide a catalyst for activities to be coordinated through regions to Trusts.			

REPORT TO PUBLIC TRUST BOARD

Enclosure 12

Date of Meeting:	10th February 2022		
Title of Report:	Data Warehouse Business Case		
Presented by:	Victoria Boswell, Associate Director of Performance		
Author:	Victoria Boswell, Associate Director of Performance		
Executive Lead Name:	Eric Gardiner, Director of Finance, Performance & Estates	**Approved by Exec**	☒

Executive Summary:	**Purpose of report**	
The structure of an advanced data warehouse is optimised to collect data from disparate sources and is the foundation for sophisticated analytics. The procurement of a flexible and agile data management platform would enable the Trust to gain high-performance data. This is necessary to support the Trust's Business Intelligence initiatives, accelerate clinical decision-making and support service transformation. The Staffordshire and Shropshire Health Informatics Service (SSHIS) supply the current data warehouse that provides the data platform for Trust reporting, and produce the extracts for the Trust's national submissions, MHSDS and SUS. This Business Case seeks to gain agreement for a new data management platform to be procured from Insource, an experienced supplier with an excellent track record. This would enable the Trust to realise its digital ambitions and help to accelerate BI development and advanced analytics.	**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. We will attract, develop and retain the best people ☒ 2. We will actively promote partnership and integrated models of working ☒ 3. We will provide the highest quality, safe and effective services ☒ 4. We will increase our efficiency and effectiveness through sustainable development ☒		
Risk / legal implications: Risk Register Reference	The current arrangement through the SSHIS has significant limitations which prevent the development required and is not sustainable going forward. It is hampering the Trust's ability to progress with our Digital and Business Intelligence Strategies. The Trust requires a solution that will address the needs of the organisation today and also provide a strategic platform for agile and flexible future development and expansion, aligned to the Trust's Digital and BI strategy, with the flexibility to evolve as requirements change over time.		
Resource Implications: Funding Source:	Revenue costs are set out in the Business case for a 5 year or 10 year contact. Under the 10-year option, the supplier Insource would include their demand and capacity tool worth £180k over 10 years and work with the		

	Performance team to configure the solution to our requirement. This would be a significant added benefit and support the Trust to develop robust capacity planning to support service transformation and recovery and demand increases post COVID. The funding source for this would be the existing funding for the HIS data warehouse (£130k). In addition to this there will be costs that can be avoided from Clickhealth (£38k). The balance would need to be funded by the Trust. The balance would need to be funded by the Trust. For the 5year option this would be £257k in 2022/23 (including double running costs) and £83k on a recurrent basis. For the 10 year option this would be £240k in 2022/23 (including double running costs) and £67k on a recurrent basis. Capital investment would be £644k.
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	This will support the development of the Heath Equity Assessments being undertaken at PCN level to inform the Mental Health Community Transformation programme and address health inequalities at a local level.
Shadow ICS Alignment / Implications:	The solution creates the opportunity for NSCHT to provide leadership within the ICS and Local Health Economy (LHE) around data management and business intelligence.
Recommendations:	Trust Board is asked to: • **Agree** in principle to replace the current SSSHIS data warehouse with a new data management platform. • **Approve** the presenting business case by Board to serve notice on the SSHIS SLA and procure a data management platform from Insource, a specialist external supplier with a track record of delivery in mental health and Lorenzo. • **Note** that notice (12 months' notice required) has been served on the SSHIS (November 2021) • **Agree** a 12 month transition while a new data management platform is implemented. • **Agree** for Insource, external supplier to be secured in the form of an award on the Gateshead Direct Award Framework.

Version	Name/group	Date issued
1.1	Finance & Resource Committee	27.01.22

North Staffordshire Combined Healthcare NHS Trust

Data Warehouse

Business Case

December 2021

Written by: Vicky Boswell, Associate Director of Performance

Supported by: Tom Jones, Head of Business Intelligence

Contents

1. Introduction and Context

The structure of an advanced data warehouse is optimised to collect data from disparate sources and is the foundation for sophisticated analytics. The procurement of a flexible and agile data management platform would enable the Trust to gain high-performance data. This is necessary to support the Trust's Business Intelligence initiatives, accelerate clinical decision-making and support service transformation.

The Staffordshire and Shropshire Health Informatics Service (SSHIS) supply the current data warehouse that provides the data platform for Trust reporting, and produce the extracts for the Trust's national submissions, MHSDS and SUS.

This Business Case seeks to gain agreement for a new data management platform to be procured from Insource, an experienced supplier with an excellent track record. This would enable the Trust to realise its digital ambitions and help to accelerate BI development and advanced analytics.

2. Background

National policy

The National Data Strategy updated in December 2020 sets out how data is the driving force in business and describes how it has been a lifeline during the global coronavirus pandemic. It points to a number of interconnected issues that currently prevent the best use of data in the UK. These are reflected in the core pillars of the strategy: Data foundations, Data skills, Data availability and Responsible data

In respect of *Data foundations,* the Strategy asserts that the true value of data can only be fully realised when it is fit for purpose, recorded in standardised formats on modern, future-proof systems and held in a condition that means it is findable, accessible, interoperable and reusable. By improving the quality of the data, we can use it more effectively, and drive better insights and outcomes from its use.

The NHSX strategy "Data Saves Lives: Reshaping Health and Care with Data" published in June 2021 sets out a clear vision and a powerful action plan to create a truly 21st century health and care system which is even more efficient, responsive, personalised and ultimately safer. This also emphasises the need for data to be on modern, flexible and agile data management platforms if benefits are to be realised and interoperability across health and social care systems facilitated.

This business case responds to these national imperatives.

Local policy – Trust's Digital Strategy

The Trust has significant digital ambitions and the supporting infrastructure and informatics services are a crucial element in supporting the delivery of the ICS and Trust's Digital Strategy.

The Trust's Digital Strategy notes that our digital ambitions for the future can only be realised if our core infrastructure is the best it can be.

There is now a pressing need to ensure that the Trust's technology and reporting supports the delivery of high quality, safe and effective care services to support people who access our services.

This conforms with one of the ambitions of the ICS for Staffordshire and Stoke-on- Trent that is to enable health and care staff to do their jobs to the best of their ability.

TOGETHER WE'RE BETTER
Transforming health and care for Staffordshire & Stoke-on-Trent

In addition, the Digital Strategy aims to ensure that all staff have the ability and connectivity to do their job by providing the right information, at the right time and the right place. The Trust continues to works with staff to ensure that information is recorded digitally and ensure that we implement new technologies to ensure that all staff have access to relevant integrated information across many systems. There has been a focus in the past 3 years to ensure that the data quality on the Trust's EPR system, Lorenzo is improved and this has substantially been achieved.

Business Intelligence (BI Strategy)

The Trust's Business Intelligence (BI) Strategy has been developed to advance the automation of reporting and development of self-serve reports to support data quality, clinical decision making and service transformation, ultimately enabling the Trust to realise the benefits of Lorenzo and other systems and improve the quality of the care we provide. The Data Warehouse is a key component of our information systems and informatics capability and is a critical enabler to our success.

The BI strategy 'plan on a page' is attached as Appendix 1 and sets out the infrastructure changes needed to deliver the benefits.

The BI strategy aims to:

- Improve accuracy, availability and accessibility of organisational reporting
- Move from Information to Insight, from reporting to high value analytics
- Provide more analysis, and platforms for analysis, including predictive analysis
- Develop realistic and aligned understanding of a robust demand and capacity planning, including arrangements for managing unplanned changes in demand and COVID responses to increased levels of acuity and demand
- Inform decision making in all areas of the organisation
- Integrate more data from other systems such as Halo (substance misuse) and EMIS

- (primary care), to build a more complete picture of service and patient care
- Improve Data Quality and change organisational culture

The Trust's Business Intelligence (BI) Strategy requires the integration of all Trust systems through a single data management platform to produce more powerful integrated reports. The BI Strategy proposed the review of the existing data warehouse as this provides the structure of data and building block for all reporting.

The Trust Data Warehouse should form the de facto source of all information used within the Trust. A single source-of-truth platform would allow for multiple systems to be ingested at pace, allowing conformed, relatable information to be stored, presented and used to make decisions.

With a conformed data warehouse and more system integration, the picture the Trust would have of patient pathways would become clearer, and we would understand when a patient had interaction with services that are traditionally accessed via different systems. Holding important organisational data centrally means that data is consistent across the organisation; information is the same regardless of who accesses it. Centrally held data can also be transformed, with additional details being added.

3. Data Warehouse Requirements: Service Specification

The Trust has developed a Service Specification (Appendix 2) that that sets out the Product requirements, Partnership approach and skill sharing required and Service levels and Key Performance Indicators.

In summary the Trust is looking for:

- **Provision a new data warehouse platform** and remove the dependency on the limitations of the current service provider, the SSHIS
- **Increase the scope of automated data processing** beyond the current service to significantly reduce manual data management and the inherent risk of human error
- To have **consistent and trustworthy output** i.e. a single version of the truth
- To have **time to make better use of data** to support the Digital Strategy and become a data driven organisation
- To have a **service that is responsive** to the evolving needs to the Trust and **collaborative** in terms of engagement approach
- To have a platform that **supports further expansion into the future** and supports the opportunities for joint innovation

The Trust requires a solution that will address the needs of the organisation today and also provide a strategic platform for agile and flexible future development and expansion, aligned to the Trust's Digital and BI strategy, with the flexibility to evolve as requirements change over time.

4. The Strategic Case for Change

The current arrangement through the SSHIS has significant limitations which prevent the development required and is not sustainable going forward. It is hampering the Trust's ability to progress with our Digital and Business Intelligence Strategies.

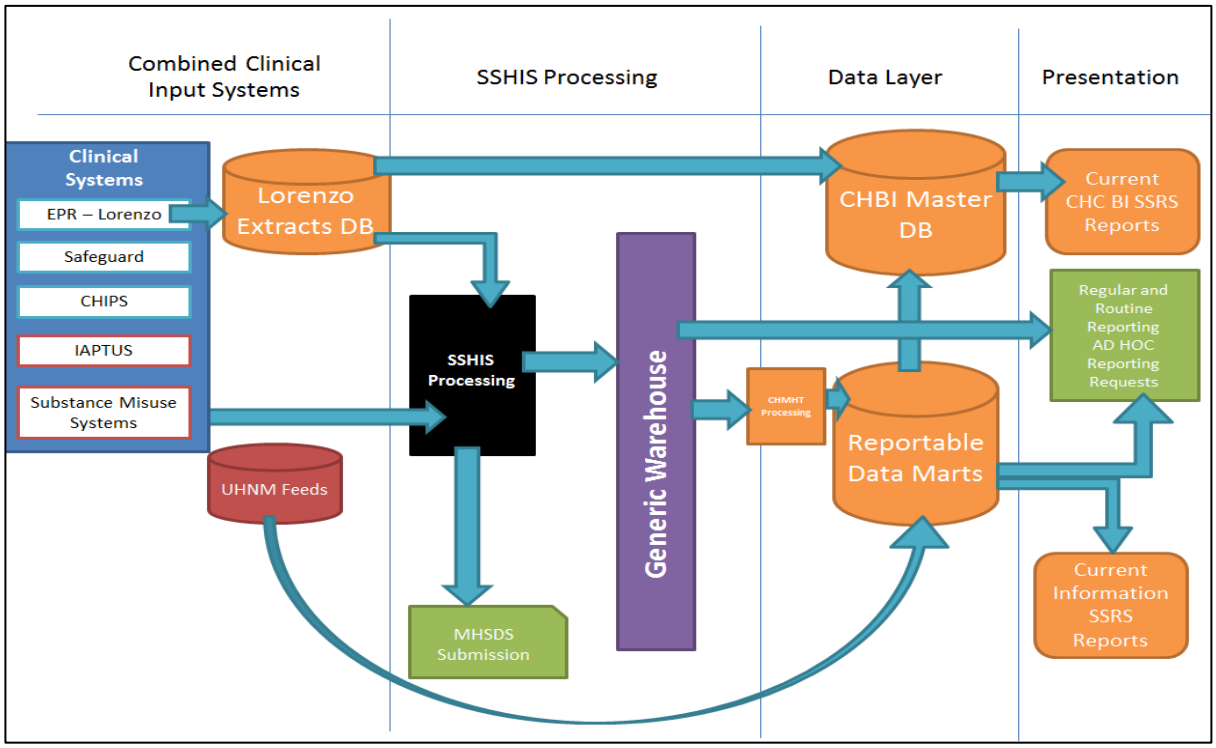
Limitations of the current Data Warehouse: Case for Change

There are issues with the current Data Warehouse and associated services provided by the Staffordshire and Shropshire HIS (SSHIS) which impacts upon the Trust's Information and BI Team, and its ability to provide timely and accurate data and reporting.

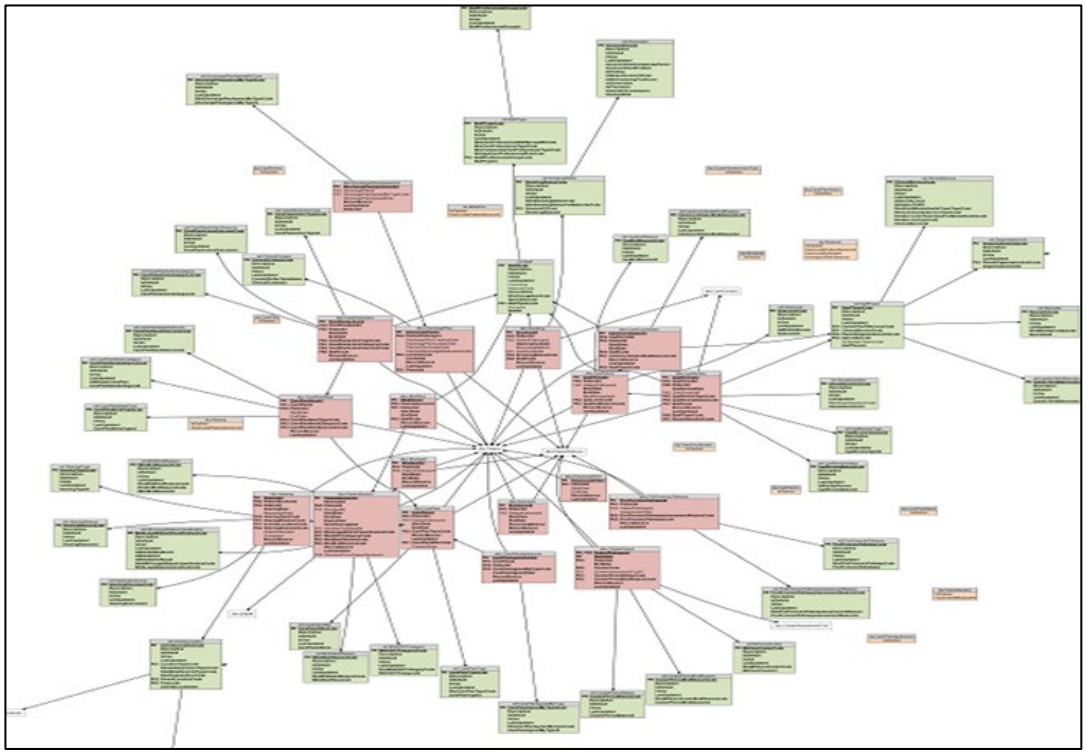
In view of this, Insource were commissioned in April 2019 to evaluate the current technical maturity of the Trust's data management capability and to proposals on what the Trust needs in relation to data management. This confirmed the primary issues with the current arrangement.

Technical limitations

- Inability to track data flows effectively due to incomplete documentation on the flows of the data warehouse ('black box' ensures that there is no clear line of vision from front end to back end as set out in the diagram below).



Detailed below and extracted from the SSHIS data warehouse documentation, this depicts the core mental health data model. It is highly complex, opaque and difficult to understand any queries against the data, which perform inefficiently due to the sheer number of table joins required. As a result, reporting and data presentation is slow and this has a negative impact upon the perception of the data consumers.



Failed loads

Failed loads occur on average a couple of times a month and result in daily reports being sent out with out of date information. The lack of a 7 day service adds to the risk and this is more of a concern given that the Performance team is producing near time data such as the daily bed report that supports bed management and feeds our daily COVID reporting.

Lack of resource, capacity and capability

There is limited flexibility and resource within the contract to make developments required at pace to meet Digital and BI Strategy objectives (there are no contract levers in the overall SLA with SSHIS if timescales are protracted or not met),

Other shared service partners have already withdrawn their support for the SSHIS data warehouse and developed their own bespoke solutions, either re-providing them internally or procuring a data management platform from an external provider. The Trust is the only remaining Trust that procures a data warehouse from the SSHIS and this has placed the future viability of

the SSHIS as an internal service provider at risk, with the potential to impact adversely on the Trust BAU services as well as the delivery of key developments and projects.

SLA with the SSHIS

The Performance Team in the Trust has worked closely with the SSHIS over the last 18 months to review the SLA and move towards a less transactional and more collaborative partnership approach and knowledge sharing. This has not materially changed the relationship or service received.

In addition, despite repeated requests for clear costs, a breakdown of the precise costs of the data warehouse is still unavailable. It must be noted that the overall cost of the SSHIS SLA is low in comparison to other data warehouse solutions, partly due to a limited service provided (there is no out of hours or weekend cover which is essential to maintain real or near time reporting).

As the data warehouse is provided as part of the overall SLA with SSHIS, there is not a partnership approach or any provision of coaching and support to analysts which would be expected in a modern contractual arrangement. This is important to ensure that skills are developed in-house and also to ensure business continuity in times of staff absence or turnover. This is more important as the Performance team is small.

The SSHIS data warehouse team is also a small team and there is a lack or economy of scale which means that if there is an absence of a single member of the team it will significantly impact on resource requirements and slow down development, resulting in unacceptable delays.

Overall, the SSHIS is slow to respond to change requests and developments and this can have a detrimental impact on the Trust and its reporting capability and accuracy. The Trust would benefit from a move to a larger supplier with more capacity and capability and the willingness to be a partner.

Summary of limitations

In summary, the current arrangement is inefficient and leads to potential for multiple versions of the truth as analysts are required to access multiple data tables to perform the same analysis. The resource is small and this leads to issues regarding responsiveness which can impact on change requests and developments and subsequently the quality of the data that the Trust relies on. In addition, the SSHIS is committed to a transactional approach despite the efforts of the Performance team to move to more of a partnership arrangement.

The Trust's data warehouse has not been developed for many years and cannot support the digital and analytical ambitions of the Trust in its current form.

In view of these current limitations as well as the technical issues highlighted above, at the very least, there is a need to put in place a new service specification which addresses the current shortcomings and this will come at a cost to the Trust. Therefore the business case proposes that remaining with the existing service is not an option to be considered.

5. Options appraisal

This option appraisal is a critical component of the implementation of the initial phase of the Trust's Business Intelligence Strategy. This was undertaken using criteria from the Service Specification. The future procurement and/or development of a data warehouse will need to be managed successfully to minimise both operational and strategic risks to the Trust.

The options identified for the delivery of the Data Warehouse are:

- Option 1: Current solution - do nothing
- Option 2: Retain and improve the existing SHHIS Data Warehouse
- Option 3: Establish a Trust internal Data Warehouse
- Option 4: Existing NHS Provider
- Option 5: Existing Lorenzo NHS Trust to build a Data Warehouse for Trust to maintain and develop
- Option 6: Outsource the Data Warehouse to a private sector provider (Insource)
- Option 7: Outsource the Data Warehouse to Dedalus Open Health Connect: Investigative Analysis

Assessment Criteria and scoring

The Assessment Criteria have been developed through a staff engagement workshop. They have been developed to enable all known issues to be addressed.

Scoring Criteria

Delivers aims and objectives of National and Local Digital Strategies

The Business Intelligence function needs to serve the macro objectives of the Trust, which are largely defined by national strategies. The Long Term Plan and its implementation plan are primarily focussed on the development and improvement of mental health services; the BI function needs to be in a position to support these developments with data driven decisions. These criteria are about making sure that the data warehouse that underpins the BI function provides a solid foundation to develop upon.

Enables the delivery of the Business Intelligence Strategy – integrating all data

These criteria are concerned that the data warehouse is configured in a way to meet the requirements of the BI Strategy and can be developed at pace in order to meet the deliverables.

Fit for purpose modern data management platform/ warehouse

These criteria are around making sure the platform meets all the fundamental requirements of a data warehouse before considering any advanced functions.

Future proof solution offering adaptability

The BI function needs to constantly meet the developing requirements of the Trust, and so the data warehouse solution needs to provide a platform that can be agile enough to allow the BI function to keep pace with these changing requirements, including readiness to take advantage of emerging modern technologies and methods. These criteria are around ensuring the solution provides this agility.

Partnership Approach with Performance/Information team

As the solution develops in line with the needs of the Trust, the performance team should be in a position to benefit from the expertise behind the platform to guide post data warehouse processing and analysis. These criteria are around ensuring that the relationship we have with the supplier supports the capacity and capability of the Performance Team.

Financial and cost

The solution needs to be financially sustainable and provide value for money, ideally with ongoing development built in to its function.

ICS and system wide support

These criteria are around ensuring the solution affords us the opportunity for improved collaboration with the local health economy.

Establishing assessment criteria is an important part of the evaluation process to determine objectively the preferred option for the Trust, consistent with its BI Strategy. The Option appraisal was redone in September 2021 to provide an up to data assessment of options.

A numerical rating scale was used to score that reflects the following assumptions:

0 – does not meet criteria
1 – Partially meets criteria
2 – Fully meets criteria

The Assessment criteria are weighted in recognition of the importance of the Trust having a future-focused data warehouse that will meet our aspirational needs as described in the BI Strategy and providing a more transparent, agile and flexible solution, thereby developing Performance team capacity. In addition the weighting reflects the need for there to be a partnership approach where supplier expertise is shared and the team of developers and analysts are supported and coached, thereby transferring important skills and developing team capability.

Summary of the outcome of the Option Appraisal

A summary of the outcome of the options appraisal undertaken by members of the Digital and Performance (Business Intelligence and Information) teams is set out below:

The details scoring is attached as Appendix 3.

Option 1 – Current solution – Do nothing and retain the existing SHHIS Data Warehouse	
Advantages	Disadvantages
Least disruptive	Not viable
Existing relationship – people & integrated technology	Transparency – ability to view data structure
Familiarity with data structure	SSHIS capacity & capacity to respond to changing requirements
	Last remaining customer - viability & sustainability
	Does not provide agility and flexibility to respond to needs
	Significant resource limitations hamper Trust's ability to report near time / daily when service failures occur
	Resource limitations result in slow response to change requests and developments
	Transactional nature of current SLA means the Trust does not have contract levers
	Lack of partnership approach to skill up and support Performance team

Option 2 - Retain and improve the existing SHHIS Data Warehouse	
Advantages	**Disadvantages**
Least disruptive	Transparency – ability to view data structure
Least expensive - provides financial value?	HIS Capacity & capacity to respond to changing requirements
Existing relationship – people & integrated technology	Last remaining customer – viability & sustainability will continue to be a concern
Familiarity with data structure	Agility and flexibility to respond to strategic needs and developments at pace
	Transactional nature of the relationship
	Does not provide value for money

Option 3 – Establish a Trust internal Data Warehouse	
Advantages	Disadvantages
Control – transparency & flexibility	Capacity & capability – design, build, maintenance & development
Ownership	Time
If there is a good design it can be expanded	Need to manage hardware / infrastructure
Monitoring extracts in house would be easier	Sustainability – staff (potential single source of failure)

	Data Infrastructure Architects can be extremely expensive. Attempting to retain these skills as full time trust staff can be disproportionate to the value they add day to day
	Is there a cost in ending the SSHIS SLA – stranded costs or TUPE?

Option 4 – Existing NHS Provider	
Advantages	Disadvantages
NHS knowledge	Potential for another organisation to favour internal demands
Mental health knowledge (if MH provider)	Commercial sensitivity
	Limitations of contractual arrangement and levers with another NHS provider
	Challenge of putting Lorenzo data into an existing data warehouse
	Is there a cost in ending the SSHIS SLA – stranded costs or TUPE?

Option 5 – Existing Lorenzo NHS Trust to build a Data Warehouse for Trust to maintain and develop	
Advantages	Disadvantages
Link option 2, building on good practice from elsewhere	Cost of build and revenue to maintain data warehouse
Specific Lorenzo understanding	Need to manage hardware / infrastructure
NHS knowledge	Capacity & capability in the Performance team – 2 posts would be required for maintenance & development
Mental health knowledge (if MH provider)	Sustainability – staff (potential single source of failure)
	Is there a cost in ending the SSHIS SLA – stranded costs or TUPE?

Option 6 – Outsource the Data Warehouse to a private sector provider	
Advantages	Disadvantages
Experts in field – they have capacity & capability	Overhead for Trust in managing contract (Service Management)
Specific Lorenzo understanding	Potential for black box or restricted capacity for change in solution
NHS knowledge	GDPR with external body as Data Processor.
Mental health knowledge (if previous experience)	Is there a cost in ending the SSHIS SLA – stranded costs or TUPE?
Track record and experience with other providers	
Speed of delivery, even if the implementation needs to be undertaken a data subject at a time	
Able to accommodate development requirements as set out in BI Strategy – integration of more systems at pace	

Ability to talk to existing customers / site visits to test solution	
Would support analysis in team	
Combination of the supplier's product and the trusts domain knowledge should deliver a guaranteed successful outcome	
The benefit of a pre-built solution is in its ability to deliver early value.	
Possibility to utilise additional existing tools built upon data warehouse offered	
Skill sharing and coaching to Performance team	
The Trust staff will have an equally valuable input to provide to the infrastructure project progress (whilst external expertise can be brought to bear with both technical and significant domain knowledge from external parties, only the trust staff are able to provide detailed knowledge of the internal systems)	

Option 7 – Outsource the Data Warehouse to Dedalus Open Health Connect : Investigative Analysis	
Advantages	Disadvantages
Real time information using the Open Health Connect product which we have access to as part of the Lorenzo Digital Exemplar programme	No current live UK Lorenzo implementation
Integrated into the Lorenzo Platform	Cost currently not defined
National standards for external data input / export	Staff training requirements (developing within the system)
Workflows to standardised processes based on identified triggers	Unclear about the potential to integrate other systems
Opportunity to develop the solution to meet our requirements	No appetite for the development by Dedalus
	Is there a cost in ending the SSHIS SLA – stranded costs or TUPE?

6. Further consideration of 4 main options

In summary, there are four main options open to the Trust:

Do nothing

The current situation is not resourced to meet the Trust needs and is not agile and responsive, and this is having a detrimental impact on the Performance Team and its ability to meet the Trust's business requirements. This may cause reputational damage. It is not sustainable long term and therefore action needs to be undertaken.

Develop further the current warehouse

Retaining the existing SSHIS is not a sustainable option given the need for a Partnership approach, and in view of BI Strategy requirements and Trust ambitions. There are significant limitations of the data warehouse structure and length of time that it takes for developments and changes to be enacted. The SSHIS does not offer the partnership approach that the Trust requires to enable skills and knowledge to be transferred.

Build

Whilst building a bespoke solution is a credible option, it is clear from the above assessment that trying to build an application from the ground up using generic products such as SQL Server makes no sense when technologies are available that will provide flexibility and functionality that also significantly reduce the development time and effort.

In addition, the main drawback is in the need to invest a great deal of knowledge in one or two people, creating a situation that is prone to failure (if said people leave) and difficult (timely/costly) to recover from. Employing a larger team to cover the work is not feasible given the size of the Trust.

Buy

Acquiring an off-the-shelf solution provides not only fast time to delivery, but also assurance of a track record or robustness and reliability. This assumes that the solution deployed is capable of meeting the exacting requirements for a future data management platform, according to the new specification.

Known third party suppliers adhere to international standards (e.g. FHIR), potentially allowing for easier collaboration/integration with other data providers. This is a significant consideration given ICS aspirations for data integration. Additional products that build on the offered solutions are available and continue to be developed.

Procurement advice has been sought and it is proposed and agreed that a Direct Award would be pursued via a Framework. If the Business case is approved, a specification of requirements would be provided and Procurement would manage a benchmarking exercise to ensure value for money.

Preferred Option

The results of the high level option appraisal identified that an outsourced solution with an external provider (Insource) is the preferred option as set out in Appendix 1.

The full Assessment criteria scoring is attached as Appendix 1. The scoring is summarised below:

Scoring before weighting is applied:

Assessment criteria	Option 1 - Do nothing - Current solution	Option 2 - Retain and improve the existing SHHIS Data Warehouse	Option 3 – Establish a Trust internal Data Warehouse	Option 4 – Existing NHS Provider	Option 5 – Existing Lorenzo NHS Trust to build a Data Warehouse for Trust to maintain and develop	Option 6 – Outsource the Data Warehouse to a private sector provider	Option 7 – Outsource the Data Ware-house to Dedalus Open Health Connect : Investigative Analysis
Delivers aims and objectives of National and Local Digital Strategies	4	11	9	9	9	11	11
Enables the delivery of the Business Intelligence Strategy - integrating all data	6	8	7	7	7	11	10
Fit for purpose modern data management platform/ warehouse	13	17	17	15	17	19	19
Implementation of the BI Strategy	8	12	9	10	10	15	13
Partnership Approach with Performance/ Information team	2	6	5	3	2	10	6
Financial and cost	6	7	6	6	6	6	6
ICS and system wide support	3	5	5	3	3	4	4
Total	**42**	**66**	**58**	**53**	**54**	**76**	**69**

Scoring after weighting is applied:

Weighting	Assessment criteria	Option 1 - Do nothing - Current solution	Option 2 - Retain and improve the existing SHHIS Data Warehouse	Option 3 – Establish a Trust internal Data Warehouse	Option 4 – Existing NHS Provider	Option 5 – Existing Lorenzo NHS Trust to build a Data Warehouse for Trust to maintain and	Option 6 – Outsource the Data Warehouse to a private sector provider	Option 7 – Outsource the Data Ware-house to Dedalus Open Health Connect : Investigative Analysis
10%	Delivers aims and objectives of National and Local Digital Strategies	40	110	90	90	90	110	110
15%	Enables the delivery of the Business Intelligence Strategy - integrating all data	90	120	105	105	105	165	150
20%	Fit for purpose modern data management platform/ warehouse	260	340	340	300	340	380	380
20%	Future proof solution offering adaptability	160	240	180	200	200	300	260
20%	Partnership Approach with Performance/ Information team	40	120	100	60	40	200	120
10%	Financial and cost	60	70	60	60	60	60	60
5%	ICS and system wide support	15	25	25	15	15	20	20
Total with weighting		**665**	**1025**	**900**	**830**	**850**	**1235**	**1100**

Taking the requirements of the Digital Strategy and BI Strategy into account, it is clear to that a specialist supplier with a track record of delivery in mental health and Lorenzo is the best option for the Trust. Acquiring an off-the-shelf solution provides a fast time to delivery, assurance of a track record and capacity and capability to develop at pace. This will enable the Trust to move from information and reporting to insight and analytics.

The provider with an established track record in the area and having worked with mental health and Lorenzo providers is Insource.

7. Benefits realisation

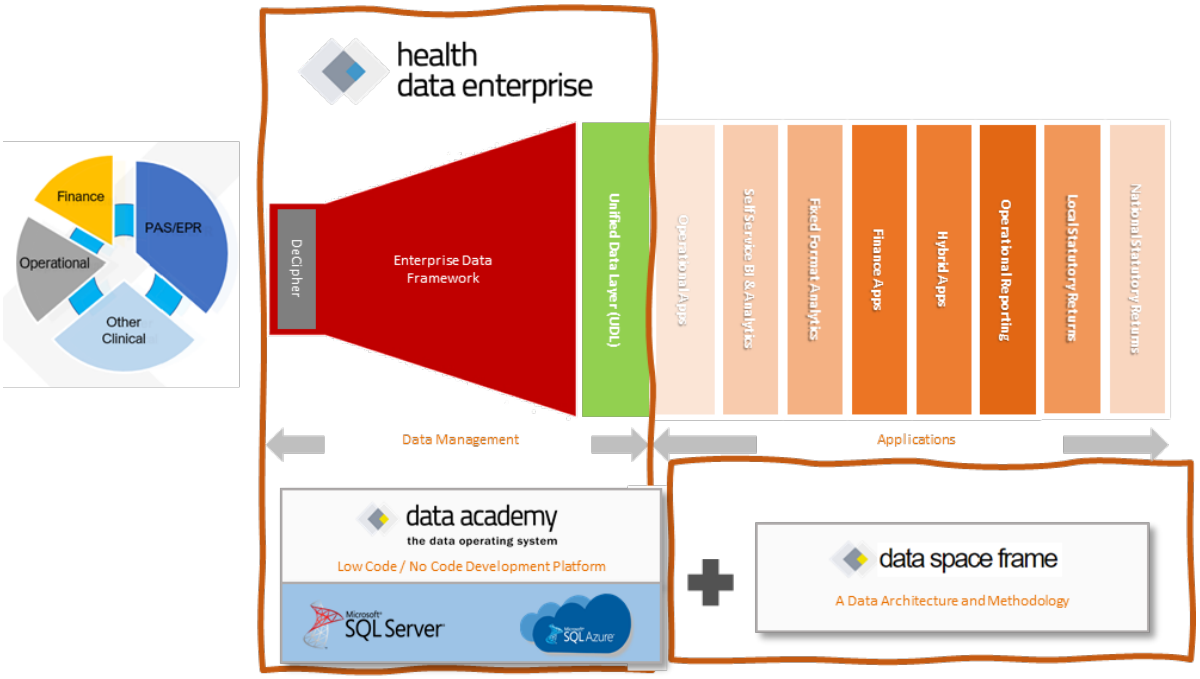
The solution should be sustainable, and should automatically keep up with changing / improving industry standards to enable the Trust to be responsive to ever more digitalisation and automation of performance activity. The data warehouse is the building block of the Trust's ability to demonstrate the quality of its patient experience, and is essential to maintaining our outstanding services.

The right product would deliver to the Trust early value coupled with flexibility and growth capability. It will short cut the delivery time significantly as the fundamental functionality required is embedded in the product. The Trust Information and BI team should be left to focus on added value activities that accelerate the Trust's data infrastructure and support clinical staff in their decision making and service transformation.

In addition, it will greatly support the ever increasing requirements for national mandatory submissions in the form of MHSDS, SUS and other requirements. This is becoming more important as the Trust's performance is judged more and more on our nationally reported data and our reputation depends on its accuracy.

8. Proposed Solution: Insource Health Data Enterprise (HDE) platform

Insource is proposing its Health Data Enterprise (HDE) platform as the core component of the solution. This proven solution will provide a platform which will enable the Trust to respond to core statutory requirements from regulators and commissioners whilst provision a trustworthy data repository for internal operational reporting and analysis.



Health Data Enterprise is a highly configurable enterprise scale data management solution for Healthcare. It integrates with any combination of PAS / EPR or clinical systems from which it consumes data and presents it as a single source of prepared, cleansed and structured unified data.

With the capability to configure to exacting requirements and specific nuances, expandable and customisable to meet all structured data processing requirements and operating in a totally automated mode, it is able to provide massive improvements in data quality and data processing. This improves efficiency, provides regulatory conformance, reduces costs and provides outputs and information that Trust staff can act on to improve the Trust's performance and provide for better patient care at lower costs. Underpinning the product is the application development platform (Data Academy). This embedded technology provides for a fully configurable, fully automated, fully managed, infinitely expandable enterprise data solution platform and is the enabling technology to meet the Trust's needs.

9. Value for Money: Insource

Demonstrable Track Record

Insource provide its solutions and services to over 30 healthcare organisations across the UK. Insource has a longstanding relationship with many of its customers and has wealth of experience across mental health providers, Lorenzo EPR sites / customers / users and Digital Exemplar Trusts, providing bespoke services tailored to each customers unique needs. The solutions and services have typically evolved with customers and their changing needs over time.

Mental Health Trusts

- Cheshire & Wirral Partnership Trust (CWP) has been a customer of Insource since 2008 using the data management platform, which has recently been upgraded to Health Data Enterprise (HDE). The services provided to CWP have evolved as the needs of the Trust has changed; from fully managed service, when the Trust experienced periods of high staff turnover and to the current support service where Insource work as an extension of CWPs team to provide ongoing assistance, support, advice, and mentoring. In addition, Insource are also supporting them on their EPR migration, ensuring data reporting continuity throughout.

- Humber Teaching NHS Foundation Trust are a mental health and community provider using Lorenzo and SystmOne. They have worked with Insource technology over the last 10 years as their data management platform. As with CWP, they have had periods of staff turnover, and Insource have flexed the service to provide additional support to ensure no disruption of strategic or in-house reporting and information capabilities.

Lorenzo

Insource has worked with several Lorenzo Digital Exemplar sites, with Hull University Teaching Hospitals NHS Trust, Royal Papworth Hospital NHS Foundation Trust and South Warwickshire NHS Foundation Trust all being customers of Insource.

- Hull is the longest standing of these and has used Insource's data platform as their data management solution for over 10 years. They are using the solution to help them accelerate their digital maturity and meet the NHS digital standards through new system developments.

- Royal Papworth have worked with Insource on a number of projects, one of which was to implement the CDS module of HDE for their statutory reporting, but also to build a bespoke billing solution to automate and replace the Trusts manual processes.

- South Warwickshire use HDE for both acute and community services and have done for several years. They are about to embark on their second PAS migration using Insource's data management platform. The platform will underpin the migration and ensure reporting continuity throughout the process.

Flexible and responsive service

The core architecture of Insource's solutions mean that at any point Insource can provide support to any customer and understand how the data management solution operates for any trust. Insource staff can instantly become part of a trust's team providing a greater level of responsive support.

Examples of this include:

- Salford Royal NHS Foundation Trust have been customers since 2017, using the Patient Pathway Plus solution, an application built on Health Data Enterprise. Over the last 18 months Insource has been called upon several times to provide resource cover at short notice when staff have been off work or to provide additional support to their teams when they have had limited capacity. The team can do this hitting the ground running and immediately understanding the system configuration.

- Liverpool Women's Hospital NHS Foundation Trust have been customers for over 5 years using HDE with a service arrangement that effectively extends their in-house team. Insource provide ongoing support for strategic and tactical projects as needed, recently providing support for a migration of one of their clinical systems, ensuring data and reporting continuity and providing assurance on the quality of the migration.

Additional Benefits

The additional value and benefits that Insource will bring are:

- **Service**
  - Insource are used to providing a bespoke service that can flex up and down as needed
  - Able to support strategic projects, such as a data migration or an EPR replacement
  - The core technology and its architecture mean that at any point Insource can provide support and will understand how the data warehouse is built

- **Platform**
  - Flexibility to develop and grow the solution to individual needs
  - Time savings on development – using HDE to build apps and processes is up to 80% quicker than developing with native SQL
  - National submissions are supported and maintained centrally by Insource, in line with changing requirements

- **Knowledge Share and Community of learning and development**

Insource are keen that users of the solution can share ideas, thoughts, issues, knowledge and best practice.

  - An online portal provides access to user forums, knowledge share and the ability to share developments and code with other users of the software.
  - Insource encourages its users to share best practice, knowledge, and developments. It has developed an online portal – Logistix – to enable this. Logistix provides access to a wealth of technical and learning resources as well as an open forum to talk to other users and has circa 80 + members, of which 60 are HDE users.

- Users are also invited to provide their feedback on requirements and new development suggestions.
- As well as forums, Insource share knowledge bases on the use of all the tools and software, technical details, changes and release notes on any product changes as well as blogs from out technical team on useful insights.
- In addition, there is also dedicated section on Lorenzo and its data connections for users of that system.
- Users can share any of their system customisations and developments with users via the portal to save time and share best practice.
- Insource also hold User Group meetings where customers and users can come together and share examples of how they are working, network with others and share enhancements to the system. This further helps strengthen the community of users and encourages them to work together.

10. Risk to the Trust of NOT proceeding with this investment request

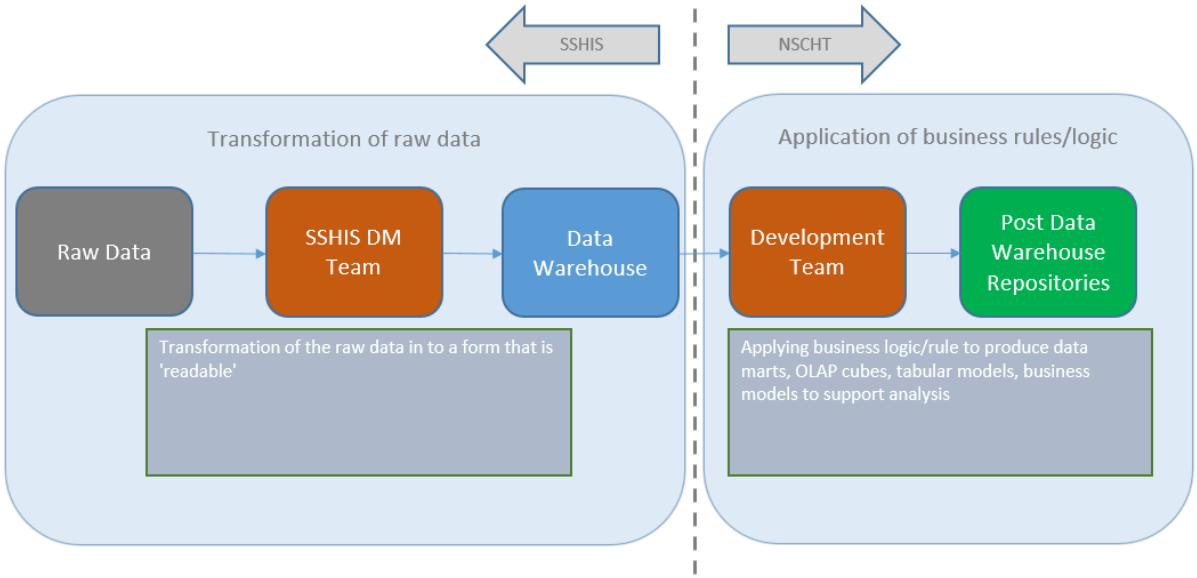
Data Warehouse Business Case Risks

Scalability

The warehouse we have at the moment presents the data in a 'sensible' structure, so the data is taken from its raw form, which is suitable for the clinical system to use, and transformed in to a structure that is more 'human readable' and appropriate for reporting. This structure is sufficient for some of our needs, but there are some needs that require further processing to transform the data into different structures or to apply additional business rules / logic. Currently this additional processing, including maintenance, is performed by the Performance team. It is natural for the development of some of these additional processes to sit with the Performance team, as it is part of our function to liaise with services and use the data available to support them in their endeavours, and working in this way allows us to quickly develop solutions for services. However, the volume of these post warehouse processes is growing over time, while the development of the warehouse is currently static.

The risk is the volume of work to maintain these developments may exceed the capacity within the team, and absences of key team members would mean the loss of knowledge for said maintenance, considering the small size of the team.

The current solution does not offer this function - some third party solutions offer much more flexibility in customising the core platform, allowing us to shift the maintenance away from the team. This is necessary to free up time for development and analysis. The Insource solution provides this flexibility and agility.



Interoperability

The current solution is built in terms of the NHS data dictionary – if there is a desire to work more closely with other organisations, interoperability may come to the fore, meaning that we may want to share (and receive) data, something that FHIR standards would facilitate. Having a solution that adheres to these standards is necessary.

Remaining with the current SSHIS data warehouse is not feasible as demonstrated in the option appraisal above. There is an issue with transparency in the current structure which impacts on our ability to view data. In addition the service is not a 7 day 24 hour service which is necessary if the Trust is to reply on daily or (close to) real time reporting. There are also limitations with the SSHIS's capacity and capability to respond to changing requirements.

Conversations with the SSHIS data management team around development regularly becomes difficult, and despite attempts to improve our relationship over time, these conversations inevitably return to the SLA with no attempt to provide an agile and responsive service; our attempts to develop are often hindered by the transactional nature of the service provided by SSHIS.

As the last remaining customer, there is an ever present concern about viability and sustainability. Finally as the data warehouse is provided as part of the overall SLA it is not possible to use contractual levers that would be possible if a clear contract was put in place.

The Trust will not be able to realise the benefits of the Digital and Business Intelligence Strategies without investment into a data management platform that would support us to realise our digital ambitions in respect of BI. This would have a profound impact on the Trust's ambition to be a Digital Exemplar.

Finally without a progressive, dynamic and pro-active supplier of the data management platform, it is likely that there will be a need to seek external expertise to undertake tasks that fall outside

the scope of the current transactional SSHIS contract. The risk inherent in this is that the expertise leaves the Trust when the contract has ended. This is neither desirable nor sustainable.

11. Planned implementation Date

Assuming that there could be Board approval in November 2021, there would be a need to go through Procurement processes and serve notice on the SHSIS.

There would need to be a period of double running as the notice with the HIS (12 months) is served. This would enable the new data management platform to be built.

A phased implementation is proposed to ensure a smooth transition from the current service provider. This will ensure the data management capability of the Trust is enhanced to support additional data processing and future expansion and innovation.

The following phasing is proposed:

Phase 1 – Establish Capability (0-6 months)

The purpose of this phase is to establish the technical infrastructure and software platform that:

- Provisions a supportable and upgradeable data management platform hosting data sourced from existing systems and managing the data processing to generate output for reporting purposes.
- Is focussed initially on the delivery of data processing to support the generation of output to meet the MHSDS and CDS statutory returns.
- Remove reliance on the existing HIS provisioned Data Warehouse solution.
- Establishes knowledge of a new data model and data processing engine within information services.

Phase 2 – Expand the content (6-12 months)

The purpose of this phase is to expand the content of the data warehouse platform to include:

- Collaboratively reviewing and agreeing three content areas for data acquisition and processing in the platform to broaden the automated data processing capability and resulting available data for internal and external reporting purposes.
- Subject to the data being available, content areas proposed for review may include:
    - Electronic staff record data (ESR).
    - Risk management related date (Ulysses).
    - Primary care data (General Practice - EMIS).
- Supplier technical team leading on the data warehouse expansion, but importantly:
    - Working with key nominated Trust staff to enable knowledge transfer and development of staff skills.
    - Introduce the pro-active support model to monitor and maintain the data warehouse.

Phase 3 Maintain and innovate (beyond year 1)

The purpose of this phase is pro-actively support the Trust on a going and collaborative basis that:

- Proactively monitors the solution and provide guidance and advice to ensure optimum solution performance.
- Provide advice and guidance on future (to be determined) data processing to support other aspects of the Trust's business and providing oversight of the continued adherence to architecture and methodology including periodic workshops and peer training sessions.
- General coaching and mentoring as part of a proactive support service.
- The importance of change should not be underestimated therefore the supplier will provide expertise to help support.

Supporting change management

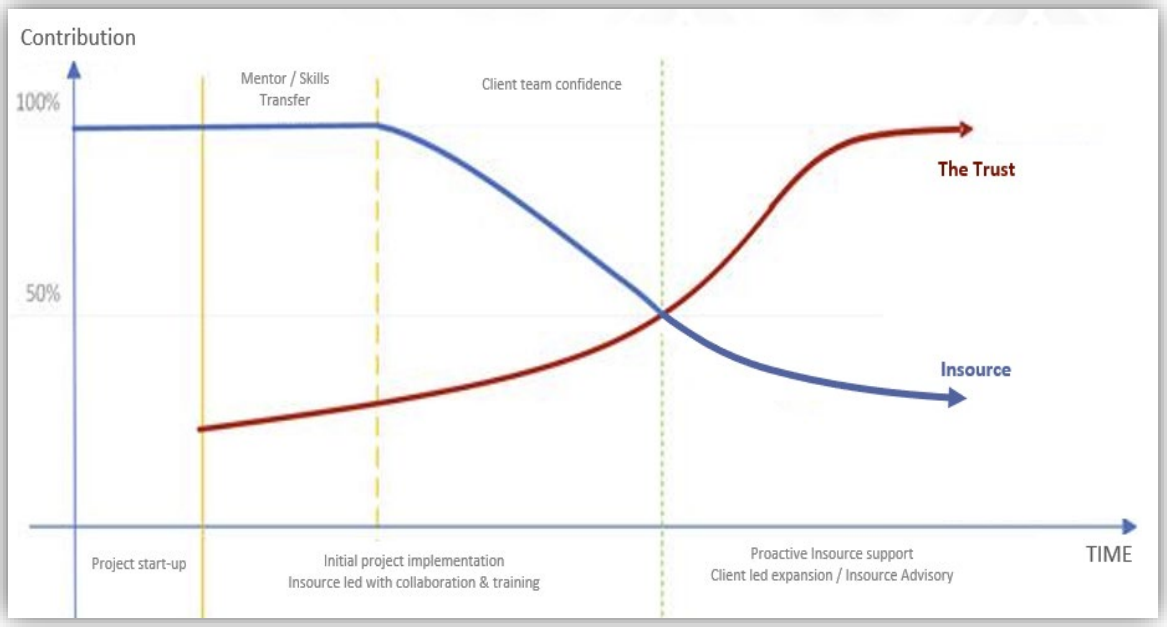
The importance of change should not be underestimated and therefore Insource would provide expertise to help support the adoption of the solution within the Trust for the first 2 years of the contract. Key areas of focus will be stakeholder communications and engagement during Phase 1 and Benefits Management in Phase 2 and support during year 2 to measure benefits and coach ongoing change management methodology and approaches.

The proposed training programme will comprise the following elements:

- Structured training
- 'on the job' skills transfer during initial implementation
- Mentoring / Peer programming (1:1 workshop style to build confidence, understanding and share knowledge)

This will ensure that all users have the right level of knowledge from technical expertise, to system configuration, through to understanding translations of data from source and how to effectively use the data outputs.

During the initial phases of the project, Insource's input will be higher, and the proportion of input will reduce over time, so that it would gradually transition from a leading role to a partnership and supporting role, as knowledge and skills are shared throughout the duration as illustrated below:



This approach ensures a smooth transition of skills and knowledge over time in a practical way so that the Trust team can gradually take on a more hands-on role, as their skills and experience increase. This model has been found to be highly effective in being able to create robust technical and procedural foundations quickly, without building dependency for 'business as usual' on Insource in the long term.

The approach ensures key stakeholders are at the centre of all implementations. Initial stages of engagement incorporate activities from stakeholder identification, vision and objectives for the future, analysis of 'As Is' operations and 'To Be' ways of working together with problem identification. This stage is crucial to understanding fully the business requirements and the problems the solution will overcome. Discussing these with key stakeholders ensures a collective shared understanding as a basis for moving forward.

Working jointly with the Senior Responsible Officer and Project Owner(s) all key stakeholders essential to successful delivery are identified and stakeholder engagement sessions established to ensure they know what the organisation is aiming to achieve and why. Roles & Responsibilities are mapped to ensure everyone involved in the project knows what they are responsible and accountable to deliver.

Benefits management will be a key area of focus particularly during, and immediately following, Phase 2 of the programme. A collaborative approach is required to provide key stakeholders with the assurance and skills they need to ensure that systems & processes are being utilised to the fullest potential by all stakeholders and that benefits are being managed and tracked correctly and appropriately.

12. Financial Assessment

The SSHIS have advised that the cost of the data warehouse in the SLA are £130k. The SSHIS has advised the costs of a 24/7 service and database administration would be around £207k. It has not been possible to get a full breakdown of costs of the current SLA.

The costs provided below are for the preferred option of the Trust. This is the cost of a 7 day service that would meet an advanced specification required to implement the BI strategy and provide the partnership approach that we seek, rather than the current transactional arrangement. In this way the external option provides significant added value as outlined above.

To note that there will be a period of double running as the SSHIS is served with notice. This ensures that the Trust maintains business continuity with reporting and a 6-12 month period of the implementation phase for the new data management platform. The cost of the SSHIS double running costs could be accounted for in 2021/22 and recognised as a provision (a present obligation resulting from a past event).

It is unlikely that redundancy or TUPE will apply for SSHIS staff although this would need to be assessed and confirmed.

Costs are based on a service transition date of 1st December 2021, assuming approval to proceed is provided and that procurement processes can proceed quickly on a Procurement Framework.

Insource would also be able to provide additional support, for example around waiting time management or demand and capacity solutions and this would obviate the need for the Trust to procure specialist expertise to support specific technical developments. In the last year the additional cost to the Trust of sourcing technical expertise of this nature has been £38k.

During the initial phases of the project, the external supplier's input will be higher, and the proportion of input will reduce over time, so that they gradually transition from a leading role to a partnership and supporting role, as they share knowledge and skills throughout the duration. This enables the Trust to fund implementation costs up front from capital.

Financial Summary

5 year option

Annual Cost £'000	21/22 (4 months)	22/23	23/24	24/25	25/26	26/27 (8 months)	Total
Capital Investment	**644,270**						**644,270**
Revenue Costs:							-
Pay							-
Non Pay	32,710	122,329	122,329	122,329	122,329	65,419	**587,445**
Cost of capital (Depn)		128,854	128,854	128,854	128,854	128,854	**644,270**
HIS Data Warehouse current costs	130,000	86,667					**216,667**
Cost Saving (HIS)		(43,333)	(130,000)	(130,000)	(130,000)	(130,000)	**(563,333)**
Cost Avoidance (Clickhealth)		(38,000)	(38,000)	(38,000)	(38,000)	(38,000)	**(190,000)**
Total Revenue Costs	**162,710**	**256,516**	**83,183**	**83,183**	**83,183**	**26,273**	**695,048**

* the 22/23 HIS costs could be provided for in 2021/22

5 Year Pricing	21/22 (4 months)	22/23	23/24	24/25	25/26	26/27 (8 months)	Total
INITIAL LICENCE (CAPEX)	479,270	-	-	-	-		**479,270**
IMPLEMENTATION	165,000	-	-	-	-		**165,000**
ANNUAL LICENCE	4,239	12,716	12,716	12,716	12,716	8,477	**63,580**
SERVICES	28,471	109,613	109,613	109,613	109,613	56,942	**523,865**
Total	**676,980**	**122,329**	**122,329**	**122,329**	**122,329**	**65,419**	**1,231,715**

10 year option

Annual Cost £'000	21/22 (4 months)	22/23	23/24	24/25	25/26	26/27	27/28	29/30	30/31	31/32	32/33 (8 months)	Total
Capital Investment	**1,123,400**											**1,123,400**
Revenue Costs:												0
Pay												0
Non Pay	32,710	122,329	122,329	122,329	122,329	122,329	122,329	122,329	122,329	122,329	65,419	**1,199,090**
Cost of capital (Depn)		112,340	112,340	112,340	112,340	112,340	112,340	112,340	112,340	112,340	112,340	**1,123,400**
HIS Data Warehouse current costs	130,000	86,667										**216,667**
Cost Saving (HIS)		(43,333)	(130,000)	(130,000)	(130,000)	(130,000)	(130,000)	(130,000)	(130,000)	(130,000)	(130,000)	**(1,213,333)**
Cost Avoidance (Clickhealth)		(38,000)	(38,000)	(38,000)	(38,000)	(38,000)	(38,000)	(38,000)	(38,000)	(38,000)	(38,000)	**(380,000)**
Total Revenue Costs	**162,710**	**240,002**	**66,669**	**66,669**	**66,669**	**66,669**	**66,669**	**66,669**	**66,669**	**66,669**	**9,759**	**945,823**

* the 22/23 HIS costs could be provided for in 2021/22

10 Year Pricing	21/22 (4 months)	22/23	23/24	24/25	25/26	26/27	27/28	29/30	30/31	31/32	32/33 (8 months)	Total
INITIAL LICENCE (CAPEX)	958,400	-	-	-	-	-	-	-	-	-	-	**958,400**
IMPLEMENTATION	165,000	-	-	-	-	-	-	-	-	-	-	**165,000**
ANNUAL LICENCE	4,239	12,716	12,716	12,716	12,716	12,716	12,716	12,716	12,716	12,716	8,477	**127,160**
SERVICES	28,471	109,613	109,613	109,613	109,613	109,613	109,613	109,613	109,613	109,613	56,942	**1,071,930**
Total	**1,156,110**	**122,329**	**122,329**	**122,329**	**122,329**	**122,329**	**122,329**	**122,329**	**122,329**	**122,329**	**65,419**	**2,322,490**

Demand and Capacity tool – additional benefit

Under the 10 year option, the supplier Insource would include their demand and capacity tool worth £180k over 10 years and work with the Performance team to configure the solution to our requirement. This would be a significant added benefit and support the Trust to develop robust capacity planning to support service transformation and recovery and demand increases post COVID.

Capital Cost

Implementation and initial licences would be £644,270 in the first year. This would be depreciated over the initial life of the contract, 5 years.

Funding Source

Funding Proposal
The funding source for this would be the existing funding for the HIS data `warehouse (£130k). In addition to this there will be costs that can be avoided from Clickhealth (£38k). The balance would need to be funded by the Trust. The balance would need to be funded by the Trust. For the 5 year option this would be £257k in 2022/23 (including double running costs) and £83k on a recurrent basis. For the 10 year option this would be £240 in 2022/23 (including double running costs) and £67k on a recurrent basis.

13. Workforce Impact

There would not be a direct impact on staffing within the Trust, although there will be disruption with a move to a new data management platform which will have an impact on capacity and resilience in the Performance team as all reports would need to be rebuilt from the new data management platform.

A new partnership approach would enable database management knowledge skills and expertise to be passed onto the Performance Team and this would be of significant benefit in developing and upskilling the team. The new supplier would provide general coaching and mentoring as part of a proactive support service.

It is unlikely that redundancy or TUPE will apply for SSHIS staff although this would need to be assessed and confirmed. TUPE would apply if members of the SSHIS team supporting the data warehouse are substantially working in this area i.e. spending the majority of their time assigned to the NSCHT contract. In the case of the SSHIS data warehouse provision, it is the Trust's understanding that there is not a dedicated team and therefore TUPE is unlikely to apply. However, should the precise detail reveal otherwise then it would be likely that there are vacancies in the SSHIS that staff would be redeployed into; the Trust would also challenge any information presented to suggest that TUPE would indeed apply.

14. Activity Impact

There will be no direct impact on activity or activity reporting.

There will be a need to develop new reports from a new data management platform should this be procured.

However, given the need to double run reporting from the legacy data warehouse and new procured data management platform there should be no interruption in the provision and submission of national (MHSDS), commissioner and Trust operational management reports.

There will be a requirement to assure data quality in the new reports and validate with clinical teams. This will be managed as part of an implementation plan.

15. Procurement Impact

If the business case is approved a specification of requirements would be developed. Procurement advice has been sought and it is proposed and agreed that a Direct Award could be pursued on the Gateshead Framework.

16. Informatics Impact

The current solution is hosted on SSHIS systems, possibility of a third party solution being hosted on third party systems will result in the decommissioning of SSHIS servers.

17. Estates and Facilities Impact

There is no identified estate changes required or any expected impact.

18. Risks and Mitigations

The initial risks identified below will form part of the more detailed risk analysis, mitigations and ownership as part of the development of the mobilisation plan.

Risk Summary

Risk	Detail	Mitigation
Finance *(To be read in conjunction with finance report)*	There is a risk that the sum of money allocated will not meet requirement for development of data requirements and data integration, enabling full implementation of BI Strategy and associated benefits, and meet the Trust's digital ambition.	Full review of all system needs and horizon scanning for potential (health and social care) system requirements. During the initial phases of the project, the external supplier's input will be higher, and the proportion of input will reduce over time, so that they gradually transition from a leading role to a partnership and supporting role, as they share knowledge and skills throughout the duration. This enables the Trust to fund implementation costs up front.
Value for money	There is a risk that the current financial envelope may be regarded as sufficient to meet BI requirements if value for money is not clearly demonstrated.	Procurement advice has been sought and it is agreed that a Direct Award could be pursued via a Framework. If the business case is approved a specification of requirements would be provided and Procurement would manage a benchmarking exercise to ensure value for money.
Sustainability	There is a risk that the current data warehouse is not sustainable as other shared service partners have already withdrawn their support from the SSHIS data warehouse and developed their own	Procuring the data warehouse from a specialist provider will provide a viable, flexible and sustainable platform to build on, and an economy of scale to ensure access to expertise and new developments.

	bespoke solutions, either re-providing them internally or procuring a data management platform from an external provider. Combined is the only remaining Trust who procure a data warehouse from the SSHIS and this has placed the future viability of the SSHIS as an internal service provider at risk, with the potential to impact adversely on the Trust BAU services as well as the delivery of key developments and projects.	
Contract management	There is a risk with the current service as there are no contract levers in the SLA with the SSHIS that can be used if timescales are protracted or not met.	There will be a clear contract out in place with a new supplier with KPIs and penalties to ensure a reliable service is provided to the Trust.
Assuring data quality and a single version of the truth	There is a risk that clinical teams and operational managers may not have confidence in the quality of data that may be structured differently.	There will be a requirement to assure data quality in the new reports and validate each report with clinical teams. This will be managed by the Performance team as part of an implementation plan.
Change management	There is a risk that the significant change involved in establishing a new data management platform could impact on business continuity The importance of change should not be underestimated.	The supplier will provide expertise to help support the adoption of the solution within the Trust for the first 2 years of the contract. Key areas of focus will be stakeholder communications and engagement during Phase 1 and Benefits Management in Phase 2 and support during year 2 to measure benefits and coach ongoing change management methodology and approaches.
Business continuity	There is a risk that national and commissioner reports could be interrupted with a move to a new data management platform, impacting on the Trust's ability to evidence the quality of the services it provides and in meeting its mandatory	Current SLA notice period is 12 months. Given the need to double run reporting from the legacy data warehouse and new procured data management platform there should be no interruption in the provision and submission of national (MHSDS),

	reporting requirements, resulting in reputational damage.	commissioner and Trust operational management reports. This will be phased in the implementation plan.
Partnership approach and skill and knowledge transfer	There is a risk that the data warehouse supplier will not share skills and knowledge to improve capability of the Performance team and support the team with more advanced technical developments. This is necessary for the Trust to progress and become a data driven organisation.	Specification will include requirement to deliver the partnership approach expected, with an emphasis on a responsive partnership relationship, collaboration and skill sharing. The new supplier would provide general coaching and mentoring as part of a proactive support service.
Performance team capacity to meet growing demands	There is a risk that the volume of post warehouse processes is growing over time, while the development of the warehouse is currently static. Risk that the increasing volume of work undertaken to maintain these developments by the Performance Team may exceed the capacity within the team.	Daily review of workload, planned reporting and ad hoc requirements to ensure high value reports and key national priorities are met. However, strategic developments requiring more resource such as advanced analytics and demand and capacity planning put on hold if additional resource is not secured. New data management platform would improve capability and capacity.
Workforce	There is the risk that the current SSHIS team may be subject to TUPE which would require consultation and a potential delay.	Unlikely given that the current SSHIS team is not dedicated to support the data warehouse. If TUPE should apply the staff are likely to be redeployed. SLA notice period is 12 months enabling smooth transition.

19. Summary

There is an urgent need for the Trust to replace the existing SSHIS data warehouse if it is to realise its Digital and BI ambitions

The Trust requires an agile and fast paced external developer who has the infrastructure and data management platform already built to enable all systems to be integrated at pace. In addition, there is a need for a supplier with the capacity and capability to respond in a flexible and agile way to our changing business needs. Finally the solution needs to provide sharing of skills and expertise to develop the capability and efficiency of the Performance team. Insource would meet the specification and provides value for money.

This would realise significant benefits for the Trust and enable it to optimise reporting and analytics in a way that is not possible at the present time and with the current supplier.

20. Recommendations

- **Agree** in principle to replace the current SSSHIS data warehouse with a new data management platform.
- **Approve** the presenting business case by Board to serve notice on the SSHIS SLA and procure a data management platform from Insource, a specialist external supplier with a track record of delivery in mental health and Lorenzo.
- **Note** that notice (12 months' notice required) has been served on the SSHIS (November 2021)
- **Agree** a 12 month transition while a new data management platform is implemented.
- **Agree** for Insource, external supplier to be secured in the form of an award on the Gateshead Direct Award Framework.

Approvals	
Group (as relevant)	**Date**
Directorate Management Team	
Senior Leadership Team	
Finance & Resource Committee	
Board	

Appendix 1 - Option Appraisal Assessment Scores

Proposed Assessment Criteria		Option 1 Do nothing - Current solution	Option 2 - Retain and improve the existing SHHIS Data Ware-house	Option 3 – Establish a Trust internal Data Ware-house	Option 4 – Existing NHS Provider	Option 5 – Existing Lorenzo NHS Trust to build a Data Warehouse for Trust to maintain and develop	Option 6– Outsource the Data Ware-house to a private sector provider	Option 7 – Outsource the Data Ware-house to Dedalus Open Health Connect : Investigative Analysis
1. **10%**	**Delivers aims and objectives of National and Local Digital Strategies**	**4**	**10**	**9**	**9**	**9**	**11**	**11**
1.2	Promote the vision, aims and objectives of National Strategies and the Trust's Digital Strategy	**0**	**1**	**2**	**1**	**1**	**1**	**1**
1.3	Roadmap which aligns with the NHS Long Term Plan objectives and national strategies.	**0**	**2**	**1**	**2**	**2**	**2**	**2**
1.4	Programme in place to achieve the NHS Long-term Plan Objectives.	**0**	**1**	**1**	**1**	**1**	**1**	**1**
1.5	Enables the achievement of Trust's Digital by Choice Vision	**1**	**1**	**2**	**1**	**1**	**1**	**1**
1.6	Enables the exploitation and innovation of technology e.g. Artificial Intelligence, Data Modelling	**0**	**1**	**0**	**1**	**1**	**2**	**2**
1.7	Allows Trust to discharge relevant statutory functions	**2**	**2**	**2**	**2**	**2**	**2**	**2**
1.8	Enables the delivery of the Business Intelligence Strategy - integrating all data	**1**	**2**	**1**	**1**	**1**	**2**	**2**
2. **15%**	Enables the delivery of the Business Intelligence Strategy - integrating all data	**6**	**8**	**7**	**7**	**7**	**11**	**10**

2.1	Can be implemented within required tolerances (cost/time in line with the Strategy)	**0**	**1**	**1**	**1**	**1**	**2**	**2**
2.2	Independent structure to maintain functionality in spite of data source change.	**2**	**2**	**2**	**1**	**1**	**2**	**2**
2.3	Solution should provide a single rationalised data layer on which all downstream data requirements can be satisfied.	**1**	**2**	**2**	**2**	**2**	**2**	**2**
2.4	Ability to include manual data in a structured format including direct entry (web and validation)	**1**	**1**	**1**	**1**	**1**	**1**	**1**
2.5	Upgrades to be managed and implemented by the supplier maintaining all of the localisation and expansion without additional development requirement.	**1**	**1**	**0**	**1**	**1**	**2**	**2**
2.6	System integration - capability / capacity to consolidate all systems in line with the BI Strategy milestones – full range of connectivity options	**1**	**1**	**1**	**1**	**1**	**2**	**1**
3 **20%**	**Fit for purpose modern data management platform/ warehouse**	**13**	**17**	**17**	**15**	**17**	**19**	**19**
3.1	Track record of managing Lorenzo data extracts and structure to enable full Lorenzo dataset extraction.	**2**	**2**	**1**	**0**	**2**	**2**	**2**
3.2	Monitoring and resolution of data extract activity and issues.	**2**	**2**	**2**	**2**	**2**	**2**	**2**
3.3	Provision of out of hours service	**0**	**2**	**2**	**2**	**2**	**2**	**2**
3.4	Built on industry standard formats (SQL, CSV, FHIR, and HL7) with	**2**	**2**	**2**	**2**	**2**	**2**	**2**

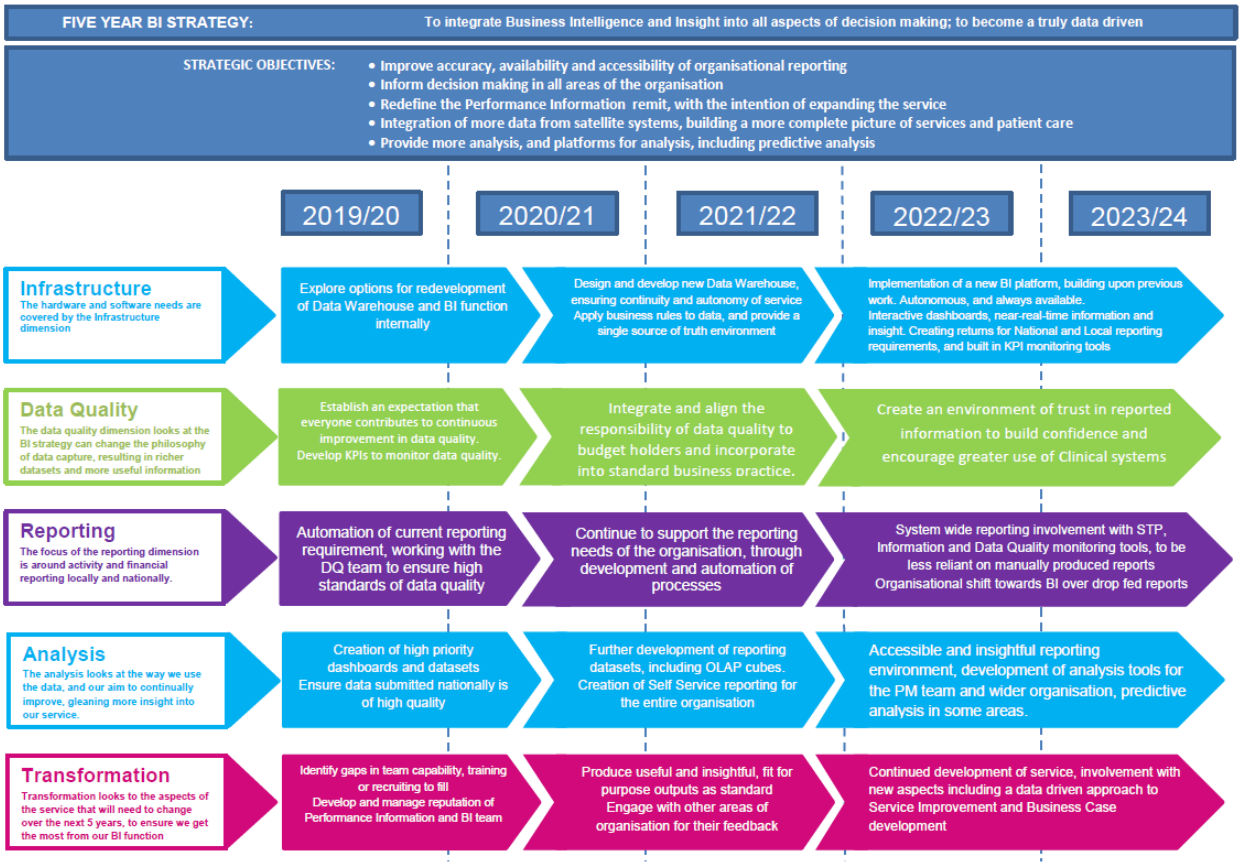
	independence of source systems.							
3.5	Ability to provide real/near time data reporting	**0**	**1**	**1**	**1**	**1**	**1**	**2**
3.6	Managed solution including all backup, restore and upgrade functionality included Trust developed items.	**2**	**2**	**1**	**2**	**2**	**2**	**2**
3.7	The data layer should provide a reliable, trustworthy source of data	**1**	**2**	**2**	**2**	**2**	**2**	**2**
3.8	Simplification, transparency, visibility and completeness of data structure to enable understanding & analysis of data	**1**	**1**	**2**	**1**	**1**	**2**	**1**
3.9	Multi stage development environments with integrated governance processes. (develop, test, train, live)	**2**	**2**	**2**	**2**	**2**	**2**	**2**
3.1	Integrated reporting platform included with local development functionality and automated end user reporting capability.	**0**	**1**	**2**	**1**	**1**	**2**	**2**
4 **20%**	**Implementation of the BI Strategy**	**8**	**12**	**9**	**10**	**10**	**15**	**13**
4.1	Future proof solution offering adaptability	**0**	**1**	**1**	**1**	**1**	**2**	**2**
4.2	Allows Trust the required level of ownership/control and confidence in delivery	**1**	**2**	**2**	**1**	**1**	**2**	**1**
4.3	Capability to deliver the platform at pace in line with the Trusts BI requirements target delivery within 6 months including identified reporting subset (mandatory submissions and high value)	**1**	**1**	**0**	**1**	**1**	**2**	**1**
4.4	Process to ensure system is aligned with changing reporting requirements ISN's	**1**	**1**	**1**	**1**	**1**	**1**	**1**

4.5	Provides a future proof data structure and architecture - able to respond in an agile way to changing national, contractual and internal requirements.	**1**	**1**	**1**	**1**	**1**	**2**	**2**
4.5	Capability and capacity to produce and respond to changing mandatory national requirements from all Trust systems (Lorenzo, ESR, IAPTUS etc) in line with national standards and in accordance with BI Strategy milestones	**1**	**2**	**1**	**2**	**2**	**2**	**2**
4.7	Hosted infrastructure environment, sized to Trust current and future storage and performance requirements.	**2**	**2**	**1**	**1**	**1**	**2**	**2**
4.8	Configurable and extensible solution developed according to Trust specification and milestones requirements	**1**	**2**	**2**	**2**	**2**	**2**	**2**
5 **20%**	**Partnership Approach with Performance/ Information team**	**2**	**6**	**5**	**3**	**2**	**10**	**5**
5.1	Track record of delivery of Trust Business requirements	**1**	**1**	**0**	**1**	**0**	**2**	**1**
5.2	Evidence of agility and adaptability to changing business requirements	**0**	**1**	**0**	**0**	**0**	**2**	**1**
5.3	Evidence of collaborative approach and relationship building with partners	**0**	**1**	**1**	**1**	**1**	**2**	**2**
5.4	Evidence of engagement and problem solving with analysts	**1**	**2**	**2**	**1**	**1**	**2**	**1**
5.5	Sharing of knowledge, skills and expertise with analysts, providing coaching/ mentoring	**0**	**1**	**2**	**0**	**0**	**2**	**1**
6. **10%**	**Financial and cost**	**6**	**7**	**6**	**6**	**6**	**6**	**6**

6.1	Cost	**2**	**2**	**1**	**1**	**1**	**1**	**1**
6.2	Demonstrates financially sustainability	**2**	**2**	**2**	**2**	**2**	**2**	**2**
6.3	Value for money - allows for savings to be realised (reduced duplication, improved joint working)	**1**	**1**	**1**	**1**	**1**	**1**	**1**
6.4	Will produce benefits and savings for the Trust over the course of the BI Strategy implementation	**1**	**1**	**1**	**1**	**1**	**1**	**1**
6.5	Promote integrated working of systems in the Trust and externally to realise benefits	**0**	**1**	**1**	**1**	**1**	**1**	**1**
7. **5%**	**ICS and system wide support**	**3**	**5**	**5**	**3**	**3**	**4**	**4**
7.1	Enables partnership working across the ICS	**1**	**1**	**1**	**1**	**1**	**1**	**1**
7.2	Supports easy and agile data sharing across the ICS	**2**	**2**	**2**	**1**	**1**	**1**	**1**
7.3	Creates the opportunity for NSCHT to provide leadership within the ICS and Local Health Economy (LHE) around data management and business intelligence	**0**	**2**	**2**	**1**	**1**	**2**	**2**
	Total	**42**	**66**	**58**	**53**	**54**	**76**	**69**
	With weighting applied	**665**	**1025**	**900**	**830**	**850**	**1235**	**1100**

Appendix 2 - Business Intelligence Strategy Plan on a Page

Business Intelligence Strategy



Appendix 3 – Service Specification

Data Warehouse Solution

Service Specification

Contents

Introduction

The Trust's Business Intelligence Strategy has been developed to advance the automation of reporting and development of self-serve reports to support data quality, clinical decision making and service transformation, ultimately enabling the Trust to realise the benefits of Lorenzo and other systems, and improve the quality of the care we provide. The data warehouse is a key component of our information systems and informatics capability and is a critical enabler to our success.

The right product would deliver to the Trust early value coupled with flexibility and growth capability. It will short cut the delivery time significantly as the fundamental functionality required is embedded in the product. The Trust Information and BI team should be left to focus on added value activities that accelerate the Trust's data infrastructure and support clinical staff in their decision making and service transformation.

The data warehouse solution should support the ever increasing requirements for national mandatory submissions in the form of MHSDS, SUS and other requirements. This is becoming more important as the Trust's performance is judged more and more on our nationally reported data and our reputation depends on its accuracy. In addition, it should be sustainable, and should automatically keep up with changing / improving industry standards to enable the Trust to be responsive to ever more digitalisation and automation of performance activity.

This document is intended to be a specification of requirements for the delivery of a data management solution for implementation in North Staffordshire Combined Healthcare NHS Trust.

1.1 Product Requirements

1.1.1 Technologies

The delivered solution should be based on core Microsoft technologies.

- Windows Server
- SQL Server
- Deployable on premise/in cloud – using Microsoft Azure
- Upgradable in the future to operate on Azure PaaS, ensuring the trust has the flexibility to move its technology platforms without the need for extensive re-development.

1.1.2 Solution

- The data warehouse solution should be based on a reference able product that has been deployed in trusts similar to North Staffordshire Combined Healthcare NHS Trust.
- The solution should be configurable to meet the exact needs of the trust such that the data output is fully representative of the trusts current position.
- The Trust uses Lorenzo as its core EPR and it would be preferable for the data management provider to have prior experience of mental health data and importing information from Lorenzo.

- The proposed solution should look to use open technology where appropriate such as HL7 / FHIR.
- The Trust is moving to a cloud first strategy and as such would be looking at the proposed solution to be delivered either through cloud hosting or software as a service (SaaS).

1.1.3 Development

The trust will want to be able change and expand the content of the data warehouse.

This should ensure a future proof solution offering agility and adaptability. The Trust's BI function needs to constantly meet the developing and changing requirements of the Trust, and so the data warehouse solution should provide a platform that can be agile enough to allow the BI function to keep pace with these changing requirements, including readiness to take advantage of emerging modern technologies and methods.

There should be no limitation to the extent to which the content in the data warehouse can be:

- Reconfigured
- Expanded
  - Include additional data into the solution
  - Expand the output of the solution to include additional derived data content
- Changed

This must also be possible in the context of the fact that the delivered solution is Product based, and therefore can be upgraded with effecting the changes implemented.

1.1.4 Technologies

The use of a graphical user interface (GUI) based off the shelf tool is required. This is for the development needed to implement the change process. This must be possible without the need to implement bespoke hand-coded approaches.

However, the solution should not preclude the use of generic SQL server content if needed by the trust. Where this choice is taken, it should be possible to combine the developed SQL Server content with the core product processing as needed.

1.1.5 Data Extraction

The processes implemented by the data warehouse product and any additional processed developed using the GUI tool must support and use all of the following where appropriate.

Full data load processing	The reprocessing of all data content using a full extraction of source data from the original data source
Incremental processing	The processing of only data that has changed since the last update process (either full, incremental or delta)

Delta feed processing	The processing of a feed of data that contains only changed data.
Ad-hoc data loads	The ability to build and perform a one off data extraction and load process

1.1.6 Core Data Processing

The core data processing should include functionality that will initially calculate output based on standardised NHS data derivation rules. Where appropriate activity data should be passed through an HRG and PSS processor to enrich the data content with the additional output from these groupers.

The core data processing should include the ability to take trust localised reference data and map this against the NHS DD national standards. This should include ICD10, OPCS4 and SNOMED where appropriate. IT should be possible for the trust to maintain the mapping in order to ensure that all output meets the trusts requirements for a corporately verified single version of the truth.

The core processing of the solution must be configurable to allow the injection of business rules that will alter the data output such that when completed is a corporately verified single version of the truth configured to meet exactly the trusts requirements. This data will be verified as truly representative of the trusts current position. These changes may include;

- The creation of additional tables that can be linked to data contained within other Trust created tables and core content tables
- Additional fields onto existing and new tables
- Additional business rules that calculate new content and adjust the calculation of existing content
- Additional validation rules, to produce DQ check output

1.1.7 Functionality

The data warehouse product operation should be supported by

- Data Lineage
- Data Dictionary
- Management information console
- Separated environment
- DevOps Capable
- SQL server version independent

Further descriptions of these requirements are as follows:

1.1.7.1 Data Lineage

The ability to track the provenance of any data items in the data warehouse, to include both source and output content. The lineage information should provide details of what transformations and processes have been applied to a piece of source data, and in which processes within the data warehouse process it and its derivatives are used.

1.1.7.2 *Data dictionary*

A detailed dictionary of the output data content. Providing as a minimum

- A description of the field and it's use
- The field type
- Table name in which the field is stored
- Method of field derivation (mapped, lookup, calculated etc)
- Functional Area in which the field exists (IP, OP, etc.)

1.1.7.3 *Management information console*

For daily operational purposes, the solution should provide a management console to allow the monitoring of the administration of the functioning of the solution. This should include.

- Daily performance metrics
- Content analysis (data population metrics, high level DQ statistics)

1.1.7.4 *Separate environments*

Since there is a requirement to be able to add, edit and maintain the content and processing of the solution. It must be possible to operate separate environments for the purpose of development and testing.

Development	Environment designed specifically for the development and change of the data warehouse content, operated independently of all other environments. When development is completed it must be possible to simply and smoothly update both the test and production environments.
Test	An environment dedicated to testing the DW in isolation of all other environments.
Production	The live environment where the BAU use will be applied.

1.1.7.5 *DevOps Capable*

The platform should be able to be integrated with professional DevOps environments to automate the development and release cycle to encourage a move towards Continuous Integration and Continuous Delivery.

1.1.7.6 *SQL Server Version independent*

The product must have a track record of transparently supporting later versions of SQL Server. Ideally, it would provide support for new SQL functionality transparently and without the need for additional development where appropriate.

1.1.8 Business Requirements

The Trust's Business Intelligence Strategy requires the integration of all Trust systems through a single data management platform to produce more powerful integrated reports.

The data management solution should be available 24 hours. The data warehouse product should support the following functional business requirements.

- Reporting from industry standard reporting tools (Power BI, Tableau,

- Qlikview etc.)
- Support for industry standard BI tools
- Production of trust statutory reporting both local and national
    - CDS
    - MHSDS
- Data quality reporting
- Contain the following data subject areas
    - Master Patient Index
    - Outpatient Activity
        - Referrals, Waiting lists, Appointments
    - Inpatient Activity
    - Waiting lists, admissions, spells, discharges
    - Care plans
    - Care pathways

The data management service should be responsive to the evolving needs to the Trust, and should provide a platform that supports further expansion into the future and opportunities for joint innovation. Change control processes should enable timescales to deliver outputs linked to national updates of MHSDS requirements.

1.1.9 Future proof solution offering adaptability

The BI function in the trust needs to constantly meet developing and changing requirements. The data warehouse solution should provide a platform that can be agile enough to allow the BI function to keep pace with these changing requirements, including readiness to take advantage of emerging modern technologies and methods.

2.1 Partnership Approach, knowledge and skill sharing

The Performance team in the North Staffordshire Combined Healthcare NHS Trust is a small resource and the relationship that the trust has with the supplier supports the capacity and capability of the Performance Team. This should be evident in the following ways by demonstrating:

- a track record in relationship building with providers
- a partnership approach based on engagement and collaboration
- Evidence of engagement and problem solving with analysts
- Evidence and commitment to share knowledge, skills and expertise with analysts, providing coaching/ mentoring

As the solution develops in line with the needs of the Trust, the performance team should be in a position to benefit from the expertise behind the platform to guide post data warehouse processing and analysis.

The data warehouse provider should offer added value by sharing developments that are already deployed in other trusts.

2.2 Financial and Cost

The solution needs to be financially sustainable and provide value for money, with ongoing development built in to its function.

2.3 Service Levels and Key Performance Indicators

2.3.1 Hours of Operation

The data warehouse will be available 24 hours, 7 days a week, except for the agreed maintenance, planned downtime and service availability. There will be a daily incremental data refresh and a full refresh will once at weekend will be configured.

PAS refreshes i.e., the availability of data from Lorenzo and other source systems will be down to the Trust to configure in collaboration with the suppliers.

Local networking connectivity will be the responsibility of the Trust.

2.3.2 Service Availability

The infrastructure to provide this Service should be designed to be resilient so as to achieve a high availability of Infrastructure and software availability (not less than 98% availability, notwithstanding planned downtime).

2.3.4 Planned Down Time

The underlying infrastructure that supports this Service will periodically require upgrades / maintenance that may require it to be taken offline. In the event of this, a change control process will be instigated. The data warehouse provider should notify the Trust of any downtime 10 business days in advance to give the Trust an opportunity to reschedule at a mutually agreed time.

Structural changes requiring full re-builds should be agreed in advance with the Trust during core hours.

2.3.5 Unplanned Service Outage

In the event of an unplanned service outage, the data warehouse provider should immediately notify the Trust IT Leads of the loss in service and regularly update progress towards service restoration.

Once normal service has resumed, an Incident Report will be produced and provided to the Trust identifying the root cause of the loss of service and any remediation plans to avoid future recurrence. The first cut of the Incident Report will be available after the initial resolution time and at the latest 24 hours after the resolution time.

Key personnel to be contacted for any processes will be agreed as part of the contract.

2.3.6 Response and Resolution Times

The IT Infrastructure Library 2011 (ITIL 2011) defines priority as a combination of a service request's impact and urgency.

To calculate the priority of the incident or service request relating to this Service select the urgency and impact using the table below and identify the value at the intersection.

The impact of the service request is the measure of how business critical it is. Impact is usually directly proportional to a number of users influenced by the service request.

Urgency is the necessary speed of resolving an Incident or implementing a service request. Urgency for certain services may vary in time.

A Major Incident is an incident with extreme impact to business, or an excessive disruption of service. It will have a priority of 1.

The Priority & Resolution times below are aligned with ITL as per the below:

Priority Matrix		Impact		
		1 - High	2 - Medium	3 - Low
Urgency	1 - High	1 - Critical	2 - High	3 - Moderate
	2 - Medium	2 - High	3 - Moderate	4 - Low
	3 - Low	3 - Moderate	4 - Low	5 - Planning

Priority Level	Description	Support Response Time	Resolution Time (working days)
Priority 1 (P1): CRITICAL	System is unavailable to all users rendering access to the system impossible Total failure of the system supported interface via hardware where no immediate workaround is available or where there is an agreed risk to database integrity Total communications failure. I.e. cannot connect to system and or data access mechanisms. Domain service accounts permissions are revoked or expire	1 hour	1 day

Priority Level	Description	Support Response Time	Resolution Time (working days)
Priority 2 (P2): URGENT	Severe degradation in system performance affecting all users due to the failure of the software Data integrity is compromised i.e. data reporting layer is not refreshed overnight	2 hour	2 days

	Connectivity available, but applications not functioning as expected i.e. SQL server services, HDE services. Data integrity is compromised. I.e. partial data presented, or data is not refreshed as per agreed schedule Data loading mechanism reports a failure Custom business rules incorrectly defined Logical data processing error		
Priority 3 (P3): ROUTINE	A service critical option (module or hardware) is inoperable but a safe workaround is available Operating system presenting with errors, but not causing operational issues Overrunning maintenance windows Data not refreshed within the normal expected processing hours	1 day	3 days
Priority 3 (P3): ROUTINE	A service critical option (module or hardware) is inoperable but a safe workaround is available Operating system presenting with errors, but not causing operational issues Overrunning maintenance windows Data not refreshed within the normal expected processing hours	1 day	3 days
Priority 4 (P4): SERVICE REQUEST	Requests for additional training Requests for additional consultancy Requests for advice on local configuration Incidents/problems caused by items/reasons not supported by the Supplier under the terms of this Contract, including (but not limited to) third party software, network, infrastructure, Authority supplied hardware, etc.	3 days	Variable on reason for request 1 week to 2 months

NB. Response time's clock start is initiated following notification of a problem from a user.

As the service evolves, the above table will be reviewed to ensure the times and categories are appropriate for the service.

2.3.7 Key Performance Indicators (KPIs)

- **Service KPIs**

The table below details the KPIs that are relevant to this Service.

KPI Description	Frequency	Target
Tenant Daily Refresh Report	Monthly	100%
SUS Submission Report	Monthly	100%
Production of MHSDS files	Monthly	100%
Exception Reporting Core Warehouse Refresh	Quarterly	100%