North Staffordshire Combined Healthcare NHS Trust

MEETING OF THE TRUST BOARD

TO BE HELD IN PUBLIC
ON THURSDAY, 5th October 2017, 10:00AM,
BOARDROOM, LAWTON HOUSE, TRUST HEADQUARTERS,
BELLRINGER ROAD, TRENTHAM LAKES SOUTH,
STOKE ON TRENT, ST4 8HH

	AGENDA	
1.	**APOLOGIES FOR ABSENCE** *To NOTE any apologies for absence*	Note
2.	**DECLARATIONS OF INTERESTS RELATING TO AGENDA ITEMS**	Note
3.	**DECLARATIONS OF INTERESTS RELATING TO ANY OTHER BUSINESS**	Note
4.	**MINUTES OF THE OPEN AGENDA – 7th September 2017** *To APPROVE the minutes of the meeting held on 7th September 2017*	Approve Enclosure 2
5.	**ACTION MONITORING SCHEDULE & MATTERS ARISING FROM THE MINUTES** *To CONSIDER any matters arising from the minutes*	Note Enclosure 3
6.	**CHAIR'S REPORT** *To RECEIVE a verbal report from the Chair*	Note
7.	**CHIEF EXECUTIVE'S REPORT** *To RECEIVE a report from the Chief Executive*	Note Enclosure 4
8.	**REACH RECOGNITION AWARD ON EXCELLENCE** *To PRESENT the REACH Recognition Team Award - Access and Home Treatment* *To be introduced by the Chief Executive and presented by the Chair*	Verbal Presentation
9	**STAFF RETIREMENTS** *To EXPRESS our gratitude and recognize staff who are retiring* *To be introduced by the Chief Executive and presented by the Chair*	Verbal

	QUESTIONS FROM MEMBERS OF THE PUBLIC	
10.	*To RECEIVE questions from members of the public*	Verbal
	ENCOURAGE, INSPIRE AND IMPLEMENT RESEARCH AND INNOVATION AT ALL LEVELS	
11.	**RESEARCH AND INNOVATION STRATEGY** *To RECEIVE the Research and Innovation Strategy from Dr Buki Adeyemo, Executive Medical Director*	Assurance Enclosure 5
	TO PROVIDE THE HIGHEST QUALITY SERVICES	
12.	**NURSE STAFFING MONTHLY REPORT - August 2017** *To RECEIVE the Nurse Staffing Monthly Report from Ms M Nelligan, Executive Director of Nursing & Quality*	Assurance Enclosure 6
13.	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 5** *To RECEIVE the Month 5 Performance Report from Miss Suzanne Robinson, Director of Finance, Performance and Digital*	Approval Enclosure 7
14.	**EMERGENCY PLANNING RESPONSE AND RESILIENCE** *To RECEIVE the Emergency Planning Response and Resilience Report and approve the work plan from Dr Nasreen Fazal-Short, Acting Director of Operations*	Approval Enclosure 8
	TO ENHANCE SERVICE USER AND CARER INVOLVEMENT	
15.	**SERVICE USER AND CARER COUNCIL** *To RECEIVE an update from, Ms Wendy Dutton, Chair of the Service User and Carer Council*	Assurance Verbal
	CREATE A LEARNING CULTURE TO CONTINUALLY IMPROVE	
16.	**WRES – WORKFORCE RACE EQUALITY STANDARD** *To RECEIVE for discussion the WRES from Mr Paul Draycott, Director of Leadership and Workforce*	Approval Enclosure 9
17.	**DIVERSITY AND INCLUSION STRATEGY UPDATED ACTION PLAN** *To RECEIVE the Diversity and Inclusion Strategy Updated Action Plan from Mr Paul Draycott, Director of Leadership and Workforce*	Assurance Enclosure 10
	MAXIMISE AND USE OUR RESOURCES INTELLIGENTLY AND EFFICIENTLY	

18.	**FINANCE REPORT – MONTH 5 (2017/18)** *To RECEIVE for discussion the Month 5 financial position and approve the Month 5 position reported to NHSI from Miss S Robinson, Director of Finance, Performance and Digital*	Approval Enclosure 11
19.	**ASSURANCE REPORT FROM THE FINANCE & PERFORMANCE COMMITTEE** *To RECEIVE the Finance & Performance Committee Assurance report from the meeting held 28th September 2017 from Mr Tony Gadsby, Chair/Non-Executive Director*	Assurance Enclosure 12
20	**CYBER SECURITY REPORT** *To RECEIVE a Cyber Security Report from Miss S Robinson, Director of Finance, Performance and Digital*	Assurance Enclosure 13
21	**CAMHS ASSURANCE REPORT** *To RECEIVE the CAMHS Assurance Report from Dr Nasreen Fazal-Short, Acting Director of Operations*	Assurance Enclosure 14
	ATTRACT AND INSPIRE THE BEST PEOPLE TO WORK HERE	
22	**TOWARDS OUTSTANDING ENGAGEMENT REPORT** *To RECEIVE the Towards Outstanding Engagement Report from Mr Paul Draycott, Director of Leadership and Workforce*	Assurance Enclosure 15
	CONTINUALLY IMPROVE OUR PARTNERSHIP WORKING	
23.	**PARTNERSHIP STRATEGIC PLAN** *To RECEIVE An update from Mr A Hughes, Joint Director Strategy and Development (NSCHT/GP Federation)*	Assurance Enclosure 16
	CONSENT AGENDA	
24.	**ASSURANCE REPORT FROM THE QUALITY COMMITTEE (VIRTUAL MEETING)** *To RECEIVE the Quality Committee Virtual Assurance report for the 5th October 2017 Trust Board meeting from Mr P Sullivan, Chair/Non-Executive Director*	Assurance Enclosure 17
	DATE AND TIME OF THE NEXT MEETING	
	The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday, 9th November 2017 at 10:00am.	
	MOTION TO EXCLUDE THE PUBLIC *To APPROVE the resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admissions to Meetings) Act 1960)*	

THE REMAINDER OF THE MEETING WILL BE IN PRIVATE

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

TRUST BOARD

Minutes of the open section of the North Staffordshire Combined Healthcare NHS Trust Board meeting held on Thursday, 7th September 2017 At 10:00am in the Boardroom, Trust Headquarters, Lawton House Bellringer Road, Trentham, Stoke on Trent, ST4 8HH

Present:

Chairman:

Mr T Gadsby
Non-Executive Director

Directors:

Mrs C Donovan
Chief Executive

Dr B Adeyemo
Medical Director

Mr P Sullivan
Non-Executive Director

Dr N Fazal-Short
Acting Director of Operations

Ms J Walley
Non-Executive Director

Mr P Draycott
Executive Director of Leadership &Workforce

Dr K Tattum
GP Associate Director

Miss S Robinson
Director of Finance, Performance and Digital

Ms M Nelligan
Executive Director of Nursing and Quality

Mr A Hughes [part]
Joint Director of Strategy and Development

In attendance:

Mrs L Wrench
Associate Director of Governance

Mrs L Wilkinson
Acting Corporate Governance Manager (minutes)

Mr J McCrea
Associate Director of Communications

Ms T Tainton
Vice Chair of Service User Carer Council

Ms J Harvey
Staff Side Representative (UNISON)

Mr T Crowley [Observing]
MIAA (Mersey Internal Audit Agency) Managing Director

Members of the public:
Hilda Johnson
Phil Copestake

Staff Retirements
Gwen Holland
Tina Mottram
Chris Sims

REACH Individual Recognition Award
Kathryn Hemmings

The meeting commenced at 10:00am.

790/2017	**Apologies for Absence** Apologies were received from: Mr D Rogers Chairman, Ms W Dutton Service User Carer Council Chair, Ms L Barber Non-Executive Director	**Action**

	Mrs Donovan welcomed Mr Tim Crowley, the Managing Director for MIAA (Mersey Internal Audit Agency) who was invited to observe the North Staffordshire Combined Healthcare's Trust Board. Ahead of the CQC Well Led Review AQUA and MIAA have been commissioned to undertake a full well led review which will provide an excellent baseline for our Trust's Board Development Plan going forward and help us in our journey to become outstanding. AQUA has a vast experience with Mersey Internal Audit (MIAA) of performing well led reviews. Ms Tainton was introduced and thanked for attending in Ms Dutton's absence. Warm wishes of a speedy recovery were extended to Ms Dutton.	
791/2017	**Declaration of Interest relating to agenda items** There were no declarations of interest relating to agenda items.	
792/2017	**Declarations of interest relating to any other business** There were no declarations of interest relating to any other business.	
793/2017	**Minutes of the Open Agenda – 13th July 2017** The minutes of the open session of the meeting held on 13th July 2017 were approved.	
794/2017	**Matters arising** The Board reviewed the action monitoring schedule and agreed the following:- ***772/17 – Acute Inpatient Ward 3 –*** *Agenda item for today's Trust board meeting.* ***773/17 Nursing Safer Staffing –*** *Item was discussed at Quality Committee 31st August 2017* ***779/17 Learning from Deaths -*** *Item was discussed at Quality Committee 31st August 2017* ***780/17 Finance Report Month 2 –*** *Agenda item to be discussed during today's Closed Trust Board* ***787/17 Trust Communications –*** *It has been agreed to strengthen People, Culture, and Development Committee communications which will report into Trust Board via the assurance summary.*	

795/2017	**Chair's Report** Mr Gadsby reported that STP does still continue to be the focus. It remains a concern that the STP still has an interim chair and we look forward to a new chair being appointed that can take STP forward. The Trust continues to engage with the STP. Ms Donovan is leading on this. Ernst Young (External Auditors) have been brought in to facilitate some of the Governance issues which is positive. ***Received***	
796/2017	**Chief Executive's Report** Mrs Donovan, Chief Executive, presented this report which provides an update on the activities undertaken since the last meeting in July 2017 and draws the Board's attention to any other issues of significance or interest. **CARE QUALITY COMMISSION (CQC) TO RETURN TO TRUST** It is anticipated that the CQC will be returning to the Trust soon as part of their new inspection process. As opposed to a comprehensive inspection two types of visits will take place – one will be an announced well-led inspection and there will also be unannounced inspections of our core services. The Trust has responded to more than 200 separate data requests from the CQC for information relating to our various services. There have been a number of CQC refresher courses for our clinical and corporate staff and team leaders providing them with more information on the new regime. Ongoing support is being provided to teams, their clinical directors and heads of service. Updated versions of the Trusts Vision and Values poster and a Board poster have been produced and distributed around the Trust. **TRUST SHORTLISTED IN NATIONAL AWARDS** The Trust's ongoing awards success has continued with the Trust being chosen as a finalist in the National Positive Practice in Mental Health Awards 2017. The Trust has been shortlisted in the Mental Health and Social Care Award in recognition of the excellent partnership working between Combined Healthcare and Stoke-on-Trent City Council in developing the Meir Partnership Care Hub. The Hub has brought together and co-located health, social care and community practitioners to provide support to the patients of five GP practices in Meir. Both the Trust and local authority have brought in existing partners to develop and focus third sector provision around the locality, which is already making a difference to peoples' lives. The awards will be announced on 12 October 2017. In other awards news, the Leading with Compassion scheme has been selected as a finalist in the national Kate Granger Awards for	

Compassionate Care. The scheme, which recognises acts of compassion by NHS staff, has been chosen as one of three finalists. It was launched at Combined Healthcare and has been rolled out across 11 NHS organisations in the region. To date, more than 500 of our staff have been recognised for their compassion under the scheme. The awards will be presented on 12 September 2017 as part of the national event.

PATIENT-LED ASSESSMENT OF INPATIENT AREAS ONCE AGAIN RATES COMBINED HEALTHCARE AMONG THE TOP PERFORMERS

Combined Healthcare is once again among the very best performers in the country, according to an independent report of inpatient environments. This year's Patient Led Assessment of the Care Environment (PLACE) results have revealed the Trust is well above the national average in each of the areas assessed by the inspection team, at least half of which is made up of patients and service users. Furthermore, each of the six five Trust sites inspected achieved 100% perfect scores in one or more areas.

PLACE focuses on the cleanliness on inpatient areas, as well as food and hydration, privacy and dignity, how well premises are equipped for people with dementia and how well they meet the needs of people with disabilities.

Inspections took place at inpatient areas at Harplands Hospital, Dragon Square, Summers View, Florence House, Darwin Centre and Assessment and Treatment Unit. Perfect 100% scores were achieved by the following Trust sites in one or more areas:

- Harplands Hospital – 100% in food and hydration on its inpatient wards
- Dragon Square – 100% in cleanliness and disability
- Assessment and Treatment Unit – 100% in privacy, dignity and wellbeing, and disability
- Darwin Centre – 100% in cleanliness, food and hydration on its inpatient areas, condition, appearance and maintenance, and disability
- Florence House – 100% in cleanliness
- Summers View – 100% in cleanliness, food and hydration on inpatient areas, condition, appearance and maintenance, and disability

AGM A GREAT SUCCESS

Partners, service users, carers and staff were welcomed to the Trust's Annual General Meeting (AGM) on 10th August 2017 at The Bridge Centre in Stoke-on-Trent. It was an excellent event and a great opportunity to celebrate everything the Trust has achieved over the past year. As part of the AGM we also unveiled our 2016/17 Annual Report and 2016/17 Quality Account, both of which are available to view via our website at www.combined.nhs.uk.

STAFFORDSHIRE TOP PERFORMING STP IN THE COUNTRY FOR IAPT RECOVERY RATES

Staffordshire and Stoke-on-Trent are leading the way nationally when it

comes to supporting people with common mental health difficulties into recovery. The county has the highest recovery rate of any Sustainability and Transformation Plan (STP) in England for those accessing improving access to psychological therapies (IAPT) services. The IAPT recovery rate in Staffordshire and Stoke-on-Trent is 61.2% - the only STP in England to have achieved over 60%. The figures form part of the first progress dashboards published by NHS England and NHS Improvement for the country's 44 STPs.

FUNDING BID FOR 24/7 RAID SERVICE A SUCCESS

A bid to secure new transformation funding for our mental health liaison services has been successful. The funding will enable the Trust's Rapid Assessment, Interface and Discharge (RAID) team to provide a 24/7 service to meet mental health needs at Royal Stoke University Hospital. Nationally there is a commitment to deliver a 'core 24' standard of mental health liaison services in at least 50% of acute hospitals by 2020-21. As there will be a delay in receiving the funding until April 2018, we are working with commissioners to look at whether they can bridge the funding gap between October and April in order to support the local health economy over the winter period.

DISCOVER YOUR FUTURE RECRUITMENT CAMPAIGN

The Discover Your Future recruitment campaign has continued with further one-stop events at Harplands Hospital for registered nurses mental health (RNMHs), registered nurses learning disability (RNLDs) and registered nurses adults (RNAs). The Trust has been running a promotional campaign on Signal Radio to promote the events and wider campaign and the next one-stop sessions take place on Friday 29th and Saturday 30th September 2017. Those applying have the opportunity to apply for available posts on the day, be interviewed by a panel and potentially leave with a job offer.

A new poster and leaflet aimed at nurses who have newly moved in to the area and are looking for a great new job in the NHS has been produced. We are in discussion with Stoke-on-Trent City Council about using their locations and channels to get the leaflet and posters displayed in areas outside the NHS.

PRAISE FROM NHS ENGLAND FOR COMBINED'S WORK ON WORKFORCE RACE EQUALITY

The Trust was delighted to welcome Yvonne Coghill OBE, Director of Workforce Race Equality Standard (WRES) Implementation for NHS England, to the Trust to lead a Board Development session on diversity and inclusion. WRES holds trusts to account for the action they take to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. It was great to hear from Yvonne that our Trust Board and Executive team is among the leading organisations in the NHS in terms of its diversity.

Yvonne also led our first Black, Asian and Minority Ethnic Focus Group. The purpose of the session was to enable the Trust to review the experience offered to this group, identify where improvements can be made and

highlight any good practice.

PAUL DRAYCOTT TO LEAVE COMBINED TO TAKE UP EXCITING NEW OPPORTUNITY AT SOUTHERN HEALTH NHS FOUDATION TRUST

Paul Draycott, Director of Leadership and Workforce, is leaving Combined Healthcare to take up an exciting new opportunity as Director of Workforce and Organisational Development at Southern Health NHS Foundation Trust, one of the largest mental health, learning disability and community health providers in the country.

Paul has been a highly valued member of the Trust Board and Executive team since March 2014. He is well respected and very popular with colleagues at all levels of the organisation, as well as with staff side representatives and stakeholders. He has made a significant contribution to our journey of improvement and will be greatly missed. Paul will be part of a completely new management team at Southern Health and is very much looking forward to the challenge. The title of the post to reflect the full portfolio has been amended to Director of Workforce, Organisational Development and Communications and has gone out to national advert.

RECOGNISING EXCELLENCE AND ACHIEVEMENT IN COMBINED HEALTHCARE (REACH) AWARDS

Thank you to everyone who has made a nomination for our annual REACH Awards, which this year take place on Thursday 5th October 2017 at the Moat House, Stoke-on-Trent. The awards celebrate staff, teams, volunteers and service user representatives who have gone above and beyond as part of their work. We are in the process of deciding the winners from over 230 nominations received across the categories and look forward to welcoming hundreds of nominees, service users, carers, partner organisations and sponsors for what is one of the highlights of Combined Healthcare's year.

NEW SYSTEM LAUNCHED TO SUPPORT STAFF TRAINING

The Trust has launched the Learning Management System (LMS), a new staff training site that enables people to do most of their e-learning from anywhere – be it at work, away from work and at home. It also allows staff to view their current training requirements and compliance status. The LMS is already proving a success, with hundreds of lessons and assessments having been completed and passed.

STAFFORDSHIRE AND STOKE-ON-TRENT SUSTAINABILITY AND TRANSFORMATION PLAN (STP) AND NORTH STAFFS AND STOKE-ON-TRENT ALLIANCE

The Trust has been working with the Staffordshire clinical leads group helping them to create a simple narrative to describe the STP through the eyes of staff and patients/service users. Time was also spent focusing on what clinical impact they wanted to have and how they could refocus the clinical leads group to achieve their purpose.

On the digital workstream, the Trust is looking to build agreements on data sharing, common standards and interoperability and is working with

	STP partners to do this. As part of this there will be a supplier event to bring all respective suppliers together across Staffordshire to see how the Trust can collaborate in delivering its priorities. A meeting of Chairs, CEOs and GP leaders across North Staffordshire confirmed a unanimous commitment to wrapping teams around primary care. In respect of recent rumours of Combined Healthcare merging with Staffordshire and Stoke-on-Trent Partnership NHS Trust (SSOTP) and South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT), it was agreed that this would not be happening as Combined are absolutely committed to the integration of services across North Staffordshire. The next steps for us will be building on the conversations we have had across the Trust about strengthening geographical working. ***Received***	
797/2017	**Questions from the public** Ms Harvey commented that there had been no structural engagement around STP to date which could pose difficulties when engagement commences as unions will be far behind in the debate. There is a view against STPs at the moment due to the potential for job losses across Staffordshire but as yet there has been no dialogue with trade unions. Mrs Donovan advised the Trust whole heartedly support the view of the trade unions. Mr Hughes is currently helping the STP to think through how governance needs to change and the principles underpinning that. Mr Donovan and Mr Draycott have been working with the Clinical Leads Group to ensure service users and staff have a stronger voice. Mr Draycott will be requesting more engagement of staff formally through the STP process and ensure this is embedded going forward. Ms Walley highlighted that transparency is fundamental regarding how this is taken forward if it is going to have any legitimacy and stated that we should use every opportunity to use the national contracts at every level we have to ensure we have this transparency.	
798/2017	**REACH Recognition Award** **Individual Award September 2017** **Kathryn Hemmings, Staff Nurse, Stoke Heath Substance Misuse Team, Substance Misuse Directorate** As a substance misuse nurse at Stoke Heath Prison, Kathryn supports those nearing the end of their prison sentence and preparing for release back into the community. The substance misuse team at Stoke Heath secured funding from the Welsh Assembly and Commissioners in Shropshire to provide 'Take Home Naloxone' at the prison. This is a safeguard for people using opiates,	

	including those currently abstinent who are at risk of relapse and overdose, as well as those leaving prison or treatment services. Kat volunteered to be Naloxone champion to take this forward. She has developed a clear structure and pathway enabling staff to implement the provision of Naloxone to patients released from our care. This has involved working with the Welsh Assembly, Commissioners and Stoke Heath, providing training for staff and patients, dealing with issues around governance and working with community substance misuse teams. Kat's introduction, delivery and monitoring of this initiative has proved a real success, with staff having a clear understanding of their roles and responsibilities in providing this life saving intervention. The value that best represents Kat is 'Compassionate'. She is a highly motivated and hardworking member of the team who is well-liked by all for her pleasant, approachable and compassionate style and persona. The Board congratulated Kathryn on her REACH Recognition award **Received**	
799/2017	**Staff Retirements** Mrs Donovan recognised staff who are retiring this month as follows: **Chris Sims – Ward Clerk** Chris has worked for the trust since 2001. She initially worked as housekeeper before becoming ward clerk. Chris has worked in many areas including on Oak Ward at Bradwell Hospital, Lymewood ward at Bradwell Hospital and Meadowcroft, Bucknall. She has also worked within adult services before working on 4 and then Ward 6. Chris is a valued member of the ward 6 team and is very supportive of the MDT and the NOAP division as a whole. Chris always comes to work with a smile on her face and nothing is too much trouble for her. The ward has seen a number of changes since she joined us but Chris has taken this in her stride and helped to maintain a team ethos. Chris is a very caring and compassionate person who strives to help others when she can. We are lucky enough to have Chris return on a part time basis so that she continues her good work and outstanding contribution to the delivery of care for the patients on ward 6. **Gwen Holland – Community Psychiatric Nurse** Gwen has spent the majority of her working career within the Older Person's Directorate and since 2012 moved to the County Memory Service. Gwen demonstrates enormous compassion to her service users, carers and the wider team. Gwen's commitment to service users and carers remains an inspiration to our team and numerous service users and carers have spoken about Gwen's compassion, time and care.	

Gwen's passion for her role and team is almost surpassed by her love of bright and quirky shoes and her ability to pick up on the feelings and needs of others. Her caring abilities were always her major attribute and all the patients and carers whom she has met, talk about her with warmth and genuine affection for the contribution she made to make that difference to them in their lives.

So, making that difference has always been the quality that Gwen personified within the team and what people will remember her for. That spirit drove Gwen to challenge herself and that is what others will recall. She faced daily the test of being as best that she could be for herself and to positively participate in all team activities. That inner strength shone through and was inspirational to the whole team. With her courage and self-sacrifice Gwen is actually the emotional conscience of the team and was the perfect advocate for her clients and carers. She would passionately articulate the emotional and spiritual needs of others that is the hallmark of kindness, consideration for the person in need and a colleague that will be missed

Tina Mottram – Clinical Service Manager
Tina commenced her career when she joined the Trust in 1989 working as a Health Care Support Worker on Ward 4 at St. Edwards Hospital. She commenced nurse training as one of the first Project 2000 nurses.

Tina qualified in 1994 and worked at Lymebrook Resource Centre on Ward 91 City General (Acute Mental Health Admissions); Sutherland Centre; Ward 18 (Rehabilitation Ward St. Edwards Hospital); Wilkins House Acute Admissions Ward at St. Edwards working under the leadership of the then Ward Manager Carol Sylvester.

In 2000 Tina made her first move into substance misuse at the old Edward Myers Unit at the City General. The field of substance misuse is where Tina specialised and fulfilled her potential attaining both her Diploma in Addiction Studies and later attaining a BA (Hons) in Specialist Nursing Practice.

She worked in a number of specialist roles including the Deputy Clinic Manager + City General Substance Misuse Link Nurse before becoming Ward Manager at the Edward Myers Unit in May 2010. Within this role Tina moved the ward forward delivering a service that was highly regarded by the service users and was successful in several tendering bids.

Tina was also instrumental in recognising the important role that Service Users played in developing services. This led the formation of the New Beginnings Service User Group. This is now established as a very successful peer support group and has been recognised locally and further afield for its excellent supportive work.

In May 2015, Tina was promoted to the Clinical Service Manager in One Recovery Staffordshire; where she continued to attempt to deliver a high quality service with the service user's interests totally at the heart of her thinking.

	As more than one staff member have stated “there will only be one Tina”. Tina plans to continue working on a part time basis which will provide her with more time to venture on her long haul holidays and to spend time with her grandchildren. ***Received***	
800/2017	**Stuarts Story - Presented by Maxine Tilstone, Ward Manager Ward 1 Harplands Hospital** Stuart is a 37 year old male that has been known to our services for over 20 years. He has a diagnosis of EUPD, OCD and anxiety and has had numerous admissions to hospital dating back to St Edwards Hospital. Stuart has been in and out of hospital with no real progress being made. He had one period of 9 years where he lived with another person but became so dependent on them that he was unable to manage his own needs when that relationship ended. Stuart has issues in dealing with other people and change which leads to Stuart seriously self-neglecting his own needs, and leads him to becoming hostile and aggressive towards others. Stuart has been placed in care facilities in this area but these have broken down due to difficulties with his routine. Last year Stuart had an eight month admission on ward 2 and following the breakdown of another placement, has been with ward 1 since New Year ’s Eve. We have identified other placements suitable for Stuart’s needs but this would mean him moving further from home and also his close friend who is a great support to him. The ward have sourced other options and identified a company that will work intensively with Stuart on the ward at first and then in his own accommodation and living independently in the community. Stuart is at the present time managing his emotions well and is positive towards his future for the first time in a long time. This has been quite a journey for both staff and Stuart and we are all moving in the same direction towards Stuart’s recovery **STUART’S STORY** *I have had to cope with mental health issues all my life and it has not been a good experience. I have been in and out of hospital for years and nothing has ever changed with me. When on the wards I don’t cope very well with change, which includes new people coming to stay on the ward. Being around other people that I do not like upsets me and makes me upset which leads to me becoming angry. I always like to go to Ward 2 but I am not allowed due to my behaviour in the past. I have promised this would not happen again but nobody believes me and I find ward 1 loud and scary.* *The staff have helped me to sleep better, as I used to go to bed at 3 to 4 in*	

	the morning but now I am in bed by midnight each night. I have also always struggled with any changes in my routine and again the staff have helped me to be less anxious when trying to manage my personal care needs and altering the way my day goes. *I do not like ward 1 but I know they have helped me during my stay on the ward. There have been times where I have laughed with other patients and staff and I am encouraged to spend time off the ward. What I have also liked is they have always been respectful to my friend Phil and made him feel welcome. Most of the time the staff approach me in a warm way but there has been times that I have felt this was not the case and I have lost my temper. I struggle when I feel my choices are not respected and again this has led to me becoming upset. I just want to leave and live somewhere where I can be myself.* *The ward has now managed to arranged for a company to come to the ward and help me with my routine. I really hope this works for me as it will lead to me having my own home in this area and will allow me to see my friend who is my only support on a regular basis.* Thanks Stuart Mr Hughes asked how the ward had managed issues re: the noise on the ward during recent building work. Maxie explained knowing noise levels were going to be high we asked Stuart's friend to visit in the mornings as opposed to evenings so Stuart is off the ward. Ms Johnson commended the team for their hard work Ms Nelligan thanked Maxine Tilstone and Carol Sylvester and asked for thanks to be passed to Stuart for sharing his story.	
801/2017	**Nursing Staffing Monthly Report – June and July 2017** Ms M Nelligan, Executive Director of Nursing & Quality presented the report and highlighted the following: The performance relating to fill rate during June 2017 was 84% for registered staff and 102% for care staff on day shifts and 81% and 108% respectively on night shifts. Overall a 95% fill-rate was achieved. July 2017 was 83% for registered staff and 99% for care staff on day shifts and 82% and 106% respectively on night shifts. Overall a 93% fill-rate was achieved. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover and Ward Manager supporting clinical duties. The data reflects that Ward Manages are staffing their wards to meet increasing patient needs as necessary. Key points to note: Ward 4 have recruited a new Ward Manager, OT and Physio Therapist.	

	A survey and staff preferences paper has been cited at the Senior Leadership Team meeting proposing a mixed shift system on wards following feedback from staff. Progressed e-rostering will be completed in the Autumn. There are still challenges in terms of registered nurse fill rates particularly on the acute wards and Ward 4 and we have to acknowledge the work the MDT teams and bank staff are doing. Without their support and ongoing commitment we would be in a different situation as we depend on little agency use. Dr Tattum asked if the fill rate during the night shifts compromises the safety of staff and other patients. Ms Nelligan advised safety and incidents reports are produced daily. A Duty Senior Nurse is also available during the evening if required and there is a qualified nurse on each ward during the night. However, we are planning for 2 registered Nurses on the acute wards which will only be achieved when we reduce vacancies. Ms Harvey advised she was impressed with the level of detail in the report particularly around the number of breaks cancelled and asked if this is typical of other Trusts. Ms Nelligan advised she was not aware any other Trusts monitoring this. Ms Harvey noted reliance on bank staff and HCSWs to cover Registered Nurse shortfalls and asked if the Trust were confident that staff are not undertaking an excessive amount of hours if substantive staff are working on the bank as well. Ms Nelligan confirmed the Trust has a centralised temporary staffing team that look at deployment of temporary staff and this is monitored. Bank staff who do not work substantively for the Trust are asked to declare hours. Ms Harvey asked if there was flexibility in terms of shift patterns for parents wanting to return to work? Ms Nelligan advised one of the items the Trust is looking at is having more flexibility of short and long shifts that work for people who have children. Ms Nelligan advised a piece of work has been undertaken with Access and Home Treatment around shift patterns and this will be reviewed across all Community areas along with caseload size. A presentation to look at the Meridian tool which looks at caseload size will be delivered at the next Quality Committee. ***Received***	
802/2017	**INFECTION, PREVENTION AND CONTROL ANNUAL REPORT** Ms Maria Nelligan, Executive Director of Nursing and Quality, presented the report highlighting key points. There has been no incidence of cross infection risks, or outbreaks of	

	infection in Q1. Preparation for the 2017 Flu campaign has commenced. North Staffordshire Combined Healthcare was acknowledged as being the highest achieving Mental Health Trust nationally last year. The Board approved the Annual Report for 2016/2017. ***Received / Approved***	
803/2017	**SAFEGUARDING CHILDREN AND ADULTS REPORT** Ms Maria Nelligan, Executive Director of Nursing and Quality, presented the report and highlighted the following. There were 108 Child Safeguarding referrals made by the Trust in 2016-17. A training strategy is in place and has been refreshed; this identifies which staff groups are required to participate in each level of training. This adheres to local and national guidelines to ensure that NSCHT staff receive appropriate training to meet their needs. In 2017 e-learning was introduced for levels 1/2 which releases time to provide monthly sessions for level 3 so staff will have more opportunity to attend. The Trust achieved 72% compliance for Level 3 training and 93% for PREVENT Dr Tattum highlighted that some of the figures are very low and wondered how they compare to other services providing a similar service and if there any perceived barriers to referral. Ms Nelligan advised she was happy to benchmark. In terms of barriers, the teams are very proactive and incidents are discussed at weekly meetings with safeguarding leaders. Ms Nelligan confirmed Lead Nurses for CCGs are part of our safeguarding groups and they have no concerns around our practices or reporting. ***Received***	
804/2017	**QUALITY STRATEGY AND ACTION PLAN** Ms Maria Nelligan, Executive Director of Nursing and Quality, presented the report for information. Priorities for the year were developed with Service users and carers in March 2017. Progress against quality priorities will be cited at Quality Committee on a quarterly basis. Mr Draycott commented that it was good to see diversity and inclusion included within the action plan along with accessible information.	

	Received	
805/2017	**SERIOUS INCIDENTS QUARTER 1 REPORT** Dr Buki Adeyemo, Executive Medical Director presented the report This report provides assurance on Trust processes relating to serious incidents, duty of candour and mortality surveillance. The report covers the period from 1st April 2017 to 30th June 2017 (Quarter 1 2017/18). There have been 9 incidents which are being investigated and consideration of the Duty of Candour requirements will be made. The vast majority of natural deaths are reported from the Neuro and Old Age Psychiatry Directorate and relate to elderly people who have had some contact with the memory service; in the main these deaths relate to people who have been out of service for over 12 months and deaths that do not meet the criteria for SI investigation. There were 2 incidents involving 'Slips, trip and falls' in the NOAP directorate; these incidents occurred on ward 4 and resulted in 2 people suffering fractures requiring surgery. Ms Nelligan advised work is being undertaken around a rapid improvement programme for falls this will be reported into the Quality Committee. There were 2 unexpected deaths in the Substance Misuse Directorate in Q1. This is a reduction on the number of deaths reported in previous quarters in 2016/17. It is anticipated that there could be an increase in reporting due to the Directorate incorporating Community Services. ***Received***	
806/2017	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 4** Suzanne Robinson, Executive Director of Finance, Performance and Digital presented the report highlighting the following: • 97.2% patient have been gate kept by the crisis resolution/home treatment team • 98.9% of patients on a care programme approach for at least 12 months have received a HONOS assessment • 100% of IAPT service users are treated within 6 weeks of referral • Readmissions have significantly reduced from 15% in April to 5% in July • Agency spend is underspent compared to the ceiling in Month 4 In Month 4 there are 3 metrics rated as Red and 1 related metric as Amber; all other indicators are within expected tolerances. Exceptions:	

	• CPA 91.8% at M4 from 91.5% at M3 • Delayed Transfers of Care (DTOC) - 15.9% at M4 from 14.6% at M3. Dr Fazal-Short advised in terms of a winter plan there has been an internal plan developed for ourselves and an external plan to involve our partners. • National operational CPA - 90.0% at M4 from 91.2% at M3 • Bed occupancy - 92.6% at M4 from 92.9% at M3 Mr Sullivan queried the number of patients out of area, Dr Fazal-Short advised this is unusual to have so many but this figure is moveable. Mrs Donovan highlighted that out of area PICU and Stepdown beds are the main areas of discussion in the MH Work Stream. ***Received***	
807/2017	**WINTER PLANNING** Dr Fazal-Short, Acting Director of Operations presented the report. In response to the NHSI letter of 14th July where expectations were outlined for CCG's to build resilience for the coming winter, NSCHT has considered the themes identified and produced the attached winter plan. This addresses both internal and external actions and will feed into the comprehensive winter plan that is being developed by the A&E delivery board. The Trust has an active role in the system wide Winter Planning group and will support the submission of a strong and credible plan for the coming months. This paper describes the NSCHT response to the winter planning requirements and in particular addresses expectations on: 1) Delayed Transfers of Care 2) Seasonal influenza planning 3) Demand and capacity planning 4) Winter Pressures Action Plan There is a potential option to increase capacity on site on ward 4 from 15 beds to 19 beds. This will require the completion of a business case, negotiation with commissioners and the mitigation of the risk related to recruiting staff. ***Received***	
808/2017	**FIRE ANNUAL REPORT / SAFETY UPDATE** Dr Fazal-Short, Acting Director of Operations presented this report. The Trust operate from approximately 30 different sites and during the period there have been 29 reported fire and smoking related incidents.	

	There were no serious injuries or deaths reported as a result of these incidents. Completion of mandatory Fire training was slightly below the Trusts own target and should be a priority to demonstrate the continued commitment to a strong fire safety culture. Overall compliance for training of staff is 83%. Trajectory for October 2017 is 100% compliance. The fire policy will be reviewed and updated by the fire safety advisor before September 30th 2017. Fire risk assessments and annual reviews have been carried out at all Trust sites and are subject to a risk based programmed inspection regime, with the highest risk premises: the main hospital and all in- patient sleeping areas having the most frequent inspections, i.e. at least once annually and as required if any circumstances change or following any incidents. Ms Walley confirmed she was pleased detailed inspections of building regulations had been undertaken confirming this is a detailed report that provides assurance. ***Received***	
809/2017	**SERVICE USER AND CARER COUNCIL** Ms Tess Tainton, Vice Chair of the Service User Carer Council presented the report. Ms Tess Tainton was appointed as the new Vice Chair of the Service User Carer Council. A workshop meeting held in August covered a presentation from the Research and Development team this was to encourage service users and carers to become actively involved in Research including opportunities to influence possible research topics. Also discussed was Dragons Den and there will be a joint proposal from Service User and Carer Council and Research and Development team to take the concept forward . The REACH awards – Council members discussed possible criteria for judging and having their own award for next year. An update was given on the Suicide Prevention Work plan which has been circulated to the council for comment. ***Received***	
810/2017	**FINANCE REPORT – MONTH 4 (2017/18)** Miss Suzanne Robinson, Executive Director of Finance, Performance and Digital presented the report.	

	The Trust's in month position is £179k surplus which is better than plan by £107k. Cumulative the position is £49k which is better than plan by £153k. In relation to Cost Improvement the Trust target for the year is £3.2m. This takes into account the requirement to deliver a £1.4m control surplus for 2017/18. The Trust wide CIP achievement is £220k (37%) at M4 compared to plan which is £368k behind plan. The recurrent value of schemes transacted is £837k (26%) against £3.2m target. The recurrent forecast as at M4 is £2.829m (88%); this represents a recurrent shortfall against the target of £368k (12%). The cash balance at 31st July 2017 has decreased to £6.636m due to an increase in the value of receivables and a reduction in the payables, which is £747k higher than planned, however the Trust anticipates be on plan by March 2018. The Trust's permitted capital expenditure at year to date at Month 4 was £493k and the forecast is to be £248k under plan. The forecast for NHSi is to meet plan. Use of resource rating of 2 which is in line with plan. The Board were asked to note the report ***Received***	
811/2017	**ASSURANCE REPORT FROM THE FINANCE & PERFORMANCE COMMITTEE** Mr Sullivan, Vice Chair of the Finance and Performance Committee/Non-Executive Director, presented the report from the meeting held on 31st August 2017 and highlighted the following: - A 5 year Cash and Capital Plan, evaluating the affordability of the current plan against statutory limits. Shortfalls on cash were identified which reduced the overall funding available for 2017/18 capital, including the under delivery of Cost Improvement and reduction in depreciation due to year end impairments. The Committee supports the recommendation to: o Set a minimum cash balance of £3.5m, which the trust will not fall below; o Reduce the 2017/18 Capital plan to allow a maximum capital spend of £2.041m. The Committee received an update for Cost Improvement for month 4 and were concerned that the total identified was still significantly short of the target. £2.485m is currently forecast to be delivered against the £3.197m target. The Q1 Deep Dive, presented at the Committee on 3rd August 2017, reflected on some of the issues in the delivery and identification of Cost Improvement. There remains a risk that the majority of schemes identified	

	are not transformational and therefore, presents a risk around the long sustainability of plans. The Committee were assured that there was sufficient focus being placed on Cost Improvement but are unable to give assurance around the ability to deliver the target for 2017/18. The Committee were assured that all remaining schemes will be transacted at Month 5, to provide greater visibility around the deliverability risk, of schemes included in the 2017/18 forecast. The CYP waiting times were presented, showing a dip in performance against the local, 4 week target, to 88%. CYP were over performing against national 18 week waiting time target. The Committee raised concerns around the 4 week target, having previously been assured by the Head of Directorate over the improved performance. It was noted that the transformation of Children's Front of House Services (The HUB) is likely to have a positive impact on performance of CAMH's waits. It was noted that the performance around ASD waiting lists was a real success story, where the legacy waits had all been seen. The Committee is assured that CYP has a robust understanding of demand and capacity, to effectively manage waits in the future. Dr Fazal-Short advised there will be a paper presented at October Trust Board regarding CAMHS Waiting Times. ***Received***	**NFS**
812/2017	**ASSURANCE REPORT FROM THE PEOPLE AND CULTURE DEVELOPMENT COMMITTEE** Mr Sullivan, Vice Chair of the People and Culture Committee/Non-Executive Director, presented the report from the meeting held on the 4th September 2017 in Lorien Barbers absence and highlighted the following: **Board Assurance Framework** The Committee reviewed the Quarter 1 2017/18 BAF and noted the following challenging areas: • Time to recruit rates remain below the mental health national average – student nurses joining the Trust from next month helps to mitigate against this. • Workforce Planning – a review of locality approaches to working and a temporary reduction in HR staffing which has created a challenge • Talent Management and Succession Planning – this is being currently reviewed **Staff Story** The Committee heard about the positive experiences of an apprentice who worked for the Trust and has since found a promotion at UHNM. The Committee discussed the positive nature of the experience of the member of staff and the learning from it. It was agreed to explore the Trust's	

	apprenticeship progression process to ensure that there are internal opportunities within the Trust. **Agency Spend and Rectification Plan** The rectification plan was presented to the Committee with the additional expenditure linked to ROSE, Ward 4 and the CAHMS LD consultant post, but was still being managed under the agency cap target. The Committee noted the contents of the letter received by the Trust from Mr Jim Mackey (NHS Improvement) on 17.07.2017 requesting the Trust's ongoing commitment to reduce agency spend. The following policies were approved by the Committee and ratified by Trust board: • Maternity, Paternity, Adoption and Shared Parental Leave • Freedom to Speak Up • Bullying & Harassment Policy • Temporary Staffing Policy • Preceptorship Policy **Mandatory & Core Required Training** A review of mandatory and core required training across the Trust had taken place to enable agreement about training, frequency and performance targets. Compliance levels had also been benchmarked nationally and a decision made to set the compliance targets at 85%, with a suggested stretch target of 95%. ***Received***	
813/2017	**ASSURANCE REPORT FROM THE QUALITY COMMITTEE** Mr Sullivan, Chair of the Quality Committee/Non-Executive Director, presented the assurance report to the Trust Board from the Quality Committee held on 31st August 2017. The meeting opened with a story presented by the Clinical Director from the Learning Disabilities Directorate which included a short video from a client sharing her experience of in-patient and community services. In particular, feelings were shared about the Intensive Support Team and the positive impact in helping this lady to develop tools and techniques for improving the quality of her life. This was a powerful story and was well received by the committee. The recommendations were supported by the Committee for approval of a number of policies which were ratified by the Board. • 1.44 Dual Diagnosis • 1.05 Attendance at Coroner's Court • MHA21 Transportation Policy and Procedure	

	• Covert Medication Policy • 1.03 Medicines Management Policy • 1.42 NICE Policy and Procedure • 4.23 Psychological Interventions Policy • R08 Personal Searches • Seclusion Policy (addendum added) • 1.64 Care Management and Care Co-ordination Policy • 5.05 Fire Policy • 5.21 Gas Escapes • 5.22 Management of Mercury guidance • 5.23 Safe Use of Mobile Phone • 5.26 Sharps Find Procedure • 5.27 Safe Use and Purchase of Electrical Equipment • 5.29 Unsafe Gas • 5.36 Central Alert System It was noted that from April 2017, Trusts are required to collect and publish information on how they intend to respond to and learn from deaths of people who die under the management of their care. It was agreed that it was appropriate for this guidance be appended to the Trust's current Serious Incident (SI) Investigation Policy 5.32. Each Directorate presented in detail their performance as part of the new reporting arrangements to the Committee. Committee members felt that this new style of reporting, capturing information from performance reviews enabled a much more focussed discussion around cross cutting issues. Items to note for report to the Board: • Adult In-patient Service – PIU challenges and opportunities. The Directorate managed staffing challenges during peak holiday time. Overall generally positive. Sickness at lowest level for 12 months. • Adult Community – it was noted that Stoke Healthy Minds (IAPT services) recovery rates are best in West Midlands. Medical recruitment is a challenge but reflects regional position. • CAMHS – Sustained improvement in respect to waiting times. Significant investment in staff, systems and processes. • Learning Disability Service – Service to be proud of and to celebrate, particularly in comparison to service delivery nationally. "We have a fantastic model!". • NOAP – to recognise RAID improved performance. Recognise challenge as move towards winter months. • Substance Misuse – Took over new service in 2 weeks which was remarkable and a significant achievement. Staff commended. The importance of Substance Misuse maintaining a profile in with the STP process. **Received**	
814/2017	**ASSURANCE REPORT FROM THE AUDIT COMMITTEE**	

	Mr Gadsby, Chair of the Audit Committee/Non-Executive Director, presented the assurance report to the Trust Board from the Audit Committee held on 30th August 2017. A report was presented regarding Internal Audit actions and progress in terms of implementation as of August 2017. The Committee took assurance that risk is well managed across the organisation Recommendations were supported by the Committee for approval of a number of policies which were ratified by the Board. • Reimbursement - Approved • Patient's Property - Approved • Property and Land Transactions - Approved • Local Counter Fraud – Approved **SFIs and Scheme of Delegation** Members noted the summary of key changes and approved the required changes which was ratified by the Board. **RSM Internal Audit Progress Report** The committee received the RSM internal Audit Progress Report *Internal Audit Benchmarking:* The committee received the benchmarking report on internal audit assurance levels across all assurance reviews completed in 2016/17 which shows that the trust is well above average in terms of substantial assurance when compared to all clients nationally, scoring 55% in 2015/16 and 41% in 2016/17 compared to the national figure of 19%. It was also noted that during the last 2 years reviewed, the trust had received no 'no assurance' ratings with the national figure being 4%. RSM were keen for the committee to understand that although the trust scored highly in terms of substantial assurance this was not because the audit programme focussed on areas known to be performing well and that the trust did also review 'tricky' areas. **Ernst and Young External Audit** The committee received the Annual Audit letter from external auditors EY which provides a summary of the audit results report and details that the trust received an unqualified opinion for both the annual accounts and in terms of value for money. The letter also acknowledged theTrust was meeting its financial targets and also acknowledged the recent CQC inspection report. **Received**	
815/2017	*To RECEIVE a verbal update on progress from Mr A Hughes, Joint Director Strategy and Development (NSCHT/GP Federation)*	

	Mr Hughes provided a verbal update and highlighted the following: - The P in STP has been changed to Partnership as opposed to Plan - Preparation is underway for a Governance workshop 2nd October 2017 - On the 23rd August 2017 Mr Hughes, Mrs Donovan and Julie Oxtoby presented 'Multi-Specialty Community Provider' presentation to the Stoke-on-Trent Health and Well Being Board - Developing partnerships o Provision of services within prisons o Securing funding across three STPs around supporting ways in which we can keep younger people out of TIER 4 beds. ***Noted***	
816/2017	**Any Other Business** **No other business**	
817/2017	**Date and time of next meeting** The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday, 5th October 2017 at 10:00am, in the Boardroom, Lawton House, Trust HQ.	
818/2017	*** Motion to Exclude the Public** The Board approved a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted.	

The meeting closed at 1.05pm

Signed: _____ Date_____
Chairman

Board Action Monitoring Schedule (Open Section)

Trust Board - Action monitoring schedule (Open)					
Meeting Date	Minute No	Action Description	Responsible Officer	Target Date	Progress / Comment
07-Sep-17	811/17	CAMHS Assurance - Paper to come to October Trust Board	Dr N Fazal-Short	05-Oct-17	Agenda item

North Staffordshire Combined Healthcare NHS Trust

REPORT TO Trust Board

Date of Meeting:	Thursday 5 October 2017
Title of Report:	Chief Executive's Report to the Trust Board
Presented by:	Mrs Caroline Donovan
Author of Report: Name: Date: Email:	Caroline Donovan, Chief Executive Caroline Donovan Thursday 5 October 2017 caroline.donovan@northstaffs.nhs.uk
Committee Approval/Received prior to Trust Board:	
Purpose / Intent of Report:	For information
Executive Summary:	**This report updates the Board on activities undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest.**
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• **Quality Strategy** • **Digital Strategy** • **Governance Strategy** • **Innovation Strategy** • **Workforce Strategy** • **Financial Strategy**
Relationship with Annual Objectives:	n/a
Risk / Legal Implications:	n/a
Resource Implications:	n/a
Equality and Diversity Implications:	n/a
Relationship with the Board Assurance Framework	1. **Provide the highest quality services** 2. **Create a learning culture to continually improve** 3. **Encourage, inspire and implement research and innovation at all levels** 4. **Maximise and use our resources intelligently and efficiently** 5. **Attract and inspire the best people to work here** 6. **Continually improve our partnership working** 7. **Enhance service user and carer involvement**
Recommendations:	To receive this report for information

Chief Executive's Report to the Trust Board
5 October 2017

PURPOSE OF THE REPORT

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

LOCAL UPDATE

1. CARE QUALITY COMMISSION (CQC) UPDATE

The Care Quality Commission (CQC) will be carrying out a well led assessment of the Trust during the week of 30th October. The well led inspection will have a much stronger focus on the Trust Board and senior management team compared to our previous CQC visits. The CQC have also begun their unannounced core service visits involving our clinical teams, starting on Monday 2nd October with the Community CAMHS Team at Dragon Square and Adult Community team at Greenfields. This is a great opportunity to communicate to the inspectors about the fantastic work that is happening and the progress we have made since we received our overall 'Good' rating earlier this year.

Meanwhile, we were proud to have been selected to feature in a CQC publication as one of the most improved trusts in the country. A number of managers and frontline staff are being interviewed by the CQC to find out about our improvement journey. This is a great vote of confidence and a testament to the huge amount of commitment and person-centred care from our staff.

A number of members of the Executive team have been trained to be Executive Reviewers in the new well-led' inspection. I am really keen for us to be reviewers so we can continue to learn from other Trusts and bring back good practice to help us continually improve as part of our journey towards Outstanding.

I have also was part of the CQC team conducting a well-led inspection in Taunton last week, which was one of the first in England..

The CQC have also reviewed the Stoke-on-Trent health and care system - as part of a national programme of 12 reviews of commissioning across the interface of health and social care and an assessment of the governance in place for the management of resources. The reviews are looking specifically at how people move between health and social care, including delayed transfers of care, with a particular focus on people over 65 years old. Although the review does not specifically include mental health services or specialist commissioning, it is focusing on the experiences of people living with dementia as they move through the system. Myself, Buki and Maria were interviewed as part of this.

2. ADVANCING QUALITY ALLIANCE PROGRAMME

The Advancing Quality Alliance (AQuA) is a health and care quality improvement organisation at the forefront of transforming the quality and safety of healthcare. The Trust have recently joined AQuA to strengthen quality improvement within the organisation. Three programmes will be running until March 2018 namely Patient Safety Leaders, Restraint Reduction and Access and Waiting Times. The Programme Lead for our organisation will be Maria Nelligan, Executive Director of Nursing & Quality. AQuA are also working with the Trust to do a well-led assessment which will inform our Board and senior leaders development programme going forward

3. CAMHS IN SCHOOLS TEAM LEADER JULIA FORD SHORTLISED FOR HSJ AWARDS

We were excited to learn that Julia Ford, our CAMHS in Schools Team Leader, has been shortlisted in the national HSJ Awards. Julia has been chosen as a finalist in the Clinical Leader of the Year category for her inspiring work in leading the team, which provides mental health services and support to a number of local schools. Julia and her colleagues travelled to London on 2nd October to give a presentation to the judging panel and will find out whether they have won when the awards are held on 22nd November.

4. VISIT TO HARPLANDS HOSPITAL BY POLICE AND CRIME COMMISSIONER

We welcomed Matthew Ellis, Staffordshire's Police and Crime Commissioner to Harplands Hospital on 12th September to meet with our staff and directors and discuss the importance of working together in partnership to protect and keep safe the most vulnerable within our communities. Matthew heard from Ward 1 Manager Maxine Tilstone and Ward 3 Manager Laura Jones, as well as members of our Community Triage Team about the work we do to support our service users. He also saw first-hand the work that is underway to build our new Psychiatric Intensive Care Unit, which is due to open in 2018.

The Police & Crime Commissioner is supportive of plans to develop facilities within Staffordshire and for a second place of safety specifically in the North of the County. A place of safety provides a dignified space for when a police officer detains someone in a public place on a S136 of the Mental Health Act because they believe he/she is mentally unwell and may be a danger to themselves or others. We are currently working with our local commissioners to identify the funding to help make this happen.

5. CHRISTINE MALBON WINS FESTIVAL OF LEARNING TUTOR AWARD

Well done to STR Worker Christine Malbon, who has been announced as the regional winner of the Festival of Learning Tutor Award from the Learning and Work Institute, an independent policy and research organisation dedicated to lifelong learning, full employment and inclusion. Christine won the Central region award for her exceptional achievements in adult education. The award recognises those who have supported learners to go on and lead successful and rewarding lives. To become a support worker, Christine needed to re-train and completed a Level 3 Community Mental Health Care certificate. She also began to give advice and support to fellow learners who had low confidence levels, helping them achieve success.

Her calm, reassuring and confident approach was noticed and she soon began to teach the Community Mental Health Care certificate. She has now started her own journey delivering education programmes for health care support workers. She was nominated by Julie Richardson, Residential and Resettlement Coordinator, who said: "Christine is committed to her work, extremely knowledgeable of her subject and passionate about recovery in mental health. It is these values that come shining through when she is delivering the training."

6. LEADING WITH COMPASSION SCHEME A FINALIST AT KATE GRANGER COMPASSION AWARDS

The Leading with Compassion scheme, which we lead across the region, made it to final three in the Organisation Category of the Kate Granger Awards for Compassionate Care, presented at the NHS EXPO in Manchester. Our Chair David Rogers, Director of Leadership & Workforce Paul Draycott, and Laura Rogers, Staffordshire Leadership and OD Lead, attended the event on behalf of the Trust. The scheme has been rolled out across 11 NHS organisations in the region. To date, more than 500 Combined staff have been recognised and received a personalised badge and card recognising the impact they have made. Kate Granger, who sadly passed away in 2016, worked tirelessly to raise awareness around compassion in the NHS through her #hellomynameis social media campaign and the awards continue this inspiring work. You can make a Leading with Compassion nomination at www.nhscompassion.org/nscht/.

7. BECOMING A NATIONAL DIGITAL EXEMPLAR

As part of our ambition to become a national exemplar in the use of digital, we are submitting a bid for funding from NHS Digital and DXC (our partner in the implementation of our ROSE electronic patient record (EPR)) to improve children's mental health. We are making the bid via NHS Digital and DXC's £12m funding pot to support innovation and good practice across trusts which use the Lorenzo EPR. Our Children and Young People's directorate have done such a fabulous job in enabling young clients to access community services in a much more timely way. They receive a high number of referrals that don't need to be seen by CAMHS services and through strengthening our working with schools young people and other agencies we can improve services even more. This is an exciting opportunity that I hope we will be successful in.

We have also bid for national funding to make our RAID service an all age one so children and young people can be supported more effectively at Royal Stoke University Hospital. We are partnering with commissioners and providers across Staffordshire, Shropshire and the Black Country in this.

8. RECORD-BREAKING REACH AWARDS

Every year we recognise staff, teams, partners, service users, carers and volunteers who have truly excelled and made a real difference through our REACH Awards. I am delighted that we have attracted a record number of nominations for this year's REACH – almost 300! Our REACH ceremony takes place on Thursday 5 October at the Moat House Stoke-on-Trent and is sure to be a fantastic occasion and a celebration of those who have truly inspired us.

9. TONY SCOTT NEW BEGINNINGS GARDEN OFFICIALLY OPEN

I am delighted that the Tony Scott New Beginnings Garden at Harplands Hospital is now officially open. A tea party was held to launch the garden, which has been made possible thanks to a £12,000 grant from Tesco's Bags of Help scheme. Staff and service users from Growthpoint carried out the work to the garden – named in memory of Tony Scott, one of the founder members of the independent New Beginnings group which supports our Substance Misuse services. We were pleased to welcome Tony's family, who were among those in attendance. The garden is a pleasant and calm place for patients, visitors and staff to sit, contemplate, meet and enjoy the peaceful surroundings. A key feature in the garden is a Peace Pole which conveys a message of peace in the four most spoken languages in Stoke-on-Trent – English, Punjabi, Urdu and Polish. If you haven't had a chance yet, and you're near the garden in future, please take the time to look around and relax.

10. NATIONAL RECOGNITION FOR TRUST'S DIVERSITY AND INCLUSION WORK

Our work on Diversity and Inclusion has received national recognition in two separate ways. Lesley Faux, Diversity and Inclusion Lead, and staff side Chair Jenny Harvey attended an event on 13th September at the House of Lords organised by the Employers' Network for Equality and Inclusion (ENIE). ENIE is the UK's leading employer network promoting equality and inclusion in the workplace. We were proud to be invited to attend and fly the flag for all the work we are doing to promote equality and inclusion in Combined Healthcare and across the NHS. The following day, Lesley travelled to Leeds to give a presentation to colleagues from NHS Employers about **Symphony of Hidden Voices** – a series of events, activities and online places where hidden voices with perspectives on mental health care can find and engage with each other. **Symphony of Hidden Voices** was created initially at an event at Port Vale Football Club in June. NHS Employers got in touch with us shortly afterwards to say how impressed they were and invited us to show what we're doing to their Diversity and Inclusion Partners Programme.

11. STP LEADERSHIP PROGRAMME

On 6th September we commenced our primary care leadership programme to provide twenty one local clinical leads, from the Staffordshire localities the opportunity to develop systems leadership skills. This will enable them to work as a network together moving the New Models of care agenda forwards. Simon Whitehouse, the Staffordshire STP Director opened the course with a discussion session.

This 8 day programme will run over an 8 month period and will teach core management skills and also equip local leaders with wider OD and political skills in order to navigate the new healthcare system. This will be underpinned with action learning and coaching in order to share learning and establish a sustainable network.

Alongside leadership development the programme will be supplemented with knowledge inputs. These inputs will relate to new contractual relations and performance measures synonymous with these new care models, as well as imparting knowledge from related vanguard schemes.

The participants will undertake a project throughout the life of the programme and will present findings on 26th April, 2018. Regular progress updates will feed into the North Staffordshire and Stoke-on-Trent Alliance Board as well as the Staffordshire STP OD and Leadership work stream.

12. NEWCASTLE ACCELERATED DESIGN EVENT

North Staffordshire and Stoke-on-Trent Alliance Board agreed at its meeting on the 14 June 2017 that Newcastle-Under-Lyme would be ITS first pilot area. The first initial meeting took place on the 4 July 2017 where it was agreed that the approach to develop a locality model would be to apply an Accelerated Design Event (ADE) to consider an Extensivist Model.

An Accelerated Design Event is an event that bring together groups of people to work through challenges and issues quickly and develop action.. Every ADE is unique; it is created to achieve specific outcomes, using a variety of techniques and methods (including environment, facilitation processes, technology, knowledge and collaborative work techniques) that have been shown to create the conditions for large scale change.

An ADE event took place on 4th October to consider the proposed model and to:

- Create greater engagement
- Build deeper trust with each other
- Develop understanding and investment in the model
- Develops a coherent and systematic approach to agreement and implementation, which will accelerate progress
- Develop clear decision making processes
- Define governance structures focused on achieving outcomes
- Prototype a new model

NATIONAL UPDATE

13. NHS PROVIDERS SIGNALS WARNING ON WINTER PRESSURES

In a new report published at the start of September, NHS Providers gives its latest assessment of the state of play on planning for what is currently heading for a worse winter than last year – widely regarded as the worst winter for the NHS in recent times. The report has been informed by regular feedback from front-line NHS trusts and discussions with system leaders, as well as analysis of the latest data on key performance targets such as the four hour A&E standard and bed occupancy levels.

The report finds that the level of planning and support for this winter – led jointly by NHS England and NHS Improvement – is considerably more developed than last year and emergency care performance has been given greater priority. Extra social care funding is helping to increase capacity in about a third of local areas and this should help to reduce the delays faced by some patients in those areas when they are medically fit to leave hospital but unable to do so because of a lack of available support in the community. Local trusts and systems are also putting huge efforts into early resilience planning to ensure patients are protected and face fewer delays.

We are involved activity with our partners in developing a whole system winter plan. Our local plan is complete and will feed into the Staffordshire Plan to ensure that A&E is supported through the winter. Our offering in winter will include increased capacity on ward 4, which is our shared care ward, taking us up to 19 beds. We are also increasing our capacity in outreach services, supporting both A&E in 'pulling' people out of the system and supporting care homes in taking people back with additional support on challenging behaviour management.

14. NEW RESEARCH PUBLISHED ON CHILDREN'S MENTAL HEALTH

New research published by the National Children's Bureau and University of Liverpool – which shows a quarter of girls (24%) and one in 10 boys (9%) are depressed at age 14 – attracted national attention.

Commenting on the Report, Claire Murdoch, National Mental Health Director at NHS England, said: "NHS services for children and young people are expanding at their fastest rate in a decade. This year the NHS will treat an additional 30,000 children and young people, supported by an additional £280 million of funding. The report demonstrates how critical it is that all services – schools, youth services as well as the NHS – play their part in spotting problems early, and offering solutions."

Having made significant and sustained progress in reducing the waiting lists across the CYP Directorate, we are now beginning a transformation project to further develop the Central Referral Hub. This will be achieved through reconfiguration of existing resource and the introduction of an evidence based, brief intervention clinical pathway. Building on the existing model of care provided by the Central Referral Hub, this transformation will improve the front door experience for children, young people and their families - working in partnership to deliver an integrated, recovery based, preventative model that is flexible in meeting the needs of children and young people.

The proposed development of the Central Referral Hub is underpinned by the following principles:

- Timely access to a responsive service (no wrong door approach)
- The centralising of a timely, comprehensive, assessment with an enhanced access to clinical pathways
- Standardisation of approach with enhanced governance
- Equity of service
- Early intervention by an appropriately skilled professional
- Improved CYP and family/carer experience and outcomes
- Reduced length of stay in treatment
- Compliance with new anticipated waiting time targets

Looking ahead we are planning to expand the CAMHS in school's project. This model delivers clinical evidenced based programmes to whole class and year groups as well as staff training and staff support sessions aimed at improving mental Health & wellbeing, building resilience and early interventions within the Schools directly. Key learning is the importance of promoting school based interventions and the importance of CAMHS specialist support being located in the schools as part of the school community and team enables clinicians/practitioners to work more effectively with the whole school to promote good mental health and supporting pupils experiencing some mental Health difficulties at the earliest opportunity.

15. NHS70 PREPARATIONS UNDERWAY

The NHS celebrates its 70th birthday on 5th July 2018 and preparations are already underway to mark the occasion. NHS England is particularly keen to encourage and support local and regional celebrations with NHS trusts, GPs, clinical commissioning groups, sustainability and transformation partnerships and others being asked to organise:

- Open days – throwing open your doors to the public
- Exhibitions on local high streets – in libraries, community centres, etc
- Staff awards themed around the birthday
- Tea parties for staff and patients
- Competitions for local children and young people to get involved.

In October 2017, NHS England will publish an online toolkit to support health and care organisations with their arrangements. This will include practical guides, logos, leaflets, posters and materials that can be shared via social media.

As part of our celebrations, Combined Healthcare NHS Trust is planning to hold its 2018 REACH Staff Awards on Thursday 5th July.

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REPORT TO TRUST BOARD

Enclosure No:5

Date of Meeting:	5TH October 2017		
Title of Report:	Research & Innovation Strategy		
Presented by:	Dr Buki Adeyemo, Medical Director		
Author:	Sandra Storey, Sue Wood		
Executive Lead Name:	Dr Buki Adeyemo	Approved by Exec	☒

Executive Summary:	Purpose of report	
The refreshed strategy has been written to support the Trust's organisational objectives and provide a framework to encourage, inspire and implement research at all levels. The document has been written in line with the organisation's business plan and links into other key trust strategies and reflects the current NHS research priorities as identified by the National Institute for Health Research high level objectives. The strategy also reflects extension of the team's remit to include innovation and commitment to working with services users, carers and staff to develop this strategy further during the course of 2017/18. As such, the strategy will evolve and will be a dynamic document to support the organisation's future needs.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☒ Execs ☐ Date: 12.09.17	Document Version No.	
Committee Approval / Review	• Quality Committee ☒		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☒ 4. Encourage, inspire and implement research & innovation at all levels.☒ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☒ 7. Continually improve our partnership working. ☐ This report relates to all strategic objectives		
Risk / legal implications: Risk Register Ref	On-going risk with regards to reduction in funding from NIHR as a consequence of 3 year funding model. On Directorate risk register		
Resource Implications: Funding Source:	Capacity of team to deliver wide range of research and development alongside initiatives both internal and external to the Trust also ensuring commercial income generation.		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	None Known		
Recommendations:	To receive the strategy for information and assurance purposes		

North Staffordshire Combined Healthcare NHS Trust

Research and Innovation (R&I) Strategy

2017-2022

Draft V12 30 August 2017

Introduction

This document defines the Trust's Research and Innovation (R&I) Strategy and outlines the direction that will be taken to enable the delivery of high quality portfolio, commercial and home-grown research, and innovation in line with our Trust Vision to be:

"An independent, self-governing health and social care provider that demonstrates clinical sustainability, operational sustainability and financial sustainability – and works in partnership with local, regional and national providers from public, third section and commercial sections"

Research is vital; a strong commitment to research will generate the evidence to develop more effective and efficient ways to treat and prevent ill health and enable us to transform our services and improve outcomes for our service users and carers.

By fully integrating research into our clinical practice and our organisation we will outperform organisations that do not, delivering a higher standard of care and improved use of resources.

A pursuit of the use of evidence and evaluation will improve how we measure and demonstrate the impact of our work, enabling us to share what we do well, and learn about what and how we can do better. We wish to foster a culture in which decision making is underpinned by a sound evidence base and evaluation is considered an essential component in the implementation of new initiatives. A strong infrastructure that is supportive of research and evaluation will be an essential requirement to achieving this.

The R&I Strategy is closely aligned to other Trust documents such as the Integrated Business Plan (IBP) 2015/16 – 2019/20[1] and other relevant strategies such as the Quality Strategy. The R&I Strategy is also closely aligned with the Trust's vision to be outstanding.

[1] *NSCHT Integrated Business Plan 2015/16 – 2019/20*

1 Background

1.1 National Context

Research is vital in providing the new knowledge needed to improve health across the population. The NHS Constitution[2] confirms the commitment of the NHS to innovation and to "the promotion, conduct and use of research to improve the current and future health and care of the population". Apart from the contribution that NHS research can make to the health of the nation it is also acknowledged that it can make a significant contribution to the national economy in terms of the revenue that can be generated from commercial research activity and as such it is included in the HM Treasury Plan for Growth.[3]

In order that the NHS supports and harnesses the best research and innovations and becomes the research partner of choice The Department of Health requires it's organisations to promote and support participation by staff, patients and carers in research funded both by commercial and non-commercial organisations. Consequently all NHS trusts are expected to consider research to be not only core business but also a frontline activity and all parts of the NHS have a role to play in undertaking and supporting research as well as using research evidence when deciding what services, treatments and interventions it provides.

The NHS Five Year Forward View[4] outlines how the health service needs to change over the next five years in order to close widening gaps in the health of the population, quality of care and funding of services, it recognises that the timescales for translating discovery into clinical practice are often too slow, in a world that is fast developing with emerging technological advances it is necessary to ensure that cost effective innovation can be adopted in a timely manner.

The National Institute for Health Research (NIHR) was formed in 2006, with a vision to improve the health and wealth of the nation through research. The delivery arm of the NIHR, the Clinical Research Network (CRN) contributes to this vision, and provides funding to support NHS organisations in order to enable them to maintain research capacity and capability. The funding allocation is specifically linked to research activity in terms of recruitment to NIHR portfolio studies. Over recent years the funding model of our own West Midlands CRN has been refined to an activity based three year model with a weighting applied according to the complexity of the study.

The landscape for research in the UK is changing, we have seen a major overhaul in the way in which research studies are approved with responsibility shifting to the HRA (Health Research Authority) in an attempt to establish a single, more effective system for study approval and delivery. There has been an addendum to the ICH guideline for Good Clinical Practice, (the international ethical and scientific standards for research) and the implications that Brexit has for NHS research is not yet clear. We need to develop a strategy which enables us to be responsive to the changing research climate and which enables us to face the challenges and embrace the opportunities that this may create.

[2] NHS Constitution for England Department of Health 2015
[3] Plan for Growth HM Treasury 2013
[4] Five Year Forward View NHS England 2014

1.2 Local Context

The Trust can evidence its former standing as a research rich organisation, a former Keele University teaching hospital with strong academic links, a Professor of Psychiatry, a team of staff including Research Associates, a dedicated academic suite along with a Clinical Effectiveness Unit (CESU). Funding for the team is predominantly through the CRN (Currently 65.%), 22% is Trust funded and the remaining 12% is reliant upon income generation. This funding split is reflected in our research activity with the vast majority of the work undertaken being recruitment to NIHR portfolio studies.

Over the past two years our performance in recruitment to portfolio studies has improved and our overall target has been achieved with 2016/17 seeing a consistent performance above the pro-rata targets throughout the year. (Figure 1) CRN funding performance related, however since it is allocated on a three year model we have yet to realise the benefits of this improved performance. Due to overall changes in CRN allocations, over the past three years our allocation has been reduced by a total of 28.7%, maintaining our performance in recruitment is essential to maintain and improve on our current level of CRN Funding.

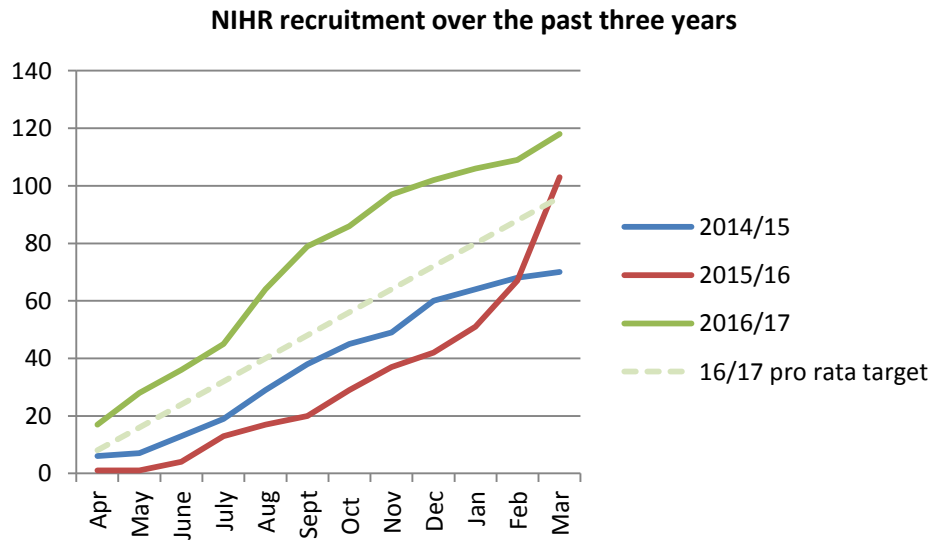

Figure 1

In order to support the Trust in achieving its objectives the remit of R&I team has effectively changed, and the team have been given the brief to extend our workload beyond NIHR delivery, engaging with clinical teams not only to promote recruitment to NIHR portfolio studies but also to support research, innovation and evidence-based practice and develop partnerships and links with external agencies and academic institutions; (previously the province of CESU). Creating sufficient capacity to respond to this increased demand has been a challenge, in the short term we have been able to utilise commercial research revenue to fund additional delivery hours, have developed partnerships to increase our capacity and benefitted from the NOAP directorate appointing a .6WTE research nurse, however the most significant contribution has been from the R&I team members themselves

who have demonstrated their on-going commitment working flexibly and innovatively above and beyond their allocated roles and responsibilities.

Commercially funded research offers NHS trusts not only the opportunity to engage in high quality interventional research and offer service users the opportunity to receive new or novel treatments, it also generates income. As an organisation the Trust is relatively new to the field of commercially sponsored research, our first commercial CTIMP (Controlled Trial of an Investigational Medicinal Product) was initiated in 2011, since then a combination of limited availability of studies, competition from larger more experienced sites and limited resources has meant that this area of our own research portfolio has seen very little growth. In order to address this and exploit our clinical expertise in Dementia care a collaborative relationship entitled the Dementia Joint working Project was forged with UHNM to jointly set up and deliver dementia research. The innovative project was successful in securing additional CRN funding for a jointly appointed dementia research coordinator and the team were recipients of both CRN West Midlands and UHNM awards. The project increased commercial development site selection and activity by 300% and currently accounts for all the commercial research activity within our portfolio. It has recently developed into NoGAP (NeurOdeGerative Active Partnerships) extending engagement and collaboration with other local NHS organisations, charities and universities with plans further harness the joint expertise and bring wider scope of research to North Staffordshire.

1.2.1 Assessment of the current position

In developing the strategy and planning the future direction for R&I consideration needs to be given to our current position in terms of identifying where our strengths lie, where we need to improve, what opportunities are available and where the potential threats lie, these are shown in the table below;

Strengths

Motivated and flexible R&I team willing to be innovative and creative with strong performance in achieving both internal and external objectives

Core R&I team are an exceptionally efficient service providing added value and generating income which is predominantly re-invested in developing clinical teams.

Wide network of external stakeholder partnerships

Commitment to research from both the Trust Board and service user council.

Individuals with specialist research skills and expertise

Research has been incorporated into PDR

Weaknesses

Research activity predominantly driven by the research team

Very limited ring-fenced R&I time within the trust and issues with capacity both for clinicians, support departments and the R&I team.

Research capabilities are limited to a few people, our strategy is reliant on these key individuals with no scope for contingency plans

Availability of appropriate NIHR studies for the trust are limited

Lack of skills in key areas, skill development will require not just training but also experience.

Opportunities

National links and partnerships

Dementia research

Developing our commercial activity (increases research revenue)

Utilising students to contribute to the research agenda

Pump priming and the potential to increase income generation- more research brings in more money.

More research brings direct benefits to the trust in that it;

- More effective and efficient services
- Better outcomes and increased patient satisfaction

Threats

Timescales – long term view to realise benefits

Financial challenges will influence and impact upon priorities

Future funding from the NIHR is dependent upon recruitment

Limited studies appropriate to Trust

Competing priorities for clinical staff

Securing funding is dependent upon external factors beyond our control, failure to generate sufficient income will lead to cost pressures.

Staffing and recruitment issues will impact upon workload and prevent clinical engagement in research activity.

2 Research and Innovation Vision

For some time our aspiration has been to develop a research culture, however in defining our vision within the R&I strategy we have to consider what this means and how it will look and feel to our patients, staff and stakeholders:

2.1 Expectations

Our patients and carers will have an expectation that research will be discussed with them during their routine clinical appointments and that the care that they receive will be based upon best available evidence.

2.2 Engagement

Individual staff electively opt to become engaged in research. Their motivation comes from recognition of the value of the evidence generated and the fact that there is sufficient support throughout the process to enable them to overcome barriers and sustain the study momentum.

2.3 Ownership

There is ownership of the research agenda throughout the Trust.

2.4 Value

Commissioners of our services are influenced by the value of the evidence produced through our research activities.

2.5 Reputation

The Trust has a reputation for delivering research and our quality and skills are recognised externally. There are a range of organisations from within the local economy and beyond that are delivering research in partnership with the Trust.

3 Achieving our vision

3.1 Internal engagement and research leadership.

We recognise that there needs to be a shift above and beyond a position in which staff and service users support and engage in the research and innovation agenda to the point whereby they are the driving force behind our R&I activity which is clearly aligned to both service developments and business objectives. This will enable us to clearly demonstrate the effectiveness and impact of our work and ensure that we understand what works and what does not and enable us to continuously improve our service and be flexible and responsive to the ever changing priorities and needs within both the health and social care system and our local population.

3.1.1 Maintaining the profile for Research and Innovation within the trust

- Leadership of R&I will be the domain of the R&I steering group. The Medical Director will chair the group and continue to act as a champion for research at board level. Board engagement will be further promoted through board development sessions. The R&I director will provide R&I leadership and facilitate engagement with senior clinicians and managers.
- The Research Forum will continue to be the vehicle for driving our home grown research, evaluation and innovation projects. Along with an extension of the remit to include innovation we will seek to extend the membership of the group and particularly to increase our service user and carer representation.
- We will continue to utilise and develop various approaches to keep staff informed of our research activities, including social media (twitter) the Research Bulletin, the R&I pages on the Trust internet. The Communications team will contribute by publicising our activity externally via press releases and the Trust internet site etc.

3.1.2 Research leadership within the Clinical directorates

- Clinical directors will be responsible for setting the direction for research and development in the directorate including NIHR portfolio activity.
- Individuals receiving Trust support (paid study leave or funding) to undertake post graduate degrees and professional doctorates will be required to participate in the forum and contribute to the trusts research activity with specific objectives being aligned to directorate / trust objectives being agreed and monitored through the PDR process.
- There will be clear links and reporting mechanisms between clinical directorates and the R&I steering group (hub and spoke model) with a review of the role of directorate representatives and their contribution to promoting the R&I agenda.
- There will be an increase in the number of clinical posts with specific responsibilities and time ring-fenced for research activity. These individuals will be involved in delivering the Trust's research agenda either through research delivery or development with specific research objectives set and monitored through PDR.

3.2 Developing our capacity and capability for Research and Innovation.

3.2.1 Individuals

- There will be an identified pathway for individuals to develop research skills, this can be utilised alongside the PDR process to enable us to grow future researchers and innovators.
- A variety of research training opportunities will be available to staff and these will include be-spoke in house events facilitated by our own research staff.
- There will be career progression opportunities linked to research skills and activity.
- Funding and opportunities will be available to enable individuals to develop high level research skills

3.2.2 Organisation

- Investment in research not only enables us to continue with our research development programme but would enable us to attract individuals with the skills, experience, networks and reputation in research. This would enable the Trust to develop a reputation and profile as an influential mental health research organisation.
- Increase the number of Principle Investigators in the Trust with particular emphasis upon recruitment of senior medical staff to increase capacity for the delivery of Clinical Trials of Medicinal Products thus increasing our capacity for commercial research.
- The direction set out in this document will be reflected in other related Trust strategies and work plans eg, training and education, workforce development, nursing strategy and quality strategy.

3.3 Embedding research into clinical practice

- There will be an alignment between clinical and research pathways with service users being informed that the Trust is research active, given information regarding relevant studies and offered opportunities to opt in.
- We will continue to incentivise and reward research activity, recognising this through the annual REACH Awards and Individual R&I sponsored awards eg. for publications and supporting individuals who wish to communicate and publish their work.
- There will be Research and Innovation events celebrating and sharing best practice
- We will engage students in research to set the agenda for their future career.

3.4 Partnerships and collaborative working

- Service Users will be engaged in all aspects of the research pathway; we will work in partnership with the Service User and Carer Council to deliver the innovation agenda and will seek to secure appropriate representation in the work we undertake.
- We have a successful (award winning) partnership with UHNM to deliver NIHR portfolio Dementia and Neurodegeneration DeNDRoN studies, we will continue to develop this model of partnership working to contribute to the NIHR high level objective of increasing the number of participants in DeNDRoN studies. Where appropriate the model will be extended to new partner organisations and with the support of the NIHR we will promote the model of good practice across the West Midlands and Nationally.
- We will identify priorities for partnership working and work to build meaningful collaborations with demonstrable outputs. Key partnerships to enable us to deliver our research vision and trust objectives are;
  - Academic Institutions
  - NHS and care partners across the patient pathway
  - Digital / IT expertise
  - Commercial companies within the pharma industry

3.5 Supporting innovation

- As part of the Strategy Launch there will be a re-branding of the department from R&D to R&I, and this will be communicated throughout the trust.
- Re-launch of a new re-vamped Dragons Den under the auspices of the research team in partnership with the Service User and Carer Council
- R&I will retain responsibility for Intellectual property within the trust, we will seek opportunities to increase our knowledge and skill in relationship to this, maintaining our membership of Mid Tech will be an essential requirement.
- In partnership with the Service User and Carer Council set out a plan for how teams will support and deliver innovation. We will identify appropriate systems and processes to support innovation opportunities and consider the requirements for implementation such as a repository for ideas, innovation scouts etc. Identify the additional resources, or different ways of working to add innovation to the R&I portfolio – and consider the implications of this.

Conclusion

Research is a key priority for the NHS and will be instrumental in enabling our organisation to achieve its key objectives for 2016-2020. This strategy sets out a framework through which we will be able to not only develop our research capacity and capabilities but also encourage, inspire and implement research and innovation at all levels. This framework will see research integrated into clinical practice. With clear accountabilities and responsibilities across the organisation, it will enable the embedding of research as a frontline activity and support our clinical staff in delivering the highest standards of evidence-based practice, working towards excellence in planning and implementing care thus making the Trust a more effective and efficient organisation.

The strategy is aligned to the ambitions as stated in the Trust's Integrated Business Plan and links into other key strategies such as the Quality Strategy and the Nursing Strategy and reflects current NHS research priorities. Achieving our Trust's aspiration hinges upon the engagement and commitment of staff and service users and we will continue to further this strategy through feedback and engagement, holding events and publicising our work to showcase achievements and promote the research agenda at a local and national level.

Building our research culture requires a longitudinal view with sustained commitment and investment which will extend beyond the five year lifetime of this strategy; this document therefore should be considered to represent the initial phase of a prolonged programme of research development and innovation. Our five year plan is reflective of a model which seeks to first engage with staff and then develop their skills and expertise and move them from research conscious, to participative, delivering studies, and ultimately to developing and initiating their own research in response to local need.

Collaborations and partnerships are essential components for a successful research rich organisation, our strategy is centred upon developing meaningful research collaborations across both healthcare and academic communities. Our Trust's key strengths lie in our local intelligence, clinical expertise and engaged service user community; we will further enhance this by developing staff with the skills, capacity, capability and appetite for research which will enhance the contribution we are able to make as a research partner.

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REPORT TO BOARD

Enclosure No:6

Date of Meeting:	5 October 2017		
Title of Report:	August 2017 Monthly Safer Staffing Report		
Presented by:	Maria Nelligan, Executive Director of Nursing & Quality		
Author:	Julie Anne Murray, Deputy Director of Nursing, AHP & Quality		
Executive Lead Name:	Maria Nelligan, Executive Director of Nursing & Quality	**Approved by Exec**	☒

Executive Summary:	**Purpose of report**	
This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during August 2017 in line with the National Quality Board requirements. The performance relating to fill rate (actual numbers of staff deployed vs numbers planned) during August 2017 was 82% for registered staff and 94% for care staff on day shifts and 84% and 105% respectively on night shifts. Overall a 91% fill-rate was achieved. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover and Ward Manager supporting clinical duties. The data reflects that Ward Manages are staffing their wards to meet increasing patient needs as necessary.	**Approval**	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☒ Date: 19.09.17	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement. ☐ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve. ☐ 4. Encourage, inspire and implement research & innovation at all levels. ☐ 5. Maximise and use our resources intelligently and efficiently. ☐ 6. Attract and inspire the best people to work here. ☐ 7. Continually improve our partnership working. ☐		

Risk / legal implications: Risk Register Ref	Delivery of safe nurse staffing levels is a key requirement to ensuring that the Trust complies with National Quality Board standards.
Resource Implications: Funding Source:	Temporary staffing costs. Budgeted establishment and temporary staffing spend.
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	None
Recommendations:	To receive the report for assurance and information

1 Introduction

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

2 Background

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

In addition to the monthly reporting requirements the Executive Director of Nursing & Quality is required to review ward staffing on a 6 monthly basis and report the outcome of the review to the Trust Board of Directors. The next 6 monthly review covering January to June 2017 is currently underway, it is concentrating on workforce planning and will be reported to November Board.

3 Trust Performance

During August 2017 the Trust achieved a staffing fill rate of 82% for registered staff and 94% for care staff on day shifts and 84% and 105% respectively on night shifts. Taking skill mix adjustments into account an overall a 91% fill-rate was achieved. Where 100% fill rate was not achieved, staffing safety was maintained on in-patient wards by nurses working additional unplanned hours, cross cover, Ward managers (WMs) and the multi-disciplinary team (MDT) supporting clinical duties and the prioritising of direct and non-direct care activities. Established, planned (clinically required) and actual hours alongside details of vacancies, bed occupancy and actions taken to maintain safer staffing are provided in Appendix 2. A summary from WMs of issues, patient safety, patient experience, staff experience and mitigating actions is set out below.

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

4 Impact

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

4.1 Impact on Patient Safety

There were 8 incident forms completed by in-patient wards during August 2017 relating to nurse staffing issues. **No harm to patients arose from these incidents** and in terms of the previous month the reported incidents are unremarkable.

Breakdown by ward is summarised as follows:

Ward	Incident Reports
Darwin	Three occasions where it was challenging to maintain clinical observations.
A&T	Two incidents, one related to inability to backfill at short notice due to sickness and one where it was challenging to maintain high levels of observations.
Ward 6	Two incidents due to high levels of observations where it was challenging to maintain.
Access	One incident where Access had to cover a ward nightshift due to there being no RN

4.2 Impact on Patient Experience

Staff prioritise patient experience and direct patient care. During August 2017 it was reported that no activities were cancelled or shortened due to nurse staffing levels.

4.3 Impact on Staff Experience

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

- 29 staff breaks were cancelled (equivalent to approximately 0.6% of breaks)
- 3 staff breaks were shortened (equivalent to 0.06% of breaks)
- 273 hrs of ward cross cover (nursing staff were reallocated to cover shortfall within other clinical areas).

4.4 Mitigating Actions

Ward Managers and members of the multi-disciplinary team have clinically supported day shifts to ensure safe patient care. Skill mix has been altered to backfill shortfalls. A total of 174 RN shifts were covered by HCSW where RN temporary staffing was unavailable. A total of 45 HCSW shifts were covered by RN staff where HCSW temporary staffing was unavailable. Additionally, as outlined in section 4.3, staff breaks have been shortened or not taken (time is given in lieu) and wards have cross covered to support safe staffing levels.

4.5 Staffing Trend

Examination of ward staffing for the past 12 months demonstrates a downward trend for overall ward staffing and for RN staffing. There is a clear correlation between the opening of Ward 4, to support the local health economy, and the downward trend. The period prior to Ward 4 opening, June - November 2016, was showing an upward trend.

The following actions have been taken to strengthen RN staffing:

- 18 RNs commencing preceptorship in October 2017
- Shift patterns are being altered in response to staff feedback

- A rolling recruitment of events including bank continues
- Increasing the presence of Duty Senior Nurses (DSN), Nurse Practitioners and WMs on wards
- Review of the Master Vendor contract and seek agency suppliers beyond this, if required

5. Summary

Safe staffing reporting indicated challenges in staffing wards during August 2017. Vacancies across all wards have contributed to this. Additionally the use of temporary staffing to support Ward 4 has reduced the availability of temporary staff to backfill other wards. A significant number of RN vacancies will be filled by October 2017 when newly qualified registered nurses graduate. The Board should note the further challenges associated with the temporary increase of beds on Ward 4 in the response to the winter pressure in the health economy. Looking forward to next year, challenges will also be experienced with the planned opening of PICU. However the November staffing report to Board will make recommendations following the 6 month staffing review. The Trust continues to employ alternate strategies with the support of the HR and communication teams to attract RNs during this national shortage.

We have been invited to participate in the NHSI Retention Support Programme which we intend to pursue, as it provides us with the opportunity to learn from other Trusts and gain support.

6. Recommendations

The Trust Board is asked to:-

- Receive the report
- Note the challenges with recruitment and mitigations/action in place
- Note the challenge in filling shifts
- Note no harm incidents were reported as a result of staffing
- Be assured that safe staffing levels are maintained

Appendix 1 August 2017 Safer Staffing

Aug-17	DAY						NIGHT						DAY		NIGHT						
Ward name	Registered nurses			Care staff			Registered nurses			Care staff			Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Overall	Safe staffing was maintained by:	Vacancies	Bed occupancy	Movement	Aug 17 sickness data
	Establishment Hours	Clinically required Hours	Total monthly actual hours	Establishment Hours	Clinically required	Total monthly actual hours	Establishment Hours	Clinically required	Total monthly actual hours	Establishment Hours	Clinically required	Total monthly actual staff hours										
Ward 1	1493	1493	1039	1395	1860	1860	665	665	332	997	997	1265	70%	100%	50%	127%	90%	Nurses working additional hours and altering skill mix. Cross cover was also provided to other wards.	4.2 RN 2.8 HCSW	97%	↑	5.91%
Ward 2	1500	1500	919	1395	1395	1644	665	665	364	665	665	943	61%	118%	55%	142%	92%	Nurses working additional hours and altering skill mix. Cross cover was also provided to other wards.	5.2 RN 3.2 HCSW	99%	↑	12.86%
Ward 3	1568	1568	1216	1395	1395	1573	665	665	472	665	697	894	78%	113%	71%	128%	96%	Nurses working additional hours and altering skill mix. Cross cover was also provided to other wards.	3.8 RN 3.2 HCSW	94%	↑	1.91%
Ward 4	1560	1560	1173	1395	1395	1311	290	290	290	698	698	684	75%	94%	100%	98%	88%	Altering skill mix.	7.2 RN 10.2 HCSW	75%	↓	0.00%
Ward 5	1103	1568	936	930	1390	1656	290	290	297	871	871	826	60%	119%	102%	95%	90%	Altering skill mix.	1.8 RN	108%	↓	6.57%
Ward 6	1103	1103	1118	1860	2400	1799	291	291	319	863	1201	1069	101%	75%	110%	89%	86%	Nurses working additional hours and altering skill mix. Cross cover was also provided to other wards.	2.1 RN	100%		1.29%
Ward 7	1215	1215	903	1395	1395	1407	290	290	284	581	581	581	74%	101%	98%	100%	91%	Nurses working additional hours and altering skill mix.	3.4 RN	102%	↑	5.03%
A&T	1578	1368	1506	1395	1860	1428	333	333	330	1000	1666	1656	110%	77%	99%	99%	94%	Altering skill mix.	1.6 RN	76%	↑	4.17%
Edward Myers	1110	1163	1109	930	930	864	291	291	299	581	591	590	95%	93%	103%	100%	96%	Cross cover was provided to other wards.	2.2 RN 5.1 HCSW	awaiting		2.70%
Darwin Centre	1388	1132	1033	1275	1448	1211	333	333	344	667	989	946	91%	84%	103%	96%	91%	Nurses working additional hours and the MDT supporting the nursing team.	2.4 RN 2.2 HCSW	77%	↓	4.00%
Summers View	1009	985	901	930	914	788	332	332	332	665	665	665	91%	86%	100%	100%	93%	MDT supporting the nursing team.	1 HCSW	93%	↓	4.95%
Florence House	544	587	605	930	825	586	332	332	332	332	332	332	103%	71%	100%	100%	89%	Altering skill mix and MDT supporting the nursing team.	Nil	100%	↑	0.00%
Trust total	**15168**	**15239**	**12456**	**15225**	**17207**	**16125**	**4778**	**4778**	**3998**	**8583**	**9952**	**10451**	**82%**	**94%**	**84%**	**105%**	**91%**					

Appendix 2 Staffing Issues

- There has been challenges and limited success in recruiting band 5 adult RNs to Ward 4 therefore the team are seeking to recruit RNs from other fields who have physical health experience, this will be supported by an education programme. We have also worked with UHNM with regards to access to their bank.

- There are currently 33.6 WTE RN vacancies reported within in-patient wards. Of these, 13.8 WTE are in the recruitment process. We continue to advertise for the remainder.

- With the exception of Ward 4 the highest RN vacancies are across the Acute AMH wards with Wards 1, 2 and 3 currently having B5 vacancies of 4.2, 5.2 and 3.8 WTE respectively of which 7 WTE newly qualified nurses have been recruited. The remaining posts have been advertised externally and are included within the recruitment events with limited success. Therefore we are reviewing skill mix and shift patterns.

- The Ward 5 RN fill rate on days was 60% during August 2017. Ward 5 establishment does not meet the safe staffing levels recommended in the 6 month reviews and this is impacting on the RN fill rate. However they continue to attempt to fill shifts based on clinical need.

- The Ward 2 RN fill rate on days was 61% during August and the ward had 5.2 WTE RN vacancies. Skill mix was altered on the ward to increase HCSW numbers during August bringing the overall fill rate to 92%. The MM continues to oversee roster practices to ensure that resources are used effectively.

- Ward teams are supported by Modern Matrons and a Duty Senior Nurse who are further supported by an on-call manager out of hours. These staff are not included in the safer staffing returns and are based on wards as opposed to Nursing Office from September.

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

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

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO PUBLIC Trust Board

Enclosure No:7

Date of Meeting:	Thursday 5th October		
Title of Report:	Performance & Quality Management Framework Month 5		
Presented by:	Director of Finance, Performance & Digital		
Author:	Performance & Information Team		
Executive Lead Name:	Suzanne Robinson	Approved by Exec	☒

Executive Summary:	Purpose of report	
The report provides an overview of performance for August 2017 covering Contracted Key Performance Indicators (KPIs) and Reporting Requirements. In addition to the performance dashboards a full database (Divisional Drill-Down) has been made available to Directorate Heads of Service and Clinical Directors to enable them to interrogate the supporting data and drive directorate improvement. This is summarised in the supporting PQMF dashboard. Data Quality (DQ) work is ongoing to validate and refine metrics reported in this paper, in relation to the transition to the Lorenzo EPR, which went live in May 2017.	Approval	☒
	Information	☒
	Discussion	☒
	Assurance	☐

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☒ • Finance & Performance Committee ☒ • Audit Committee ☐ • People & Culture Development Committee ☒ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☒ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	In Month 5 there are 4 target related metrics rated as Red and 1 target related as Amber; all other indicators are within expected tolerances. All areas of underperformance are separately risk assessed and a rectification plan is developed, overseen by the relevant sub-committee of the Trust Board.		
Resource Implications: Funding Source:	There are potential contractual penalties if the Trust is not able to meet reporting requirements. There is an agreement with Commissioners for the Trust to have 6 months period following the implementation of the new EPR in order to ensure that all reports can be made available, or to identify further actions and timescales for delivery agreed in the Data Quality Improvement Plan.		

Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	The PQMF includes monitoring of ethnicity as a key national requirement. The Trust is seeking to ensure that all Directorates are recording in a timely way the protected characteristics of all service users to enable monitoring of service access and utilisation by all groups in relation to the local population.
Recommendations:	The committee is asked to • Receive the Trust performance as at M5 • Note the rectification plans received through Board sub-committees

PERFORMANCE & QUALITY MANAGEMENT FRAMEWORK
REPORT TO PUBLIC TRUST BOARD

Date of meeting:	5th October 2017
Report title:	**Performance & Quality Management Framework** **Performance Report – Month 5 2017/18**
Executive Lead:	Director of Finance, Performance & Digital
Prepared by:	Performance & Information Team
Presented by:	Director of Finance, Performance & Digital

1 Introduction to Performance Management Report

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

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

Data Quality (DQ) work is ongoing to validate date behind the KPI reported in this paper, following the transition to the new Lorenzo EPR, which went live in May 2017.

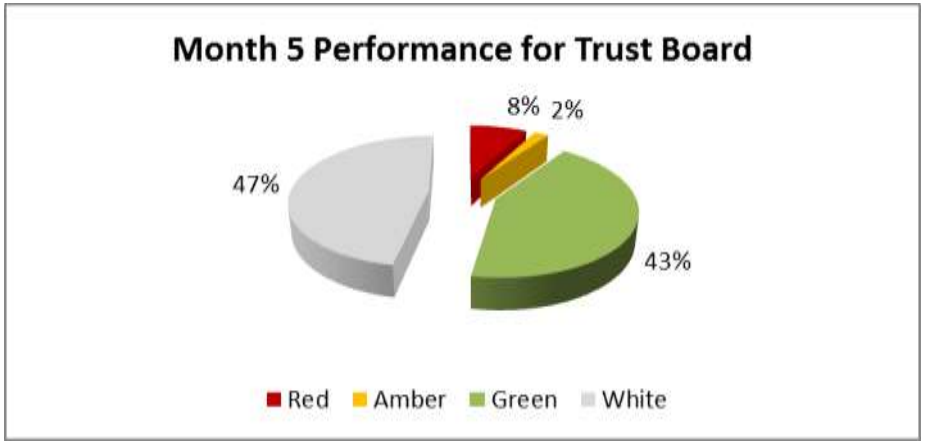
2 Executive Summary – Exception Reporting

The following performance highlights should be noted;

- **100%** of IAPT service users referred treated within 6 weeks of referral against target of 75%. This has been 100% for the last 3 months.
- **100%** of patients have been seen within 4 hours of referral to the crisis assessment team
- The readmission within 28 days of discharge continues to reduce below target (7.5%) **to 4.7%, from 5% in month 4.**

In Month 5 there are 4 target related metrics rated as **Red** and 1 as **Amber**; all other indicators are within expected tolerances.

Contracted (National/Local CCG) & NHSI KPIs					
Metric	Red	Amber	Green	White	TOTAL
Exceptions – Month 3	3	2	27	40	72
Exceptions – Month 4	3	1	26	40	70
Exceptions – Month 5	4	1	22	24	51



3 Rectification Plans

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

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4 Exceptions - Month 5

<table>
<tr><th>KPI Classification</th><th>Metric</th><th>Exec/Op Lead</th><th>Target</th><th>M4</th><th>M5</th><th>Trend</th><th>Commentary</th></tr>
<tr><td>National</td><td>Delayed Transfers of Care:

DTOC</td><td>Dir of Ops</td><td>7.5%</td><td>RED
15.9%</td><td>RED
12.9%</td><td>↘</td><td>
12.9% at M5 from 15.9% at M4

AMH – 10.9% at M5 from 6.5% at M4
NOAP – 17.2% at M5 from 19.2% at M4

Trust
<table>
<tr><th>Reason for Delay</th><th>Total Pts</th><th>Total Days</th><th>Days as % of Total</th></tr>
<tr><td>G) Patient of family choice</td><td>12</td><td>147</td><td>30.60%</td></tr>
<tr><td>D) Care Home placement</td><td>12</td><td>139</td><td>28.90%</td></tr>
<tr><td>B) Public Funding</td><td>9</td><td>103</td><td>21.40%</td></tr>
<tr><td>E) Care package in own home</td><td>3</td><td>56</td><td>11.60%</td></tr>
<tr><td>I) Housing-patients not covered by NHS and Community Care Act</td><td>2</td><td>17</td><td>3.50%</td></tr>
<tr><td>A) Completion of assessment</td><td>3</td><td>13</td><td>2.70%</td></tr>
<tr><td>F) Equipment</td><td>1</td><td>3</td><td>0.60%</td></tr>
<tr><td>H) Disputes</td><td>1</td><td>3</td><td>0.70%</td></tr>
<tr><td>C) Further non acute NHS care (including intermediate care, rehabilitation etc)</td><td>0</td><td>0</td><td>0.00%</td></tr>
<tr><td>Totals</td><td>43</td><td>481</td><td>100%</td></tr>
</table>

Delays continue to be associated with access to ongoing placements outside the Hospital (Care Home, Public funding or family/patient choice) which account for 80% of all delays. Weekly DTOC meetings take place to manage the processes and issues are escalated to health and social care commissioners for resolution. Within NOAP, the Red to Green protocol continues to be followed.

Rectification plans have been received from Directorates
</td></tr>
</table>

National	**Agency Spend** Expenditure on Agency does not exceed the agreed YTD NHSi ceiling	Dir of Leadership & Workforce	**NIL**	**GREEN (£58k)**	**RED £202k**	↗	**Cumulative YTD £1,222k against actual £1,541k - £319k worse than plan (26%)** **Main drivers of negative variance;** ROSE**: £220k** relates to the re-profiling of contracted staff who are focusing on the data warehouse configuration, data quality and validation of data post implementation. This includes a catch up of back log invoices. Expenditure on ROSE was planned and fully contained within the income received from NHS Digital. Medical Locums: **£102k**, mainly due to unplanned use of Agency covering retirements and to support the setup of new contracts (MITIE £34k). The Trust is exploring new options to attract and retain substantive Consultants such as a recruitment and retention premium. **Rectification plan received at Finance & Performance Committee**
CCG	**Bed Occupancy:** Bed Occupancy (Including Home Leave)	Dir of Ops	**85%** **(90% AMH IP only)**	**RED 92.6%**	**RED 92.3%**	↘	**92.3% at M5 from 92.6% at M4** Adult IP – 96% at M5 from 93% at M4 Neuro – 108.4% at M5 from 113.7% at M4 Older Adult – 92% at M4 and M5 The practice in NOAP is to not discharge patients until after a week when they are initially sent for home leave without the intention of returning. This is being reviewed. The pressure on adult and NOAP inpatient beds is impacted by high levels of delayed transfers of care and associated length of stay. Actions to address are aligned to those for DTOCs. **Rectification Plan: to be received Finance & Performance Committee**

National	**CPA:** The proportion of those on Care Programme Approach (CPA) receiving follow-up contact within 7 days of discharge	Dir of Ops	**95%**	**RED** **90.0%**	**RED** **86.7%**	↘	**86.7% at M5 from 90.0% at M4** There were 6 care plan not recorded in month 5. 2 (out of 3 eligible) were attributable to the NOAP directorate and the remaining 4 (out of 42 eligible) for the Adult Community directorate. Weekly reports are provided to Directorates to support the community teams to ensure that all discharges are followed up within 7 days. This supports the data validation work in ensuring that all contacts are recorded on Lorenzo correctly. Feedback is provided back to the Performance team to provide assurance that any breach in follow up did not result in any harm to the patient and highlights when the follow up contact took place. A new Standard Operating Procedure is in development and data entry guidance will be updated in light of this to ensure compliance with this key indicator. Plans are in place to rectify performance for M6. **Rectification Plan: to be received Finance & Performance Committee**

CCG	**CPA:** All Service Users to have a care plan in line with their needs - % on CPA with a Care Plan	Dir of Ops	**95%**	**AMBER** **91.4%**	**AMBER** **91.5%**	↗	**91.5% at M5 from 91.4% at M4** 1,802 CPA patients (out of 1,969 eligible) had a Care Plan recorded at month 5. AMH – 92.7% at M5 from 92.1% at M4 NOAP – 66.7% at M5 from 83.3% at M4 LD – 88.5% at M5 from 95.1% at M4 CAMHS – 57.1% at M5 from 22.2% at M4 Regular reports are provided to Directorates to support teams to ensure that all patients on CPA have a care plan recorded on the system. Feedback is provided back to the Performance team where appropriate. This supports the data validation work in ensuring that all contacts are recorded on Lorenzo correctly. **Rectification Plan: to be received Finance & Performance Committee**

5 Recommendations

The Trust Board is asked to;

- Receive the Trust performance as at Month 5
- Note the rectification plans received through Board committees

Appendix 1: Trust Performance Dashboard

Month: **August**

5

Key:-

North Staffordshire Combined Healthcare NHS Trust

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

Rectification Plans-Target to

Incomplete-Rectification Plan received but trajectory not advised

Not Received-No rectification plan received

			2017-18	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12			
	Metric	**Frequency**	**Target (2017/18)**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Target to be achieved by**	**YTD**	**Trend Rate**
NHSI Domain - Responsive																		
National	Early Intervention in Psychosis - A maximum of 2 week waits for referral to treatment	Monthly	50%	83.3%	81.8%	63.6%	100.0%	70.0%									79.7%	↘
National	IAPT % of service users referred treated within 6 weeks of referral	Monthly	75%	100.0%	99.3%	100.0%	100.0%	100.0%									99.9%	⇿
National	IAPT % of service users referred treated within 18 weeks of referral	Monthly	95%	99.7%	100.0%	100.0%	100.0%	100.0%									99.9%	⇿
National	Zero tolerance RTT waits over 52 weeks for incomplete pathways	Monthly	0	0.0		0.0	0.0	0.0									0	⇿
CCG	Compliance with 18 week waits (Referral to Treatment or Intervention) (Excluding ASD)	Monthly	92%	93.5%		82.4%	94.3%	95.1%									91.3%	↗
CCG	AMH IP	Monthly	92%	100.0%		100.0%	100.0%	100.0%									100.0%	⇿
CCG	AMH Community	Monthly	92%	89.0%		77.5%	91.9%	94.9%									88.3%	↗
CCG	Substance Misuse	Monthly	92%	100.0%		100.0%	100.0%	100.0%									100.0%	⇿
CCG	LD	Monthly	92%	100.0%		85.2%	100.0%	94.1%									94.8%	↘
CCG	NOAP	Monthly	92%	97.4%		82.3%	94.3%	94.9%									92.2%	↗
CCG	C&YP	Monthly	92%	100.0%		93.7%	100.0%	95.4%									97.3%	↘
CCG	Patients will be assessed within 12 weeks of referral to the Memory Assessment service	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%									100.0%	⇿
CCG	Percentage of adults who have received secondary mental health services who were on a Care Programme Approach who have had at least one formal review in the last 12 months *CCG Measure*	Monthly	95%	95.3%	94.4%	92.3%	91.4%	95.4%									93.8%	↗
CCG	RAID response to A&E referrals within 1 hour	Monthly	95%	94.0%	94.0%	97.0%	96.0%	98.0%									95.8%	↗
CCG	Percentage of inpatient admissions that have been gatekept by crisis resolution/ home treatment team	Monthly	95%	100.0%	98.5%	95.9%	97.2%	97.8%									97.9%	↗
CCG	S136 (Place of Safety) Assessments	Monthly	No Target	23.0	33.0	35.0	43.0	22.0									156.0	↘
CCG	- Formal Admissions	Monthly	No Target	4.0	6.0	2.0	5.0	4.0									21.0	↘
CCG	- Informal Admissions	Monthly	No Target	4.0	2.0	6.0	7.0	3.0									22.0	↘
CCG	- Under 18 Yrs Old	Monthly	No Target	0.0	0.0	0.0	1.0	1.0									2.0	⇿
National	The proportion of those on Care Programme Approach (CPA) for at least 12mths having a (HONOS) assessment within the last 12mths	Monthly	90%	91.4%	#N/A	99.7%	98.9%	98.7%										↘
CCG	AMH Community	Monthly	90%	91.5%	#N/A	99.0%	99.3%	99.1%										↘
CCG	NOAP	Monthly	90%	66.7%	#N/A	97.2%	77.3%	72.0%										↘
National	Number of people seen for crisis assessment within 4 hours of referral	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%										⇿
National	The proportion of those on Care Programme Approach (CPA) for at least 12mnths having formal review within 12mnths *NHSI*	Monthly	95%	94.3%	93.9%	91.5%	91.8%	95.0%									93.3%	↗
CCG	AMH Community	Monthly	95%	94.4%	94.2%	91.4%	92.1%	95.2%									93.5%	↗
CCG	LD	Monthly	95%	100.0%	93.6%	83.3%	88.5%	89.2%									90.9%	↗
CCG	NOAP	Monthly	95%	72.7%	72.7%	91.7%	83.3%	68.0%									77.7%	↘
CCG	C&YP	Monthly	95%	0.0%	0.0%	75.0%	0.0%	0.0%									15.0%	⇿
National	Mental health delayed transfers of care (target NHSI) (M1-4.7%, M2-4.5%, M3-4.2%, M4-4.0%, M5-3.7%, M6-3.5%) Target revised to 7.0% in M3	Monthly	7.5%	14.8%	16.6%	14.6%	15.9%	12.9%									15.0%	↘
CCG	AMH IP	Monthly	7.5%	7.4%	10.1%	8.8%	6.5%	10.9%									8.7%	↗
CCG	LD	Monthly	7.5%	0.0%	0.0%	0.0%	0.0%	0.0%									0.0%	⇿
CCG	NOAP	Monthly	7.5%	23.2%	24.7%	17.8%	19.2%	17.2%									23.2%	↘
National	The proportion of those on Care Programme Approach (CPA) receiving follow-up contact within 7 days of discharge	Monthly	95%	95.7%	96.9%	91.2%	90.0%	86.7%									92.1%	↘
CCG	Readmission rate (28 days). Percentage of patients readmitted within 28 (or 30 days) days of discharge.	Monthly	7.5%	15.0%	6.7%	5.1%	5.0%	4.7%									7.3%	↘
CCG	All Service Users to have a care plan in line with their needs - % on CPA with a Care Plan	Monthly	95%	95.0%	95.0%	92.3%	91.4%	91.5%									93.0%	↗
National	% of clients in settled accommodation	Monthly	No Target	88.5%	48.5%	86.4%	86.4%	84.8%									78.9%	↘
NHSI Domain - Caring																		
National	Mixed Sex Accommodation Breach	Monthly	0	0.0	0.0	0.0	0.0	0.0									0.0	⇿
National	Staff FFT Percentage Recommended – Care	Quarterly	61.5%	N/A	N/A	N/A	N/A	N/A										
NHSI Domain - Safe																		
National	Duty of Candour Each failure to notify the Relevant Person of a suspected or actual Reportable Patient Safety Incident	Monthly	0	0.0	0.0	0.0	0.0	0.0									0.0	⇿
CCG	All service users who have been in hospital/long term inpatient health care for more than one year should have a physical health check	Quarterly	95%	N/A	N/A	100.0%	N/A	N/A										
CCG	Preventing Category 3 and 4 Avoidable Pressure Ulcer	Monthly	0	0.0	0.0	0.0	0.0	0.0									0.0	⇿

	Metric	Frequency	Target (2017/18)	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target to be achieved by	YTD	Trend Rate
CCG	MRSA Screening (% of patients screened on admission)	Monthly	100%	100.0%	100.0%	100.0%	100.0%	100.0%									100.0%	⇔
CCG	Never Events	Monthly	0	0.0	0.0	0.0	0.0	0.0									0.0	⇔
CCG	Medication Errors leading to Moderate/Severe harm/death	Monthly	No Target	0.0	0.0	0.0	0.0	1.0									1.0	↗
CCG	Preventing Future Deaths Regulation 28	Monthly	No Target	0.0	0.0	0.0	0.0	0.0									0.0	⇔
CCG	Suspected Suicides	Monthly	No Target	2.0	1.0	2.0	7.0	6.0									18.0	↘
CCG	Inpatient	Monthly	No Target	0.0	0.0	0.0	0.0	0.0									0.0	⇔
CCG	Inpatient on home leave	Monthly	No Target	0.0	0.0	0.0	0.0	0.0									0.0	⇔
CCG	Community Patient (in receipt)	Monthly	No Target	2.0	1.0	0.0	7.0	6.0									16.0	↘
CCG	Community patient (in receipt) within 3 months of discharge from service	Monthly	No Target	0.0	0.0	0.0	0.0	0.0									0.0	⇔
CCG	Community patient who had an inpatient stay in last 3 months prior to death	Monthly	No Target	0.0	0.0	0.0	0.0	0.0									0.0	⇔
CCG	Unexpected Deaths	Monthly	No Target	0.0	0.0	0.0	7.0	6.0									13.0	↘
CCG	Inpatient	Monthly	No Target	0.0	0.0	0.0	0.0	0.0									0.0	⇔
CCG	Inpatient on home leave	Monthly	No Target	0.0	0.0	0.0	0.0	0.0									0.0	⇔
CCG	Community Patient (in receipt)	Monthly	No Target	0.0	0.0	0.0	7.0	6.0									13.0	↘
CCG	Community patient (in receipt) within 3 months of discharge from service	Monthly	No Target	0.0	0.0	0.0	0.0	0.0									0.0	⇔
CCG	Community patient who had an inpatient stay in last 3 months prior to death	Monthly	No Target	0.0	0.0	0.0	0.0	0.0									0.0	⇔
CCG	Use of Restraint: Number of patient restraints-prone	Monthly	No Target	1.0	4.0	5.0	0.0	3.0									13.0	↗
CCG	Slips Trips & Falls	Monthly	No Target	43.0	23.0	45.0	31.0	27.0									169.0	↘
CCG	Slips Trips & Falls leading to Moderate/Severe harm/death	Monthly	No Target	6.0	4.0	1.0	2.0	2.0									15.0	⇔
CCG	Self Harm Events: Inpatient	Monthly	No Target	48.0	25.0	35.0	44.0	34.0									186.0	↘
CCG	Self Harm Events: Community	Monthly	No Target	35.0	31.0	28.0	26.0	19.0									139.0	↘
CCG	DNA Rate Analysis by Directorate (split by CCG)	Monthly	No Target	5.7%	6.3%	6.9%	7.0%	7.1%									6.6%	↗
CCG	AMH IP	Monthly	No Target	6.1%	5.9%	5.0%	4.0%	3.3%									4.9%	↘
CCG	AMH Community	Monthly	No Target	6.3%	6.8%	7.8%	8.0%	8.0%									7.4%	⇔
CCG	LD	Monthly	No Target	2.9%	2.5%	2.7%	3.0%	2.6%									2.7%	↘
CCG	NOAP	Monthly	No Target	4.6%	6.0%	0.0%	6.0%	6.1%									4.5%	↗
CCG	C&YP	Monthly	No Target	7.4%	7.5%	7.7%	8.0%	8.3%									7.8%	↗
CCG	Average Length of Stay: North Staffs CCG	Monthly	No Target	18.0	31.6	30.0	22.7	40.1									142.4	↗
CCG	Adult IP	Monthly	No Target	15.7	21.4	15.0	11.1	32.6									95.8	↗
CCG	CYP	Monthly	No Target	0.0	67.1	122.5	81.4	129.3									400.3	↗
CCG	NOAP	Monthly	No Target	117.3	68.4	101.6	37.9	63.3									388.5	↗
CCG	Substance Misuse	Monthly	No Target	10.5	13.5	N/A	N/A	N/A									24.0	
CCG	LD	Monthly	No Target	0.0	157.5	2.6	131.7	4.0									295.8	↘
CCG	Average Length of Stay: Stoke CCG	Monthly	No Target	23.6	33.0	31.7	31.2	35.4									154.9	↗
CCG	Adult IP	Monthly	No Target	25.6	34.1	41.0	30.2	50.2									181.1	↗
CCG	CYP	Monthly	No Target	88.2	51.1	88.0	95.9	32.5									355.7	↘
CCG	NOAP	Monthly	No Target	106.3	86.3	86.5	95.7	66.4									441.2	↘
CCG	Substance Misuse	Monthly	No Target	12.4	N/A	N/A	N/A	N/A									12.4	
CCG	LD	Monthly	No Target	0.0	0.0	2.4	20.0	2.4									24.8	↘
National	Never Events Incidence Rate	Monthly	0	0.0	0.0	0.0	0.0	0.0									0.0	⇔
National	Proportion of reported patient safety incidents that are harmful	Monthly	No Target	2.0%	1.8%	0.0%	0.0%	3.6%									1.5%	↗
National	CAS alerts outstanding	Monthly	0	0.0	0.0	0.0	0.0	0.0									0.0	⇔
NHSI Domain - Well Led																		
National	Completion of Mental Health Services Data Set ethnicity coding for all Service Users	Monthly	90%	100.0%	100.0%	100.0%	100.0%	100.0%									100.0%	⇔
National	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS	Monthly	99%	99.8%	90.3%	99.3%	99.5%	99.6%									97.7%	↗
National	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users	Monthly	90%	96.0%	96.0%	96.0% (Prov)	26 Sept (Jun final Jul Prov)										96.0%	
National	% Year to Date Agency Spend compared to Year to Date Agency Ceiling	Monthly	0%	N/A	7.0%	20.0%	10.0%	26.0%										↗
National	Ward 4	Monthly	0%	N/A	9.0%	10.2%	0.0%	1.0%										↗
National	Core	Monthly	0%	N/A	2.0%	9.8%	1.0%	15.0%										↗
National	Sickness Absence Percentage: Days lost	Monthly	5.1%	3.1%	3.5%	2.4%	3.9%	4.9%									3.5%	↗
National	Corporate	Monthly	5.1%	1.8%	2.7%	2.6%	1.8%	3.4%									2.5%	↗
National	AMH Community	Monthly	5.1%	3.8%	3.7%	2.7%	4.2%	4.7%									3.8%	↗
National	AMH IP	Monthly	5.1%	4.4%	5.3%	2.8%	5.2%	7.6%									5.1%	↗
National	C&YP	Monthly	5.1%	1.4%	2.6%	2.0%	2.9%	3.4%									2.4%	↗
National	LD	Monthly	5.1%	0.9%	2.8%	1.9%	3.3%	4.8%									2.7%	↗
National	Neuro and Old Age Psychiatry	Monthly	5.1%	3.8%	2.5%	1.7%	5.1%	4.9%									3.6%	↘
National	Substance Misuse	Monthly	5.1%	6.4%	7.4%	3.5%	5.6%	8.9%									6.4%	↗
National	Staff Turnover (% FTE)	Monthly	>10%	0.9	1.1	0.6	0.6%	1.5%									0.51	↗
National	Corporate	Monthly	>10%	0.8	1.3	0.0	0.4%	3.8%									0.43	↗
National	AMH Community	Monthly	>10%	0.7	0.9	0.6	0.8%	1.4%									0.43	↗
National	AMH IP	Monthly	>10%	0.7	0.0	1.3	0.7%	0.0%									0.39	↘
National	C&YP	Monthly	>10%	1.6	1.6	1.7	0.9%	1.7%									1.00	↗

	Metric	Frequency	Target (2017/18)	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target to be achieved by	YTD	Trend Rate
National	LD	Monthly	>10%	0.9	2.2	0.0	1.5%	0.9%									0.62	↘
National	Neuro and Old Age Psychiatry	Monthly	>10%	0.8	0.7	0.7	0.0%	0.9%									0.44	↗
National	Substance Misuse	Monthly	>10%	2.2	2.3	0.0	0.0%	0.0%									0.90	↔
National	Staff FFT response rate	Quarterly	No Target	N/A	N/A	N/A	N/A	N/A										
National	Staff FFT Percentage Recommended – Work	Quarterly	No Target	N/A	N/A	N/A	N/A	N/A										
National	Overall safe staffing fill rate	Monthly	No Target	95.2%	95.3%	94.8%	93.4%	91.2%										↘
Other Indicators																		
CCG	IAPT : The proportion of people who have depression and/or anxiety disorders who receive psychological therapies (Target 3.75% per quarter)	Monthly	3.75%	1.05%	1.28%	1.21%	1.28%	1.30%									1.2%	↗
CCG	IAPT :The number of people who have entered (i.e. received) psychological therapies during the reporting quarter (Target 1,057 per quarter)	Monthly	1057	296.0	362.0	341.0	360.0	365.0									1724.0	↗
CCG	IAPT : The number of people who are "moving to recovery" of those who have completed treatment, in the reporting quarter (Target Qtr 1 to 3 - 224, Qtr 4 - 227)	Monthly	227	102.0	98.0	114.0	110.0	114.0									538.0	↗
CCG	IAPT : The number of people who have completed treatment not at clinical caseness at treatment commencement	Monthly	No Target	8.0	8.0	6.0	5.0	8.0									35.0	↗
CCG	IAPT : The number of people who have completed treatment minus the number of people who have completed treatment not at clinical caseness at initial assessment (Target: Qtr 1 to 3 - 447, Qtr 4 - 448)	Monthly	448	152.0	143.0	175.0	167.0	164.0									801.0	↘
CCG	IAPT : The number of people who are moving to recovery. Divided by the number of people who have completed treatment minus the number of people who have completed treatment that were not at caseness at initial assessment	Monthly	50%	67.1%	68.5%	65.1%	65.9%	69.5%									67.2%	↗
CCG	Bed Occupancy (Including Home Leave)	Monthly	85%	97.0%	89.4%	92.9%	92.6%	92.3%									92.8%	↘
CCG	AMH IP	Monthly	90%	94.0%	89.0%	97.0%	93.0%	96.0%									93.8%	↗
CCG	Substance Misuse	Monthly	85%	N/A	N/A	N/A	N/A	N/A										
CCG	LD	Monthly	85%	100.0%	79.0%	71.0%	68.0%	76.0%									78.8%	↗
CCG	Neuro	Monthly	85%	90.6%	91.3%	107.7%	113.7%	108.4%									102.3%	↘
CCG	Old Age Psychiatry	Monthly	85%	95.0%	92.0%	90.0%	92.0%	92.0%									92.2%	↔
CCG	C&YP	Monthly	85%	94.2%	88.6%	98.0%	93.9%	77.2%									90.4%	↘

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REPORT TO TRUST BOARD

Enclosure No:8

Date of Meeting:	5th October 2017		
Title of Report:	Emergency Planning Response and Resilience (EPRR) Update to Board on Progress		
Presented by:	Dr Nasreen Fazal-Short		
Author:	Ms Karen Day – Emergency Planning Officer		
Executive Lead Name:	Dr Nasreen Fazal-Short – Acting Director of Operations	Approved by Exec	☒

Executive Summary:	Purpose of report	
There are well laid out expectations for Emergency Planning Response and Resilience (EPRR) from NHS England and CCGs and in 2016/17 we achieved partial compliance. Substantial progress has been made subsequently with a submission of evidence for the 2017/18 self-assessment, which commences from 13th October, 2017. We are confident that we will now meet substantial compliance.	Approval	☒
	Information	☐
	Discussion	☒
	Assurance	☐

Seen at:	SLT ☒ Execs ☐ Date: 12.09.17	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	✓ To enhance service user and carer involvement.☐ ✓ To provide the highest quality services ☒ ✓ Create a learning culture to continually improve.☒ ✓ Encourage, inspire and implement research & innovation at all levels.☐ ✓ Maximise and use our resources intelligently and efficiently. ☒ ✓ Attract and inspire the best people to work here.☐ ✓ Continually improve our partnership working. ☒		
Risk / legal implications: Risk Register Ref	Risk of none compliance with EPRR expectations if the self-assessment is not validated by external review in October 2017.		
Resource Implications: Funding Source:	Allocated resources identified and noted in the report.		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	N/A		
Recommendations:	The Board is asked to note the contents of the report and approve the work plan for 2017/2018.		

Emergency Planning Response and Resilience (EPRR) Update to Board on Progress

Karen Day: Emergency Planning Officer

Executive Summary

There are well laid out expectations for Emergency Planning Response and Resilience (EPRR) from NHS England and CCGs and in 2016/17 we achieved partial compliance, with nine of the fifty two core standards not fully met.

To meet compliance with emergency planning requirements, the Trust should have had 22 individual plans completed but only 11 were in place 2016/17.

Substantial progress has been made subsequently and now we have all 22 business continuity and specific incident response plans completed and submitted for evidence for the 2017/18 self-assessment, which commences from 13th October, 2017. The evidence has been scrutinised by Senior Operational Team (SOT) and approved at Senior Leadership Team (SLT).

This means that we will have moved to only three core standards of the fifty two where further work is required. The table in the main report summarises progress and further work to be completed. We are confident that we will meet substantial compliance with this submission. We have a further work plan to move us to full compliance for the next submission in 2018.

01. Background and Context

The purpose of this paper is to provide assurance to the Trust Board on the Trusts ability to delivery our contractual responsibilities for Emergency Planning Response and Resilience (EPRR).

We submitted our self-assessment on the **15 September 2017** to the Clinical Commissioning Group (CCG) and NHS England in preparation for the annual "confirm and challenge session" which is due to take place on the **13 October 2017**.

The assessment covers a total of 52 core standards and 18 "deep dive" standards. Each year a topic is defined where a more in-depth review is completed, for example in 2016/17 this covered Fuel. The focus for 2017/18 is "Governance". In order to facilitate this deep dive we have included in our work plan the governance and reporting structures for EPRR which is described more fully under item number 03 in this report.

The EPRR Compliance levels and evaluation and testing conclusion are described in the table 1 below:

Table 1 – EPRR Compliance Score Matrix

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place, however they do not appropriately address one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Partial	Arrangements are in place, however they do not appropriately address six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Non-compliant*	Arrangements in place do not appropriately address eleven or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board and will be monitored on a quarterly basis in order to demonstrate future compliance.

02. Compliance Matrix Assessment

We were assessed as having 9 core standards that were amber for 2016/17 which placed us as partial compliant.

The Emergency Planning Core Team and in particular the Directorates have completed a significant amount of work during 2017/18 which has resulted in a self-assessment return with 3 ambers and we should, therefore, be assessed as substantial compliant.

The table 2 below demonstrates the detailed work that has been completed from 2016/17 to 2017/18.

Table 2 - Core Competencies:

Core Standard Descriptor	Met Compliance 2016/17	Met Compliance 2017/18	Current Status
Governance: • Accountable Officer • Trust Board approved the core standards from 16/17/Annual work plan mitigating against risks including lessons identified. • EPRR reporting structure and approved resource allocated • Overarching EPRR plan	√	√	
Duty to Assess Risk • Risk review falls in line with the annual national risk register and the regional Staffordshire risk register which is assessed through the Risk Assessment Working Group (RAWG). • On the Trust Risk System as assessed from October 2016 due October 2017. • Reason Amber is due to the scoring not being approved through SOT or reviewed from the Trust's own internal system.	√	X	
Duty to maintain plans – emergency plans and business continuity plans	x	√	
• All plans follow national templates business continuity plans meet ISO standards 22301.	√	√	
• Incident response plan	x	√	
• Business continuity policy and directorate and corporate plans.	x	√	
• CBRN plan	√	√	
• Severe weather plan	√	√	
• Pandemic flu plan	x	√	
• Fuel shortage plan	√	√	
• Surge, Escalation and winter pressures plan	√	√	
• Outbreak plan	√	√	
• Evacuation plan	x	√	
• Lockdown plan	x	√	
• IT and Estates plan	x	√	
• VIP policy and major incident communication plan	x	√	
• Full engagement from Trust wide subject matter experts, SOT, Trust Board, lesson learnt forums, LHRP, CCU and other providers.	√	√	
• Internal debrief reports	√	√	

Core Standard Descriptor	Met Compliance 2016/17	Met Compliance 2017/18	Current Status
Command and Control: • Executive and managers on-call system • Training for Gold, Silver and Loggist's. • Business continuity plans • Loggist List • Incident Response Plan	√	√	
Duty to communicate with the public • Communication Plan	x	√	
Information Sharing • Chief Information Officer Statement.	x	√	
Co-Operation • Sets of minutes (LHRP attendance) • CCU Service Level Agreement • Business Continuity Plans • Lessons learnt from exercise Aurora, Cyber Attack, Terrorist Threat Levels.	x	√	
Training and Exercise • Training needs analysis review • Business continuity exercises and post exercise report • Argus training details • Emergency planning work plan • Raven booking detail	√	√	
Hazmat CBRN Core Standards • CBRN Plan • Risk assessments are incorporated to EPRR risk assessments • Staff identified training provided and equipment inventory held locally by teams • Training to NHS England standards. • Refresher training available.	x	√	
Deep Dive – Governance • Trust Board minutes publically sharing compliance rating. • We have not publically declared in our annual report but published on our website. • Non-Executive formally holds the EPRR portfolio	x	√	

Core Standard Descriptor	Met Compliance 2016/17	Met Compliance 2017/18	Current Status
is a regular and active member of the board/governing body, now identified. • Reporting structure through the Finance and Performance Committee from the SOT meetings holding the EPRR portfolio of work. • The Accountable Officer can demonstrate SOT attendance 50% within the last 12months. • Potential to be challenged - The Accountable Officer or a Deputy with appropriate seniority can demonstrate 75% attendance to the LHRP.			

03. Deep Dive – Governance

The purpose of this section is to describe the governance, process and cycle of Emergency Planning Response and Resilience activity against the core standards described above. **Diagram 1** below demonstrates the governance and reporting structures in which EPRR team operate both internal to the Trust and links to our external partners.

The Director of Operations is the designated Accountable Officer for the Trust as appointed by the Chief Executive Officer.

The Senior Operational Team (SOT) comprises of Heads of Services for operational and corporate teams. The SOT meets regularly every month and it is part of their responsibilities to provide the EPRR delivery group oversight for the Trust.

To support the Accountable Officer in the daily activities and workload requirements a core team of staff have being assigned. As part of the core team the Trust has invested in additional support from the Civil Contingency Unit providing 2 days a week additional support which is delivered by a Civil Contingency Link Officer. This contract/service level agreement serves two functions not only to deliver the day-to-day work but also provides good communication routes with our multi-agency Staffordshire Resilience Partners.

The Trust Board operates a Board Assurance Framework which will include the EPRR core standards. The Senior Operational Team will deliver against the action plan produced each year to maintain or improve our EPRR scores. Indeed travelling towards outstanding our next objective for 2018/19 is to gain Full Compliance.

We will duly report into the Finance and Performance Committee who will be responsible to monitor progress and provide assurance to the Trust Board on the Trust's ability to deliver on its EPRR duties.

04. Process

The annual EPRR self-assessment compliance process enables the Trust to identify yearly work plans as a result of agreed areas of improvement. EPRR by its nature is cyclical and therefore we will always be required to either:

- Risk assess against national and regional risk register
- Write and Review Plans
- Test and Exercise Plans
- Business Continuity capabilities
- Co-operation, information sharing and communication

05. What happened in 2017:

In 2017 we have delivered on:

- Training: delivering training to our Gold Commanders (August and September 2017) and Silver Commanders (September 2017) and Loggist's (July-October 2017).
- Exercises including live events: Cyber Attack (12 May 2017), Newcastle Power Outage (9 August 2017), Exercise Aurora (live Staffordshire wide business continuity exercise May 2016), Grenfell Tower (NHS building assurance (19 July 2017) and heightened terrorist alerts during September 2017.
- Written a number of outstanding plans.
- Completed Directorate and Corporate Business Continuity Plans
- Tested and operated our Incident Control Room on two occasions including a live event (May 2017)
- Continue to play our part in the Staffordshire Health Economy and multi-agency delivery through the winter pressure discussions and escalation alerts with CCGs, Executive and Managers conference calls for meeting surge and capacity needs.

06. What we plan to do in 2018:

Our key focus in 2018 will be to test and exercise the numerous plans that we have written in 2017 ensuring we can be confident they are 'fit for purpose' on their ability to deliver in a live incident. The cycle of work for EPRR will also include a work plan based on delivering:

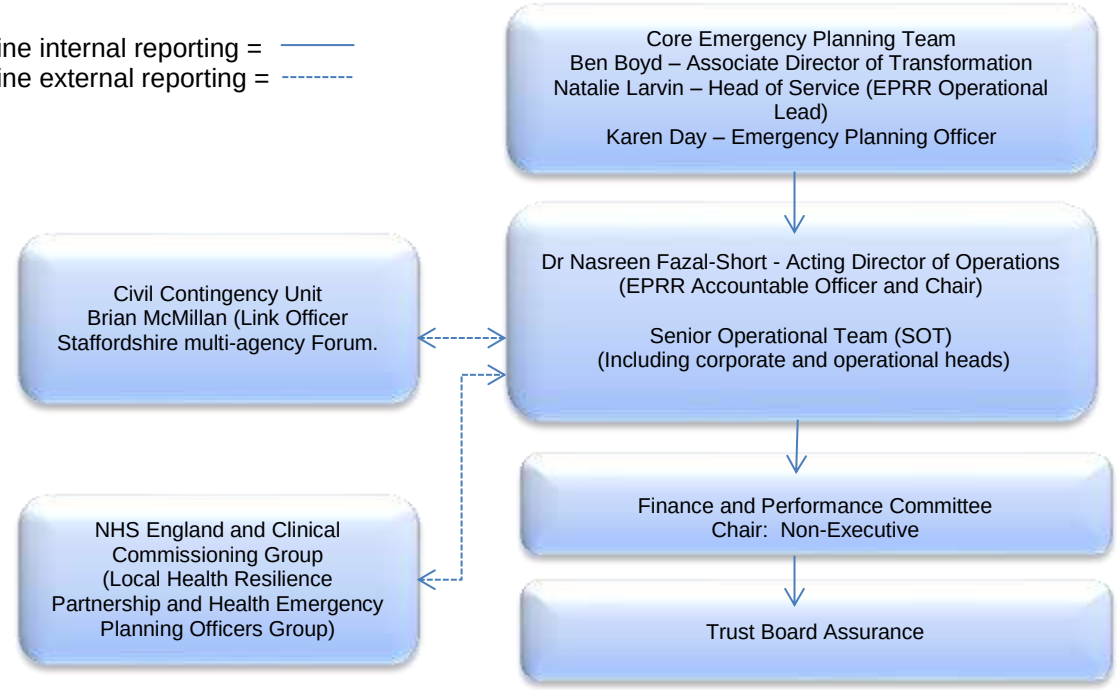
Exercising	
Carry out table top and walk-through exercises and update plans and review the Risk Register	
Training	
Gold	Exercise Nightingale
Silver	On-call Commander training and Exercise Nightingale
Loggist	Promote internal interest for more candidates to increase the capacity of Loggist's available to the Trust
CBRN	Monitor training compliance for CBRN (chemical, biological, radiological and nuclear events)
Refresh Packs and Action Cards	
On-call Packs	Review and refresh On-call Packs for Gold and Silver Commanders to support plans written in 2017
Attendance	
Attendance at Meetings	To support the Accountable Officer, representation by the Operational Lead for EPRR has been identified, to ensure appropriate seniority in our attendance at LHRP and achieve compliance
Resilience Agreement with Partners	
Partner Agreement	Detailed discussions with partners on mutual aid

07. Recommendations:

The Board is asked to note the contents of the report and approve the work plan for 2017/2018.

Diagram 1: EPRR Structure

Key:
Direct line internal reporting = ———
Direct line external reporting = ---------



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REPORT TO TRUST BOARD

Enclosure No:9

Date of Meeting:	5th October 2017		
Title of Report:	Workforce Race Equality Standard (WRES)Update		
Presented by:	Paul Draycott		
Author:	Lesley Faux		
Executive Lead Name:	Paul Draycott	Approved by Exec	☒

Executive Summary:	Purpose of report	
The Workforce Race Equality Standard (WRES) is based on the principle NHS employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. This is the Trust's third WRES report. Since April 2015, all NHS organisations were required to demonstrate through the nine point WRES metric how they are addressing race equality issues in a range of staffing areas through the NHS Standard Contract. The WRES requires NHS organisations to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address national problems such as poor BME representation on NHS Trust Boards and a range of indicators suggesting poorer experiences by BME staff in the NHS compared to their white counterparts (including less access to development, more likely to experience bullying, harassment, discrimination, disciplinary action etc). This report shares the Trust's 2017 WRES documents, including progress report on actions that have been ongoing over the last 12 months to help us to realise our goals in relation to race equality and a new WRES Action Plan for the remainder of 2017-18 to propel us further along this journey. This suite of papers also includes the updated Trust Diversity and Inclusion Action Plan for 2017-18, which has been revised to include the actions arising from WRES 2017.	Approval	☒
	Information	☐
	Discussion	☒
	Assurance	☐

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☒ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☒ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☒ 4. Encourage, inspire and implement research & innovation at all levels.☐		

	5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☒ 7. Continually improve our partnership working. ☐
Risk / legal implications: Risk Register Ref	The WRES is a key element of our Diversity and Inclusion reporting requirement to NHS England and our local commissioners and is assessed by the CQC as part of their inspection programme. It is also core to supporting and developing our Equality Act 2010 and associated Public Sector Equality Duty responsibilities.
Resource Implications: Funding Source:	Within existing resources A number of Trust 'Diversity & Inclusion Ambassador' (or similar, title to be agreed) secondments are proposed, including one for Race Equality, which will require allocation of funding. This aspect is not covered in detail in this report.
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	• Diversity and Inclusion (D&I) is very much at the heart of good NHS services and Safe, Personalised, Accessible and Recovery-Focused (SPAR) Care for all cannot be provided without an inclusive approach. This whole report is about race equality, a key component of D&I. • See risk section above. • Workforce race equality is a central element of our overall Diversity and Inclusion strategy and approach. Tackling race inequity is an imperative for all NHS organisations as part of our legal Equality Act & PSED duties, as well as NHS England, local commissioner and CQC requirements and our local D&I strategy and action plans. • There are clear economic and performance benefits to achieving full representation and equitable treatment of BME individuals across the UK and NHS labour markets, in addition to clear social, human and moral benefits.
Recommendations:	• To approve the WRES 2017 Report for publication and sharing with commissioners • To note the contents and commit to taking personal action to address racial inequity in the workplace and to leading action in your areas of responsibility • To provide feedback on any areas of the report and action plan for amendment or addition in the report prior to publication

2017 Trust Workforce Race Equality Standard (WRES) Report and Action Plan

Date: **August 2017**

Author: **Lesley Faux, Diversity & Inclusion Lead**

1. Introduction

The Workforce Race Equality Standard (WRES) was introduced in April 2015 and mandated as part of the NHS Standard Contract. Implementation of the WRES is a requirement on both NHS commissioners and NHS provider organisations.

The Trust also sees this as a vital component as we strive to improve and deliver our obligations under the Public Sector Equality Duty to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The WRES ultimately supports the Trust to increase its diversity and inclusivity enabling us to deliver services for all people within our communities. It is impossible to deliver safe, personalised, accessible and recovery focussed services if we are not diverse and inclusive.

This report contains the Trust's third WRES report which will be published on our website and shared with NHS England and our local commissioners, as well as being reviewed as part of CQC inspection processes.

The key purpose of the WRES was to address persistent workforce race inequity evident across the NHS in England. The WRES is designed to prompt inquiry and assist healthcare organisations to develop and implement evidence-based responses to the challenges their data reveal. It assists organisations to meet the aims of the NHS Five Year Forward View and complements other NHS policy frameworks such as Developing People – Improving Care, as well as the principles and values set out in The NHS Constitution.

Background

NHS Trusts produced and published their first WRES baseline data in July 2015. Since then, NHS England have published 2 national reports on the WRES, the most recent (based on data submitted in 2016) is available HERE

As in 2016, Trusts are required to submit 3 documents to Commissioners and NHS England to satisfy the WRES:

- NSCHT spreadsheet data set - ***attachment 1*** (already submitted)
- NSCHT WRES template report - ***attachment 2***
- A WRES Action Plan - ***attachment 3***

Additionally, in response to the detail sought in relation to WRES indicator 1, a further spreadsheet is attached containing workforce breakdowns for 2017 and 2016 by band, including clinical and non-clinical breakdowns - ***attachment 4***

The above information will be published on our Trust website and shared with our lead commissioners.

In 2016, (based on the 2015 WRES) the Trust was pleased to have been found by the NHS Equality & Diversity Council to be placed as the top performing mental health trust for BME staff experience on two of the WRES indicators and in the top 6 for the other 2 highlighted measures.

- **Top MH Trust for BME staff experience for:-**
  - % of staff who report experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months, and
  - % of staff experiencing harassment, bullying or abuse from staff in last 12 months
- **In Top 6 MH Trusts for BME staff experience for:-**
  - % of staff who believe that trust provides equal opportunities for career progression or promotion, and
  - % staff personally experiencing discrimination at work from manager/team leader or other colleagues

Key national level findings from the 2016 WRES are summarised in Figure 1 below. The 2016 WRES report firmly places the NHS findings firmly within a societal context and finds these results as a proxy for wider cultural change:-

> *The less favourable treatment of BME staff in the NHS takes place in a wider societal context. BME people suffer less favourable treatment from birth, through school, into college and employment. At every stage of their lives, BME people face discrimination in accessing employment, their progression through employment, their treatment within employment and when accessing or receiving services.* (NHS England 2016 WRES report, p11)

- White shortlisted job applicants are 1.57 times more likely to be appointed from shortlisting than BME shortlisted applicants, who remain noticeably absent from senior grades within Agenda for Change (AfC) pay bands.
- An increase in numbers of BME nurses and midwives at AfC Bands 6 to 9 is observed for the period between 2014 and 2016.
- BME staff in the NHS are significantly more likely to be disciplined than white staff members.
- The proportion of very senior managers (VSMs) from BME backgrounds increased by 4.4% from 2015 to 2016 – an additional 9 headcounts. However, BME representation at board and VSM level remains significantly lower than BME representation in the overall NHS workforce and in the local communities served.
- BME staff remain significantly more likely to experience discrimination at work from colleagues and their managers, although the percentage of BME staff reporting that in the last 12 months they have personally experienced discrimination at work from staff fell slightly.
- White and BME staff are equally likely to experience harassment, bullying or abuse from patients, relatives and members of the public in the last 12 months.
- BME staff remain more likely than white staff to experience harassment, bullying or abuse from other staff though this fell very slightly last year.
- BME staff remain less likely than white staff to believe that their trust provides equal opportunities for career progression. However, the gap between white and BME staff on this indicator fell from 14.5 percentage points in 2014 to 12.6 percentage point in 2015.

Figure 1: Key findings from WRES 2016 (national level results, NHS England)

2. NSCHT WRES 2017 Findings

The Trust saw improvement on the majority of WRES indicators (6 of 9) since 2016, summary of key headlines are below. Three indicators worsened, two of these marginally and one significantly. A number of our 2017 WRES indicator scores put the Trust in the **top quartile** of Trusts.

The most significant area for improvement highlighted by the 2017 WRES data was the level of BME staff reporting that they had **personally experienced discrimination** from their manager, team leader or other colleagues in the last 12 months (see Indicator 8 below). The Trust's score on this measure placed us in the **bottom quartile** of Trusts on this measure.

2017 Trust WRES Key Findings

General:-

- Over 99% of staff have declared their ethnicity (improvement since 2016)

Specific WRES Indicators:-

Indicator 1 (improvement since 2016)

- 5.90% of the Trust's workforce (excluding bank) is BME; 94.10% White
- 7.15% of the clinical workforce is BME, reducing to 4.68% when medical staff are excluded
- Most BME clinical staff are in bands 5, 6 and 7
- There are very few non-clinical BME staff (most BME people who are in this group are in bands 3, 4 and 5)

Indicator 2 (very significant improvement since 2016)

- Relative likelihood of BME staff being appointed from shortlisting across all posts = 1.2

Indicator 3 (improvement since 2016)

- Relative likelihood of BME staff entering the formal disciplinary process = 1.77. BME staff still **nearly twice as likely** to enter formal disciplinary processes)

Indicator 4 (improvement since 2016)

- Relative likelihood of BME staff accessing non-mandatory training and CPD = 0.76 ie BME staff a little more likely to access non-mandatory training and development. Conversely in 2016, BME staff were a little less likely to access non-mandatory development than white counterparts (2016 score = 1.13).

Indicator 5 (marginal improvement since 2016)

- 37% BME staff (32% for white staff) experiencing harassment, bulling or abuse ***from patient, relatives and public*** in last 12 months.

Indicator 6 (worse than 2016)

- 25% of BME staff (20% of white staff) experiencing harassment, bullying or abuse ***from staff*** in the last 12 months (2015-16: 15% BME & 20% white)

Indicator 7 (improvement since 2016)

- 86% of BME staff (89% white staff) believing the Trust offers equal opportunities for career progression (2015-16 rate: 83% BME & 87% white)

Indicator 8 (significantly worse than 2016)

- 17% of BME staff reporting they have personally experienced discrimination at work from their manager/team leader or other colleagues (5% for white staff). The rates for 2015-16 were 11% BME and 5% white.

Indicator 9 (marginal reduction, but still greater than proportionate & increasing)

- 1.9% is the average percentage difference between organisations Board voting membership and overall workforce (1.0% = equal to proportionate). The Trust is in a better position in that we have greater representation at Board than our community and staffing profile. This is further bolstered by the appointment in May 2017 in the role of Acting Chief Operating Officer and also the appointment of a NED in Sept 2017. Note: A higher than proportionate rate of BME representation is appropriate in terms of reflecting our local population, since we are aware that we currently under-represent for BME.

3. Conclusions and Next Steps

Significant progress has been made on developing race equality over the past 12 months. This has been further boosted in July and August 2017, with the inspiring attendances of Yvonne Coghill from the NHS England WRES Implementation Team at Trust Board Development session, our BAME Focus Groups and our Leadership Academy.

However, the Trust still has a long way to go in terms of achieving its goal of being representative of the local community for BME by 2020 (after medical staff excluded from the data). The challenge is greater still in terms of achieving such a balance throughout our services, staff groups, and banding structures.

Furthermore, there is an immediate and long term challenge around addressing a range of societal, historical, cultural and organisational factors which culminate in BME people experiencing poorer employment prospects and experiences than their white counterparts in the NHS on a range of measures.

Attachment 3 sets out the actions that have been ongoing over the last 12 months to help us to realise our goals in relation to race equality.

Attachment 4 sets out the actions for the remainder of 2017-18 to propel us further along this journey.

Finally, your attention is drawn to Attachment 5, which outlines from a recent CBE and BAM report 'Delivering Diversity', measures proven to be effective in facilitating greater BME inclusion and equality and sets out recommended actions for all leaders at any level.

4. Recommendations

Committee members are asked to:-

- Approve the WRES documents, including the action plan
- Commit to taking personal action to deliver on this agenda through your own area of responsibility.

Unify2 Upload Template
Workforce Race Equality Standards annual collection
as at March-2017

Organisation:	RLY	North Staffordshire Combined Healthcare NHS Trust

Validations

Unify2 Upload Template

Workforce Race Equality Standards 2017/18 template

Organisation: RLY North Staffordshire Combined Healthcare NHS Trust

INDICATOR		DATA ITEM		MEASURE	31st MARCH 2016 WHITE Prepopulated figures	31st MARCH 2016 WHITE Verified figures	31st MARCH 2016 BME Prepopulated figures	31st MARCH 2016 BME Verified figures	31st MARCH 2016 ETHNICITY UNKNOWN/NULL Prepopulated figures	31st MARCH 2016 ETHNICITY UNKNOWN/NULL Verified figures	31st MARCH 2017 WHITE Prepopulated figures	31st MARCH 2017 WHITE Verified figures	31st MARCH 2017 BME Prepopulated figures	31st MARCH 2017 BME Verified figures	31st MARCH 2017 ETHNICITY UNKNOWN/NULL Prepopulated figures	31st MARCH 2017 ETHNICITY UNKNOWN/NULL Verified figures	Notes
			1a) Non Clinical workforce														
1	Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce	1	Under Band 1	Headcount	0	0	0	0	0	0	0	1	0	0	0	0	
		2	Band 1	Headcount	19	25	0	0	0	0	20	24	0	0	1	1	
		3	Band 2	Headcount	38	39	0	0	0	0	37	37	0	0	1	1	
		4	Band 3	Headcount	66	67	1	0	3	3	76	76	2	2	2	2	
		5	Band 4	Headcount	75	74	3	3	0	0	66	67	2	2	0	0	
		6	Band 5	Headcount	43	42	0	0	0	0	39	39	1	1	0	0	
		7	Band 6	Headcount	26	25	0	0	0	0	20	20	0	0	0	0	
		8	Band 7	Headcount	10	10	0	0	0	0	16	16	0	0	0	0	
		9	Band 8A	Headcount	18	17	0	0	0	0	17	18	1	1	0	0	
		10	Band 8B	Headcount	11	11	1	1	0	0	11	11	0	0	0	0	
		11	Band 8C	Headcount	5	5	0	0	0	0	6	6	0	0	0	0	
		12	Band 8D	Headcount	1	1	0	0	0	0	1	1	0	0	0	0	
		13	Band 9	Headcount	0	0	0	0	0	0	0	0	0	0	0	0	
		14	VSM	Headcount	1	6	0	0	0	0	1	6	0	0	0	0	Director included within consultant figures (data
			1b) Clinical workforce														
			of which Non Medical														
		15	Under Band 1	Headcount	0		0	0	0	0	0	0	0	0	0	0	
		16	Band 1	Headcount	9		0	2	0	0	7	1	0	0	0	0	
		17	Band 2	Headcount	6		0	5	0	0	9	9	1	1	0	10	
		18	Band 3	Headcount	222		5	219	11	5	202	198	3	3	11	1	
		19	Band 4	Headcount	77		3	77	2	3	80	79	3	3	1	4	
		20	Band 5	Headcount	207		10	208	5	10	201	201	13	13	4	0	
		21	Band 6	Headcount	245		10	243	0	10	228	241	11	12	0	3	
		22	Band 7	Headcount	144		7	143	3	7	143	140	11	11	3	0	
		23	Band 8A	Headcount	57		1	0	0	1	58	56	1	1	0	1	
		24	Band 8B	Headcount	15		1	53	1	1	17	15	1	1	1	1	
		25	Band 8C	Headcount	12		0	14	1	1	15	15	1	1	1	0	
		26	Band 8D	Headcount	3		0	12	0	0	3	3	0	0	0	0	
		27	Band 9	Headcount	0		1	3	0	0	0	0	1	1	0	1	
		28	VSM	Headcount	0		0	0	0	0	0	0	0	0	0	0	
			Of which Medical & Dental														
		29	Consultants	Headcount	14	14	16	16	2	1	19	13	19	15	1	0	Medical Director included here
		30	*of which Senior medical manager*	Headcount		1		0		0		3		2		0	
		31	Non-consultant career grade	Headcount	7	7	6	6	0	0	8	8	6	7	0	0	
		32	Trainee grades	Headcount	11	11	8	8	0	0	2	8	4	7	0	0	
		33	Other	Headcount	1	0	1	0	0	0	0	0	1	0	0	0	
2	Relative likelihood of staff being appointed from shortlisting across all posts	34	Number of shortlisted applicants:	Headcount		1145		184		18		997		177		34	
		35	Number appointed from shortlisting:	Headcount		182		11		2		196		29		15	
		36	Relative likelihood of shortlisting/appointed:	Auto calculated		0.1589519651		0.0597826087		0.1111111111		0.1965897693		0.163818079		**0.4411764706**	
		37	**Relative likelihood of White staff being appointed from shortlisting compared to BME staff:**	Auto calculated		**2.66**						**1.20**					
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation Note: This indicator will be based on data from a two year rolling average of the current year and the previous year	38	Number of staff in workforce:	Headcount		1334		73		25		1309		82		25	Bank only workers, NEDs and Associate Members excluded
		39	Number of staff entering the formal disciplinary process:	Headcount		16		2		0		18		2		0	
		40	Likelihood of staff entering the formal disciplinary process:	Auto calculated		0.0119940030		0.0273972603		0.0000000000		0.0137509549		0.0243902439		0.0000000000	
		41	**Relative likelihood of BME staff entering the formal disciplinary process compared to White staff:**	Auto calculated				**2.28**						**1.77**			

Unify2 Upload Template

Workforce Race Equality Standards 2017/18 template

Organisation: RLY North Staffordshire Combined Healthcare NHS Trust

INDICATOR		DATA ITEM		MEASURE	31st MARCH 2016 WHITE		31st MARCH 2016 BME		31st MARCH 2016 ETHNICITY UNKNOWN/NULL		31st MARCH 2017 WHITE		31st MARCH 2017 BME		31st MARCH 2017 ETHNICITY UNKNOWN/NULL		Notes
4	Relative likelihood of staff accessing non-mandatory training and CPD	42	Number of staff in workforce (White):	Headcount		1334		73		25		1309		82		25	Bank only workers, NEDs and Associate Members excluded
		43	Number of staff accessing non-mandatory training and CPD (White):	Headcount		1471		71		31		1293		107		18	
		44	Likelihood of staff accessing non-mandatory training and CPD:	Auto calculated		1.1026986507		0.9726027397		1.2400000000		0.9877769290		1.3048780488		0.7200000000	
		45	**Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff:**	Auto calculated		**1.13**						**0.76**					
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	46	% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Percentage	32.19%		35.71%				32.33%		37.14%				
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	47	% of staff experiencing harassment, bullying or abuse from staff in last 12 months	Percentage	19.86%		14.81%				18.92%		25.00%				
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion	48	% staff believing that trust provides equal opportunities for career progression or promotion	Percentage	87.62%		83.33%				88.67%		85.71%				
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	49	% staff personally experienced discrimination at work from Manager/team leader or other colleague	Percentage	5.22%		11.11%				4.89%		16.67%				
9	Percentage difference between the organisations' Board voting membership and its overall workforce Note: Only voting members of the Board	50	Total Board members	Headcount		**11**		**1**		**1**		**12**		**1**		**0**	
		51	*of which: Voting Board members*	Headcount		4		1		0		4		1		0	
		52	*: Non Voting Board members*	Autocalculated		7		0		1		8		0		0	
		53	Total Board members	Headcount		**11**		**1**		**1**		**12**		**1**		**0**	
		54	*of which: Exec Board members*	Headcount		6		1		0		6		1		0	
		55	*: Non Executive Board members*	Autocalculated		5		0		1		6		0		0	
		56	Number of staff in overall workforce	Headcount		1334		73		25		1309		82		25	Bank only workers, NEDs and Associate Members excluded
		57	**Total Board members - % by Ethnicity**	Auto calculated		**84.6%**		**7.7%**		**7.7%**		**92.3%**		**7.7%**		**0.0%**	
		58	**Voting Board Member - % by Ethnicity**	Auto calculated		**80.0%**		**20.0%**		**0.0%**		**80.0%**		**20.0%**		**0.0%**	
		59	**Non Voting Board Member - % by Ethnicity**	Auto calculated		**87.5%**		**0.0%**		**12.5%**		**100.0%**		**0.0%**		**0.0%**	
		60	**Executive Board Member - % by Ethnicity**	Auto calculated		**85.7%**		**14.3%**		**0.0%**		**85.7%**		**14.3%**		**0.0%**	
		61	**Non Executive Board Member - % by Ethnicity**	Auto calculated		**83.3%**		**0.0%**		**16.7%**		**100.0%**		**0.0%**		**0.0%**	
		62	**Overall workforce - % by Ethnicity**	Auto calculated		**93.2%**		**5.1%**		**1.7%**		**92.4%**		**5.8%**		**1.8%**	
		63	**Difference (Total Board -Overall workforce)**	Auto calculated		**-8.5%**		**2.6%**		**5.9%**		**-0.1%**		**1.9%**		**-1.8%**	

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ATTACHMENT 2

WRES Online Template 2017 final d

https://www.engage.england.nhs.uk/register/wres-independent-template/consultation/intro/

ATTACHMENT 3

WRES ACTION PLAN
Part 1: Progress with Actions from 2016

WRES Indicator	WRES Actions	By Who	Progress Update August 2017
1. Workforce ethnicity profile **Improved in 2017 WRES**	a. To develop and implement a support programme to develop and support new bank HCSWs into substantive roles in the Trust b. Continue positive action to encourage applications from BME applicants into Trust vacancies. c. Positive action to encourage applications from the BME community for our NED vacancies, August 2016 d. Explore reasons for low staff representation of local Asian/British-Asian communities. Consider photo campaign including Asian/Asian British staff member and embed through our ongoing Trust communications	Bank Lead HR Comms team	a. Regular recruitment events and open days held over 2016-17 and into 2017-18. Continued focus on BME positive action. b. Programme of outreach into the local community to raise the profile of the Trust as an employer and put ourselves forward as an employer of choice. Examples include Trust high profile recruitment campaigns and 'one stop shop' recruitment days; Sikh Vaisakhi festival attendance with Trust stall; Sikh temple visit; positive action statements in NED recruitment advertising in 2016-17; Stoke Walk of Peace; Trust Religions and Mental Health Meeting; BAME Focus Group (Service user and public session) etc. c. NED offer made to BME individual August 2017. Commencement anticipated from October 2017. d. To continue and extend in 2017-18. We have supported our new bank and substantive HCSW staff to complete the Care Certificate. We actively encouraged and supported bank workers to apply for substantive positions as they arise (eg Ward 4 recruitment outcomes. • CARRY FORWARD ACTIONS:- -Inclusion Forum now to be established in 2017-18. -Set up system to notify bank workers of training opportunities. -Recruitment campaign in 2017-18 to include photos and case studies of Asian/Asian British ethnicity.

2. Relative likelihood of staff being appointed from shortlisting across all posts **Very significant improvement since 2016 WRES**	a. Deliver training to recruiting managers on introduction to unconscious bias. b. Roll out programme of Inclusion Imperative workshops to Trust leaders (range of levels) c. Positive action recruitment campaigns as above. d. Undertake a random sample check of appointments and promotions with a focus on ethnicity.	HR Team Diversity & Inclusion Lead WFBP for each directorate, including corporate	a. Elements of unconscious bias awareness training incorporated into R&S training as part of the People Management Programme (PMP) b. Inclusive Leadership: Introduction to Unconscious Bias training delivered June 2017 as part of the People Management Programme (PMP) followed by session on the Public Sector Equality Duty (PSED) – see CQC Action Plan. c. As above re recruitment campaigns
3. Relative likelihood of staff entering the formal disciplinary process **Improvement since 2016 WRES**	Continue to monitor ethnicity in relation to staff members subject to disciplinary investigations and hearings. No additional action indicated in the first instance (in the 2015 WRES the data was inversed, with BME staff less likely to enter formal disciplinary processes).	n/a	No action indicated in first instance. Continue to monitor ethnicity in relation to staff members subject to disciplinary investigations and hearings. New action for 2017-18 - • to work with HR, staff side and new BME Staff Network to develop new support measures and mechanisms for BME staff who are subject to disciplinary processes and to ensure fairness of approach.

4. Relative likelihood of staff accessing non-mandatory training and CPD **Improvement since 2016 WRES**	Undertake analysis of access to non-mandatory training at each level (support, middle, senior, VSM, medical) to ensure that there is equal access to development opportunities in all areas of work across the Trust. Include summary of findings in annual Diversity report 2016-17.	Diversity and Inclusion Lead	Data for 2016-17 further analysed with medical staff excluded. This analysis of 2016-17 data shows that 4.22% of all non-mandatory training across the Trust (**after medical staff are excluded**) is undertaken by BME staff. We know that, when doctors are excluded, our workforce is 3.98% BME. This means that (when doctors are excluded), BME staff are still slightly more likely to access non-mandatory training than white staff. CARRY FORWARD ACTIONS for 2017-18: • Take action to analyse data on non-mandatory training experienced by BME staff with medical staff EXCLUDED after quarters 1 and 2. • Continue to promote development opportunities for all groups of staff, including encouraging and supporting BME staff to access leadership development. • Continue to support BME staff to seek to access career progression, including particularly within nursing and other professional healthcare roles. • Additionally, work to develop BME-specific development opportunities including mentorship and Trust to lead in development of a local BME leadership programme across the STP area.

5. Percentage of staff experiencing harassment, bullying or abuse **from patients, relatives or the public** in last 12 months **Marginal improvement since 2016**	a. Develop a local RESPECT poster campaign starring Trust staff, promoting 2-way respect and that abuse of NHS staff is not acceptable b. Hold a Learning Lessons session focusing on Reflecting on Staff's experiences of personal (including racial and homophobic) abuse at work and how to make it better	Diversity and Inclusion Lead and Communications Team Patient Safety Lead and Diversity and Inclusion Lead	a. Respect poster delayed pending improved communications team capacity in 2017. b. Focus Group and Learning Lessons sessions held in Summer 2016, followed by Learning Lessons newsletter item on addressing racist and personal abuse of staff. NEW ACTION for 2017-18: Trust to continue to work to prevent and respond to personal and racist abuse of staff through continued awareness raising and targeted attention. Local 'Respect' posters to be launched September 2017. Trust communications to patients and service users to make a clear zero tolerance / 'It's not OK' statement from Q3 (including clinic letters, inpatient literature etc). Flow-chart to be developed re response to and support following personal abuse. Follow up with individuals who are subject to abuse and ask them what measures were and weren't effective in making them feel valued, safe and supported.
6. Percentage of staff experiencing harassment, bullying or abuse **from staff** in last 12 months **Worse than 2016**	no specific action indicated. Continue to monitor.	n/a	BME staff reported less harassment, bullying or abuse from staff over 12 months in the 2016 staff survey (2017 WRES) at 15% of BME staff, compared to 20% of white staff. Whilst this shows a better picture for BME staff than for white staff, the levels of reported harassment, bullying and abuse overall are a concern and should be the focus of an 'It's not ok' / 'Draw the Line' campaign in 2016-17. Action for 2017-18 Develop and implement approach to 'It's not OK' / 'Draw the Line Campaign'. Meeting planned for 22 September 2017 to plan and staff engagement session on this planned for October Feel Good Friday event on Friday 6th October. See section 8 below.

7. Percentage believing that trust provides equal opportunities for career progression or promotion **Marginal improvement since 2016**	a. Positive action recruitment campaigns as outline in indicator 1 above. Including explicit statements about equal opportunities for career progression and promotion. b. Trust to implement a positive action mentoring programme for BME staff with a view to encouraging BME staff to perform and progress c. Implement a monitoring system for internal staff appointments/promotions by ethnicity and report findings to SLT d. Share recruitment data with staff through recruitment training and other communications	communications team, HR team, Trust SLT LET team and SLT HR Team HR Team	a. Recruitment campaigns as above b. Mentoring programme currently in place for all clinical professional staff as part of the Preceptorship Programme for the first year of their employment. All students (including medical students) are assigned a mentor for placements within the Trust. All qualified clinicians are also subject to clinical supervision, which is another form of mentoring and support around career development. We have 30 training places a year to train staff to become mentors for their profession. **Carry forward action**: to develop BME specific mentoring support for BME staff not subject to preceptorship mentoring as a positive action means of addressing societal imbalances and inequities in R&S. c. This is monitored and included in Diversity Report d. Recruitment data (regarding declining rates of BME people through application, shortlisting and appointment stages) shared in PMP Recruitment and Selection Training and via WFBPs in their Directorates.
8. Staff personally experiencing discrimination at work from manager/ team leader or other colleagues **Significantly worse than 2016**	a. Trust communications on positive statements about standing up to race hate and racial discrimination b. Inclusion Imperative workshops as per 1 above, including accumulated advantage/disadvantage and unconscious bias c. Work with staff side to gather data on alleged nature of discrimination for known cases and those not formally reported, taking action as indicated by findings.	Comms team, D&I Lead, Trust SLT, HR Team HR team and Staff Side (Steve Jones)	a. Ongoing and to be further developed in 2017 through the 'It's not OK' / 'Draw the Line' campaign and approach outlined above. b. Inclusion and unconscious bias training delivered as outlined above in section 2. <u>Action for 2017-18</u> • Coordinated 'It's not OK' / 'Draw the Line' campaign and to go alongside our RESPECT posters currently in development. This to be around:- - having a very clear statement in all patient and service user letters that 'It's NOT OK' to abuse NHS staff including racist abuse, harassment or bullying - same message in patient literature given to patients on admission

			- supporting poster campaign in public/patient areas re above - racist discrimination, bullying or abuse in the workplace 'It's NOT OK' and that decisive action will be taken where there is evidence of this by Trust workers - poster campaign in staff areas? - also re the balancing of the 'what not to do' (as above) with positive messages about Proud to CARE values about how we like to treat people and be treated etc
9. Board representativeness: difference between the Board voting membership and overall workforce **Marginal reduction, but still greater than proportionate & increasing**	a. To undertake positive action to encourage applications from our BME community for 2 Non Executive Director vacancies in summer 2016. b. To learn from the above experience and develop this approach for future exec and non-exec vacancies. c. To invite Trust Board to develop mentoring relationships, including positive action to encourage staff in protected characteristic groups to seek high level mentoring support	HR and Communications teams as appropriate LET team and Trust Board Members	a. Completed. b. Completed. c. Carry forward action for 2017-18

Part 2: WRES Actions for 2017

ACTION	By Who	By When	Notes, Comments, Progress
1. Establish systems for routine detailed analysis of staff and patient data by ethnicity and discussion at Trust and Directorate leadership meetings. Need to ensure ESR, Lorenzo, Ulysses are all able to capture the data and enable the Trust to analyse it to inform future decision making - Data by band, by staff group, by Directorate, by service etc - eg how many staff nurses do we have above band 5 in inpatient services? - Understand service provision to BME service users Seek to better understand:- - What is the experience of our BME patients? - What is the experience of our BME staff?	Lesley Faux	Dec 2017	
2. Report on ESR, Lorenzo, Ulysses to inform future decision making. This will include Serious Incidents, detention under the MHA, service access and utilisation - Data by band, by staff group, by Directorate, by service etc - eg how many staff nurses do we have above band 5 in inpatient services? - Understand service provision to BME service users Seek to better understand:- - What is the experience of our BME patients? - What is the experience of our BME staff?	Lesley Faux	Apr 2018	
3. Work to eliminate barriers to BME staff entering employment at every level through the organisation. Specifically, introduce a new interview approach ensuring diverse panels for diverse shortlists (ie that all BME interview candidates will experience having a BME person on the interview panel in Trust interviews) Task and Finish Group led by HR to be established to design and implement pilot process and monitor effectiveness	Kerry Smith	Mar 2018	

4. HR to work with staff side and new BME Staff Network to develop new support measures and mechanisms for BME staff who are subject to disciplinary processes and to ensure fairness of approach. (See Birmingham Trusts model as one possible approach).	Kerry Smith	Mar 2018	
5. Trust Inclusion Forum now to be established in 2017-18. Group to perform critical challenge around delivery of diversity and inclusion through the Trust Membership to include :- - NED - Exec Director - D&I Lead - Directorate Heads - Analyst / Performance Rep	Lesley Faux	Nov 2017	
6. Positive Action BME leadership development programme – ambition to be the first STP to establish and implement this in England	Caroline Donovan (in STP OD and Leadership Workstream SRO role)	Mar 2018	
7. Spotlight services that are doing good work in BME inclusion (eg Healthy Minds positive action programme for reaching BME communities around access to IAPT services)	Joe McCrea	Oct 2017	
8. Mentoring, support and encouragement for BME nursing/clinical staff who wish to progress their careers. - develop BME specific mentoring support for BME staff not subject to preceptorship mentoring as a positive action means of addressing societal imbalances and inequities in R&S. - invite Trust Board to develop mentoring relationships, including positive action to encourage staff in protected characteristic groups to seek high level mentoring support - Support and encouragement to gain additional experience - Support to build confidence	Maria Nelligan, Director of Nursing & AHP to lead	Dec 2017	Maria Nelligan, DoN, currently arranging a 'tea and talk' session with BME nursing staff from inpatient teams

- Encouragement to participate in development opportunities - Career / Performance mentoring - Continue to promote development opportunities for all groups of staff, including encouraging and supporting BME staff to access leadership development. - Continue to support BME staff to seek to access career progression, including particularly within nursing and other professional healthcare roles. - Additionally, work to develop BME-specific development opportunities including mentorship and Trust to lead in development of a local BME leadership programme across the STP area. - Take action to analyse data on non-mandatory training experienced by BME staff with medical staff EXCLUDED after quarters 1 and 2. All Trust leaders to actively support and encourage BME staff to increase their experience and exposure across the Trust and beyond and to encourage to apply for career development posts			
9. Positive BME Role Models – seek BME staff at every level to be diversity role models for the Trust. Share story on website, etc. Role Model pin / award?	Dr Adeyemo, Medical Director, to lead.	Dec 2017	
10. Keeping all staff involved and having positive conversations about ethnicity and racial equality. 'It's OK to ask' about ethnicity (with well-intentioned curiosity) etc. Raising awareness about BME experience and micro assaults in society, workplace etc	Lesley Faux	Dec 2017	
11. Bespoke Task and Finish Group to deliver Preventing Racial Abuse / 'zero tolerance' education campaign: - RESPECT Poster campaign with images of our own BME (and other) staff. - Coordinated 'It's not OK' / 'Draw the Line' campaign and approach to go alongside our RESPECT posters currently in development:- around:- - clear statement in all patient and service user letters that	Lesley Faux	Dec 2017	Group meeting 22 September to discuss and action. Feel Good Friday event on 6 October to carry out staff engagement on this.

'It's NOT OK' to abuse NHS staff including racist abuse, harassment or bullying - same message in patient literature given to patients on admission - supporting poster campaign in public/patient areas re above - racist discrimination, bullying or abuse in the workplace 'It's NOT OK' and that decisive action will be taken where there is evidence of this by Trust workers - poster campaign in staff areas? - also re the balancing of the 'what not to do' (as above) with positive messages about Proud to CARE values about how we like to treat people and be treated etc - Flow-chart to be developed re response to and support following personal abuse. - Follow up with individuals who are subject to abuse and ask them what measures were and weren't effective in making them feel valued, safe and supported.			
12. Developing our links with local BME communities through public engagement events, religious community visits etc – twin focus of raising awareness about mental health and promoting the Trust as an employer of choice	Lesley Faux	Mar 2018	
13. Staff empowered to have positive discussions about ethnicity including: - Establish offer of a BME staff network - Develop further opportunities for staff at all levels to be involved - Further BME focus group meeting(s)	Cherelle Laryea	Mar 2018	
14. Positive outreach to seek information about issues and experience from BME service user and staff perspective:- - Direct positive action communications / surveys - Senior team to make positive outreach when undertaking team visits etc to ask BME service users and staff what their experience has been like and what could have been improved	Lesley Faux	Mar 2018	

- Reverse Mentoring by Board with BME staff			
15. Continue to work to support BME bank staff into substantive employment where the individual desires this. Support and encourage BME bank workers to aspire to more regular substantive employment. - Set up system to notify bank workers of training opportunities. - Bank staff PDRs and clinical supervision	Lynne Pulley	Dec 2017	
16. Trust recruitment campaigns in 2017-18 to include photos and case studies of Asian/Asian British ethnicity. Encourage block recruitment whenever possible as this is proven to increase the likelihood of appointing BME staff and staff from other minority groups.	Kerry Smith	Dec 2017	

Additional WRES Workforce Information in relation to WRES Indicator 1

2017 Data

Data as at 31/03/2017									2017 WRES						
Count of FTE		WRES White/BME				% of WF	% of WF		Clinical workforce only: medical staff excluded						
WRES Clinical/Non clinical	Payscale	BME	White	Undefined	Grand Total	BME	White			BME	White			BME	White
Clinical (inclg medical staff)	Band 1		1		1	0.00%	0.09%		Band 1		1		1	0.00%	0.10%
	Band 2	1	9		10	0.09%	0.85%		Band 2	1	9		10	0.10%	0.90%
	Band 3	3	198	10	211	0.28%	18.63%		Band 3	3	198	10	211	0.30%	19.70%
	Band 4	3	79	1	83	0.28%	7.43%		Band 4	3	79	1	83	0.30%	7.86%
	Band 5	13	201	4	218	1.22%	18.91%		Band 5	13	201	4	218	1.29%	20.00%
	Band 6	12	241		253	1.13%	22.67%		Band 6	12	241		253	1.19%	23.98%
	Band 7	11	140	3	154	1.03%	13.17%		Band 7	11	140	3	154	1.09%	13.93%
	Band 8a	1	56		57	0.09%	5.27%		Band 8a	1	56		57	0.10%	5.57%
	Band 8b	1	15	1	17	0.09%	1.41%		Band 8b	1	15	1	17	0.10%	1.49%
	Band 8c	1	15	1	17	0.09%	1.41%		Band 8c	1	15	1	17	0.10%	1.49%
	Band 8d		3		3	0.00%	0.28%		Band 8d		3		3	0.00%	0.30%
	Band 9	1			1	0.09%	0.00%		Band 9	1			1	0.10%	0.00%
	Medical	29	29	1	59	2.73%	2.73%		**Total**	**47**	**958**	**20**	**1025**	**4.68%**	**95.32%**
TOTAL Clinical		**76**	**987**	**21**	**1084**	**7.15%**	**92.85%**							BME clinical	White clinical
Non Clinical	Apprentice		1		1	0.00%	0.30%							(medical excluded)	
	Band 1		24	1	25	0.00%	7.32%		Medical	29	29	1	59	50%	50%
	Band 2		37	1	38	0.00%	11.28%								
	Band 3	2	76	2	80	0.61%	23.17%								
	Band 4	2	67		69	0.61%	20.43%								
	Band 5	1	39		40	0.30%	11.89%								
	Band 6		20		20	0.00%	6.10%								
	Band 7		16		16	0.00%	4.88%								
	Band 8a	1	18		19	0.30%	5.49%								
	Band 8b		11		11	0.00%	3.35%								
	Band 8c		6		6	0.00%	1.83%								
	Band 8d		1		1	0.00%	0.30%								
	VSM	0	6		6	0.00%	1.83%								
Total Non-Clinical		**6**	**322**	**4**	**332**	**1.83%**	**98.17%**								
Grand Total		**82**	**1309**	**25**	**1416**	**5.90%**	**94.10%**								
Whole Workforce 2017 WRES		**5.90%**	**94.10%**												
		BME	White												

Continued/

Continued from above

2016 Data

Data as at 31/03/2016						% of WF	% of WF
Clinical/Non clinical	Payscale Description	BME	White	Z Not Stated/Undefined	Grand Total	BME	White
Clinical (inclg medical staff)	Band 1		2		**2**	0.00%	0.19%
	Band 2		5		**5**	0.00%	0.46%
	Band 3	5	219	10	**234**	0.46%	20.26%
	Band 4	3	77	2	**82**	0.28%	7.12%
	Band 5	10	208	4	**222**	0.93%	19.24%
	Band 6	10	243		**253**	0.93%	22.48%
	Band 7	7	143	3	**153**	0.65%	13.23%
	Band 8a	1	53		**54**	0.09%	4.90%
	Band 8b	1	14	1	**16**	0.09%	1.30%
	Band 8c		12	1	**13**	0.00%	1.11%
	Band 8d		3		**3**	0.00%	0.28%
	Band 9	1			**1**	0.09%	0.00%
	Medical	31	33	1	**65**	2.87%	3.05%
Clinical Total		**69**	**1012**	**22**	**1103**	**6.38%**	**93.62%**
Non Clinical	Band 1		25		**25**	0.00%	7.67%
	Band 2		39		**39**	0.00%	11.96%
	Band 3		67	3	**70**	0.00%	20.55%
	Band 4	3	74		**77**	0.92%	22.70%
	Band 5		42		**42**	0.00%	12.88%
	Band 6		25		**25**	0.00%	7.67%
	Band 7		10		**10**	0.00%	3.07%
	Band 8a		17		**17**	0.00%	5.21%
	Band 8b	1	11		**12**	0.31%	3.37%
	Band 8c		5		**5**	0.00%	1.53%
	Band 8d		1		**1**	0.00%	0.31%
	VSM	0	6	0	**6**	0.00%	1.84%
Non Clinical Total		**4**	**322**	**3**	**329**	**1.23%**	**98.77%**
Grand Total		**73**	**1334**	**25**	**1432**	**5.19%**	**94.81%**
Whole Workforce 2016 WRES		**5.19%**	**94.81%**				
		BME	White				

2016 WRES

Clinical workforce only: medical staff excluded

	BME	White	Undefined	Total	BME	White
Band 1	0	2	0	**2**	0.00%	0.20%
Band 2	0	5	0	**5**	0.00%	0.50%
Band 3	5	219	10	**234**	0.50%	21.79%
Band 4	3	77	2	**82**	0.30%	7.66%
Band 5	10	208	4	**222**	1.00%	20.70%
Band 6	10	243	0	**253**	1.00%	24.18%
Band 7	7	143	3	**153**	0.70%	14.23%
Band 8a	1	53	0	**54**	0.10%	5.27%
Band 8b	1	14	1	**16**	0.10%	1.39%
Band 8c	0	12	1	**13**	0.00%	1.19%
Band 8d	0	3	0	**3**	0.00%	0.30%
Band 9	1	0	0	**1**	0.10%	0.00%
Total	**38**	**979**	**21**	**1038**	**3.78%**	**97.41%**
					BME clinical	White clinical
					(medical excluded)	
Medical	31	33	1	65	48.44%	51.56%

Extract from CBI and BAM report 'Delivering Delivering Diversity: Race and Ethnicity in the Management Pipeline' – July 2017

Key Findings

1. LET'S TALK ABOUT RACE

We need to end what one FTSE 100 leader described to us as "the silence around race and ethnicity." Many managers are uncomfortable discussing it and wary of causing offence. Only 54% of HR/diversity managers see their business leaders championing BAME diversity. Leaders need to find their voice and show their commitment to diversity and to building inclusive business cultures.

2. LEARN FROM THE GENDER AGENDA

Employers can transfer lessons from the progress made on gender diversity, among them the power of transparency to drive change. For now, BAME lags far behind. Only 21% of companies surveyed report publicly on BAME, compared to 71% on gender diversity. 42% even told us that the prioritisation of gender has become a barrier to progress on BAME: it has to be 'and', not 'or'.

3. FACE THE NUMBERS

83% of the HR/diversity leaders surveyed say they need better data to drive progress on race and ethnicity. Many report employee reluctance to share personal information, but data from across the employment cycle is vital to driving business improvements. Most powerfully, publicly setting and reporting on key diversity indicators is a major lever of accountability and change.

4. IT AIN'T WHAT YOU KNOW – IT'S WHO KNOWS YOU

Many BAME managers say their careers were significantly influenced by a senior executive who took a special interest. Managers at all levels need to make sure they support diversity through the emerging leaders they sponsor.

5. WANTED: ROLE MODELS AND MENTORS AT EVERY LEVEL

Role models show the company welcomes diversity. 'Next up' role models – drawn from all levels of a business, not just those at the very top – inspire confidence and ambition from those who follow them, showing that career progression is possible. Mentoring also needs to be encouraged at all levels; peer mentoring, mentoring circles and reverse mentoring offer powerful benefits.

6. FITTING IN?

Many BAME managers question the perceived 'fit' for BAME employees in their businesses, pointing to norms that favour what one interviewee called "white middle class men from elite schools and universities." Some stressed the responsibility of BAME employees themselves to understand and navigate these differences. Internally, companies need to bridge this gap, tackling outdated cultures. Externally, they need to show a more diverse 'public face' in company websites and annual reports.

7. EVIDENCE BASED DEVELOPMENT

Companies should accelerate their progress by gathering evidence from outside the business, like good practice case studies and benchmarking data. This data can be used to identify opportunities for improvement and ways to develop key decision makers throughout the business – including, critically, line managers.

Action for Leaders: How to improve BAME Diversity in the Workforce

1. BREAK THE SILENCE

- Re-boot the conversation. Show commitment, make the business case and build employee buy-in to deliver diversity
- Support BAME networks to voice BAME employees' views
- Build line managers' capacity to deliver diversity. Make it OK to be curious and ask questions.

2. CHANGE THE STORY

- Generate momentum: make BAME your focus and define a plan for change
- Use the power of transparency. Publish your strategies, your targets and your progress
- Show inclusive leadership and call out bias.

3. MEASURE IT, MANAGE IT, REPORT IT

- Measure BAME diversity throughout the talent pipeline, including representation at management levels
- Build employee trust and confidence for the use of personal data on ethnicity
- Establish pipeline indicators and use time-trend data to manage progress.

4. TAP INTO THE POWER OF SPONSORSHIP

- Create more opportunities for senior leaders to meet emerging BAME leaders and build diverse networks
- Actively seek out diverse emerging leaders to sponsor and advocate for within the organisation.

5. BUILD DIVERSITY THROUGH 'NEXT UP' LEADERSHIP

- Identify and use 'next up' mentors and role models, not just remote senior leaders. Make mentoring the norm
- Use mentoring circles and reverse mentoring
- Share stories of diverse employees and showcase cultural differences.

6. BE INCLUSIVE AND ADAPTIVE

- Make clear that the company values difference and diversity so no minority employee is left questioning their perceived 'fit' in the company
- Build adaptive cultures that respond to the differences people bring to work, rather than just asking others to fit in
- Prove to the external world that your organisation is diverse, remembering that your online presence is your public face.

7. BENCHMARK AND COLLABORATE

- Benchmark with others in your sector
- Collaborate and share good practice to accelerate change
- Build diversity training into management and leadership development and make it a requirement for career progression.

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO TRUST BOARD

Enclosure No:10

Date of Meeting:	5th October 2017		
Title of Report:	Diversity and Inclusion Strategy Updated Action Plan		
Presented by:	Paul Draycott		
Author:	Lesley Faux		
Executive Lead Name:	Paul Draycott	Approved by Exec	☒

Executive Summary:	Purpose of report	
The Trust's Diversity and Inclusion Strategy for 2016-2020 was approved in July 2016 and is available on the Trust's website HERE. This strategy encompasses all the different elements: legal requirements; NHS requirements; other equality groups and person-centred care into the Trust's unique approach to Diversity and Inclusion (D&I). This report contains the updated Trust D&I Action Plan for 2017-18, which now contains the actions emerging from the Trust's WRES 2017 (WRES papers being reviewed as a separate item on 05/10/17 agenda).	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☒ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☒ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☒ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	• Legal requirement under Equality Act and PSED – see D&I Implications section below • NHS requirement as part of NHS Contract and local commissioner contract(s) • Now a core element of Well Led domain for CQC • Links with service quality, productivity, financial performance – see D&I implications below		
Resource Implications: Funding Source:	Within existing resources [A number of Trust 'Diversity & Inclusion Ambassador' (or similar, title to be agreed) secondments are proposed, including one for Race Equality and one for LGBT inclusion, which will require allocation of funding. This aspect is not covered in detail in this report.]		

Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	It is clear that having an approach that delivers effectively on diversity and inclusion is morally the right thing to do, and there are very clear links with our Trust Proud to CARE Values; SPAR Quality Priorities and delivery of person-centred approach for all service users, carers and Trust workers. There are also important implications for societal change and development of health equality. Additionally, there is also an ever-growing business case for the productivity, quality of care and experience and financial benefits of developing more diverse and inclusive organisations. D&I is also legislated under the Equality Act 2010 and the associated Public Sector Equality Duty responsibilities, as well as by performance standards for the NHS (ie Accessible Information Standard, forthcoming Sexual Orientation Monitoring Standard). We are also required to publish our Diversity and Inclusion information to NHS England (WRES, EDS2) and our local commissioners (WRES, EDS2, Annual Report and action plan) as part of the NHS Contract and our local contract(s). Diversity and Inclusion is now also a core element of the 'Well Led' domain and, as such, is assessed by the CQC as part of their inspection programme.
Recommendations:	• To note the contents of the updated Action Plan • To personally commit to progressing the outlined actions assigned to you, your direct reports or area of responsibility • To personally commit to the embedding and furtherance of D&I throughout the Trust, and to challenge current practice and performance where challenge is due in support of greater diversity and inclusion for all • To provide feedback on any areas of the report and action plan for amendment or addition in the report prior to publication of the Plan on the Trust website

Towards Outstanding

Diversity and Inclusion

Diversity and Inclusion Action Plan 2017-18

Theme	Action to be taken	Due Date	Lead
National Standards and Templates	**1 Equality Delivery System (EDS2)** **a. EDS2 2016-17 -** assessment report completed and reviewed at Trust Board. Work on emerging Actions through 2017-18 **b. EDS2 2017-18** Throughout 2017-18, build in opportunities to consult on EDS2 at Trust service user and staff events and Directorate or service engagement events, including protected characteristics groups	• Report completed 19.06.17. Trust Committees in July • Publish & share with commissioners & NHS England 1st wk Oct 2017 following Board WRES sign off.	Lesley Faux & Paul Draycott
	2. Workforce Race Equality Standard (WRES) **a. WRES 2016-17** completed and reviewed at Trust Committees. LF to work with nominated board member to develop trends and ensuring challenge. Work on emerging Actions through 2017-18 – See end section for detailed WRES actions 2017-18 **b. WRES 2017-18 -** Preparations to commence from Q4 2017-18 and according to timescales as published See actions 28-43 for detailed WRES Actions	• Report completed 19.06.17 • Trust Committees in August and % Oct (Board) • Publish & share with commissioners & NHS England 1st wk Oct following TB sign off.	Lesley Faux Paul Draycott Dr Adeyemo to provide robust challenge
	3 NEW Gender Pay Reporting 2017-18 – Prepare first Gender Pay Report and review at Inclusion Group prior to publication	• Quarterly reports commencing July/August 2017 for Q1 report.	Kerry Smith
	4. NEW Sexual Orientation Monitoring Information Standard - Implement the new standard for patient/service user monitoring. Awareness raising with staff and service users will be required.	• According to timescales when published	Lesley Faux Vicky Boswell N Fazal-Short
	5. NEW Workforce Disability Equality Standard – commence preparations for introduction of new requirements at the end of 2017-18. Awareness raising with staff and sessions to encourage support staff in updating their personal data in relation to disability , where applicable. Develop staff confidence with regard to declaring this information, eg through sharing staff stories etc.	• Prepare for introduction in 2018	Lesley Faux Kerry Smith

Diversity and Inclusion Action Plan 2017-18

Theme	Action to be taken	Due Date	Lead
Improvements to Combined D&I Strategy Development	6. Establish new **Trust Inclusion Forum** to provide suitably robust review and challenge to Trust strategy and delivery of action plans	Quarter 2 2017-18 Put back to Q3 to review Trust D&I suite documents following Board sign off	Paul Draycott Lorien Barber Lesley Faux
	7. Ensure that **PCD** as a cycle of business regularly reviews action progress against D&I Strategy	March PCD meeting progress report	Paul Draycott (Lesley Faux) through PCD
Process & Policy	8. Review Directorate Business Continuity plans and complete Equality Impact Assessment process for these. Specific reference to disability assessment.	By end September 2017	Karen Day / Brian Macmillan
	9. Flexible Working Policy to be reviewed in respect of carers and staff with disabilities being able to specify the reason for their flexible working application.	COMPLETE SUBJECT TO APPROVALS PROCESS (JNCC 27/09/17, then PCD & TB)	Kerry Smith
	10. Audit of application of recent introduction of new Trust Committees cover sheet to ensure robust assessment of equality, diversity and inclusion impacts of papers to these committees together with more robust challenge around Diversity and Inclusion implications in Board Committees.	By 30 September 2017 COMPLETE and ongoing	Paul Draycott with Gaynor Pearce
	11. Develop and deliver action plan to progress delivery of Disability Confident Employer Commitment	Action Plan by end September 2017 Delivery on-going to end March 2018 in 1st instance	Kerry Smith

Theme	Action to be taken	Due Date	Lead
Care Delivery and Evidencing Care	11. Accessible (easy read) care plans to be rolled out across the CAMHS-LD service.	COMPLETE	S. Mountford/ Andrew Adams
	12. Ensure the Service User and Carer Council monitor and provide feedback on the Trust's delivery against their quality standard of **personalised care**. Event in planning for 3 November 2017	Develop detailed plans for 2017-18 TBA	Maria Nelligan & Julie Anne Murray
	13. Review systems for **recording and reviewing use of restrictive practice interventions** by protected characteristics groups. Monitor and review based on first 6 months of data.	Review process and data mid-November 2017	Jackie Wilshaw/ Ben Boyd / Colin Mooney
	14. Supporting and facilitating **Advocacy Services** a. Share user-friendly information for staff and service users on legislated Advocacy Services across Trust Teams b. Raise awareness of Advocacy Services via a stall at the Trust Inclusion Conference c. Share advocacy information with Service User and Carer Council / Advocacy report into July Service User and Carer Forum	COMPLETE 08/06/17 Task & Finish Group 30 July 2017 - complete July 2017 - complete	Lesley Faux Advocacy leads/ reps Veronica Emlyn
	15. Trust to consider options for trying to enhance **patient transport** to key service delivery sites	By end Quarter 3 2017-18	Nasreen Fazal-Short
	16. Transitions between services – with the shift to Multi-specialty Care Partnerships (MCP) model across North Staffs & SOT, there is a desire to integrate care better and where appropriate create ageless services where connectivity in local communities is improved.	By end March 2018	Andy Hughes
	17. To hold a **service user and carer listening event** in October to focus on patient access and experience	October 2017	Veronica Emlyn
	18. To hold **Focus Groups** from a service provision as well as staff perspective considering service and experience for people who are LGBT (07.06.17) and BME (02.08.17). Develop and implement action from feedback gained.	COMPLETE: LGBT Focus Group – 07/06/17 BME Focus Group – 02/08/17	Lesley Faux

Theme	Action to be taken	Due Date	Lead
Training and culture	19. Enhancement of **e-learning offers for Diversity & Inclusion**: a. Trust D&I training to be translated into e-learning for standard training and refresher training, incorporating key focus on person-centred care and involvement of service users in decisions about the service they receive and on statutory obligations, particularly PSED. b. An enhanced level e-learning package to be developed for Trust managers and Senior Management Team to be completed on a 'once only' basis (repeat or update with major changes in legislative requirements). c. Team specific tailored D&I workshops available on request d. Inclusion Workshop incorporated into People Management Programme	COMPLETE 3 July 2017 launch of new D&I e-learning package for all staff (as training due) 30 September 2017 - In progress linked with LMS roll-out Ad hoc 25 July 2017	Lesley Faux/ Sue Slater Lesley Faux Lesley Faux Lesley Faux
	20. a. One-off session of **Board Development on D&I** using external expert. b. Repeated for our internal **Leadership Academy** of senior managers, plus extended invite to recruiting managers c. Subsequent repeats for new starters will be managed internally.	COMPLETE:26 July 2017 COMPLETE: 2 Aug 2017 Ad hoc as required	Robert Cragg (Yvonne Coghill) As above Lesley Faux
	21. Continue opportunities for **listening to staff** in 'Big Conversations through the LiA process and by more focussed team-level work through our Towards Outstanding Engagement Team Development programme - Open Space Event in planning for January 2017 ; first cohort Towards Outstanding Engagement launched May 2017 with 16 teams currently participating in Phase I	Q1-Q3 2017-18	Paul Draycott
	22. Identify more **clinical champions for diversity** and extend work to clinical services in a more consistent and robust way New clinicians have joined the group/physically attended meetings over recent months and we have increased the diversity of the group	September 2017 & ongoing	Lesley Faux

Theme	Action to be taken	Due Date	Lead
Promotion and Communication	**23. Information and Communication Support** a. Continue to promote and develop delivery against 'Accessible Information Standard' for people with disabilities and sensory impairment and also for people with foreign language needs. b. Trust Language Identification poster (including BSL) – A3 hard copy - to be released June 2017. Translate Me software available from February 2017. c. Implementation of Trust foreign language communication support, BSL communication support and digital foreign language translation	On-going. Newsround & via D&I Group, Aug 2017. COMPLETE - June 2017 Further copies availlable on request. COMPLETE 30 June 2017 Review end September	Trust services supported by LF and VE Lesley Faux Lesley Faux
	24. Responding to and Preventing Personal Abuse of Staff a. Create and display **local RESPECT poster** tailored to services as appropriate to encourage mutual respect and discourage personal abuse of NHS staff. Use of zero tolerance on racial harassment message as appropriate to Trust services and circumstances. b. Always challenging and always reporting inappropriate behaviour re personal abuse (eg racist, homophobic, biphobic, transphobic etc abuse) c. Create and share flow chart of responses and support following personal abuse of staff	Put back to mid Oct2017, incorporating It's not OK theme from WRES leadership academy Ongoing Mid Oct, in line with (a.) above	Comms Team All Lesley Faux with modern matrons
	25. To re-advertise the opportunity to establish staff **BME and LGBT networks** across the organisation and offer support with meeting facilities, subject to demand.	By 30 September 2017	Lesley Faux
	26. Regular cycle of Diversity & Inclusion issues in the Trust to promote equality. This will include promotion of local case studies and diverse role models, both service users and Trust workers. Role models showcased at Symphony of Hidden Voices Inclusion Conference 30/06/17. Individual films to be produced of these from mid October 2017. Further Symphony of Hidden Voices planned for 2018 to create exposure to more 'hidden voices'. • Continue search for diverse Trust role models and seek agreement to create and share role profiles on Trust website.	Spring-Summer 2017 and then mainstreamed	Veronica Emlyn with Lesley Faux

Theme	Action to be taken	Due Date	Lead
Recruitment & Selection	**27. Creating a more representative workforce and addressing workforce imbalances re BME, LGBT and disability:**	Over 2017-18	Paul Draycott
	a. Careers Recruitment – work with community groups linked to under-represented areas to highlight mental health career options	Over 2017-18	Kerry Smith & J-A Murray
	b. Interviews – Pilot a new interview process in the Trust to ensure enhance diversity of panels for diverse shortlist candidates.	Detail of pilot developed by mid Oct 2017. 3 mth pilot in 1st instance.	Kerry Smith & S Copestake
	c. Have a diverse range of role models from different diversity groups in all advertising materials in hard press and social media. Adverts placed with Stonewall Proud Employers web advertising end September 2017.	ASAP and then throughout 2017-18	Kerry Smith & S Copestake
	d. Include a positive action statement in all recruitment advertising	COMPLETE: ASAP and then throughout 2017-18	Kerry Smith & S Copestake

Theme	Action to be taken	Due Date	Lead
Workforce Race Equality Scheme (WRES) detailed actions	28. Establish systems for routine detailed analysis of staff and patient data by ethnicity and discussion at Trust and Directorate leadership meetings. Need to ensure ESR, Lorenzo, Ulysses are all able to capture the data and enable the Trust to analyse it to inform future decision making a. Data by band, by staff group, by Directorate, by service etc eg how many staff nurses do we have above band 5 in inpatient services? b. Understand service provision to BME service users. Seek to better understand:- • What is the experience of our BME patients? • What is the experience of our BME staff?	Dec 2017	Lesley Faux Vicky Boswell
	29. Report on ESR, Lorenzo, Ulysses to inform future decision making. This will include Serious Incidents, detention under the MHA, service access and utilisation • Data by band, by staff group, by Directorate, by service etc eg how many staff nurses do we have above band 5 in inpatient services? • Understand service provision to BME service users Seek to better understand:- • What is the experience of our BME patients? • What is the experience of our BME staff?	April 2018	Lesley Faux Vicky Boswell
	30. Work to eliminate barriers to BME staff entering employment at every level through the organisation. Specifically, introduce a new interview approach ensuring diverse panels for diverse shortlists (ie that all BME interview candidates will experience having a BME person on the interview panel in Trust interviews (see action 27b)). Task and Finish Group led by HR to be established to design and implement pilot process and monitor effectiveness	Mar 2018	Kerry Smith with D&I Lead

Theme	Action to be taken	Due Date	Lead
Workforce Race Equality Scheme (WRES) detailed actions	31. HR to work with staff side and new BME Staff Network to develop new support measures and mechanisms for BME staff who are subject to disciplinary processes and to ensure fairness of approach. (See Birmingham Trusts 'Cultural Ambassadors' model as one possible approach).	Mar 2018	Kerry Smith
	32. Trust Inclusion Forum now to be established in 2017-18. Group to perform critical challenge around delivery of diversity and inclusion through the Trust Membership to include :- NED; Exec Director; D&I Lead; Directorate Head; Analyst / Performance Rep; consider open attendance; consider incorporating full D&I group	Nov 2017	Lesley Faux
	33. Positive Action BME leadership development programme – ambition to be the first STP to establish and implement	Mar 2018	Caroline Donovan (STP SRO role)
	34. Spotlight services that are doing good work in BME inclusion (eg Healthy Minds positive action programme for reaching BME communities around access to IAPT services)	Oct 2017	Joe McCrea & Comms Team; D&I lead
	35. Mentoring, support and encouragement for BME nursing/clinical staff who wish to progress their careers. -develop BME specific mentoring support for BME staff not subject to preceptorship mentoring as a positive action means of addressing societal imbalances and inequities in R&S. -invite Trust Board to develop mentoring relationships, including positive action to encourage staff in protected characteristic groups to seek high level mentoring support -Support and encouragement to gain additional experience -Support to build confidence -Encouragement to participate in development opportunities -Career / Performance mentoring -Continue to promote development opportunities for all groups of staff, including encouraging and supporting BME staff to access leadership development. -Continue to support BME staff to seek to access career progression, including particularly within nursing and other professional healthcare roles. -Additionally, work to develop BME-specific development opportunities including mentorship and Trust to lead in development of a local BME leadership programme across the STP area. -Take action to analyse data on non-mandatory training experienced by BME staff with medical staff EXCLUDED after quarters 1 and 2. All Trust leaders to actively support and encourage BME staff to increase their experience and exposure across the Trust and beyond and to encourage to apply for career development posts • Link with implementation of Trust coaching approach	Dec 2017	Maria Nelligan, Director of Nursing & AHP and Lesley Faux

Theme	Action to be taken	Due Date	Lead
Workforce Race Equality Scheme (WRES) detailed actions	36. Positive BME Role Models – seek BME staff at every level to be diversity role models for the Trust. Share story on website, etc. Role Model pin / award?	Dec 2017	Dr Buki Adeyemo
	37. Keeping all staff involved and having positive conversations about ethnicity and racial equality. 'It's OK to ask' about ethnicity (with well-intentioned curiosity) etc. Raising awareness about BME experience and micro assaults in society, workplace etc	Dec 2017	Lesley Faux

	38. Bespoke Task and Finish Group to deliver Preventing Racial Abuse / 'zero tolerance' education campaign:
	• RESPECT Poster campaign with images of our own BAME (and other) staff.
	• Coordinated 'It's not OK' / 'Draw the Line' campaign and approach to go alongside our RESPECT posters currently in development:- around:-
	  • clear statement in all patient and service user letters that 'It's NOT OK' to abuse NHS staff including racist abuse, harassment or bullying
	  • same message in patient literature given to patients on admission
	  • supporting poster campaign in public/patient areas re above
	  • racist discrimination, bullying or abuse in the workplace 'It's NOT OK' and that decisive action will be taken where there is evidence of this by Trust workers - poster campaign in staff areas?
	  • also re the balancing of the 'what not to do' (as above) with positive messages about Proud to CARE values about how we like to treat people and be treated etc
	• Flow-chart to be developed re response to and support following personal abuse.
	• Follow up with individuals who are subject to abuse and ask them what measures were and weren't effective in making them feel valued, safe and supported.
		Dec 2017
		
		Group meeting 22 September to discuss and action.
		
		Feel Good Friday event on 6 October to carry out staff engagement on this.
			Lesley Faux

	39. Developing our links with local BME communities through public engagement events, religious community visits etc Trust attendance including clinician representatives planned for Sikh Temple 5th November; continue to seek to make links with Stoke Central Mosque; seeking further religious resources to support patients who wish to undertake religious reading or prayer in hospital – twin focus of raising awareness about mental health and promoting the Trust as an employer of choice	Mar 2018	Lesley Faux

Theme	Action to be taken	Due Date	Lead
Workforce Race Equality Scheme (WRES) detailed actions	40. Staff empowered to have positive discussions about ethnicity including: • Establish offer of a BME staff network • Develop further opportunities for staff at all levels to be involved • Further BME focus group meeting(s) and activities	Mar 2018	Cherelle Laryea supported by CD and LF
	41. Positive outreach to seek information about issues and experience from BME service user and staff perspective:- • Direct positive action communications / surveys • Senior team to make positive outreach when undertaking team visits etc to ask BME service users and staff what their experience has been like and what could have been improved • Reverse Mentoring by Board with BME staff	Mar 2018	Lesley Faux
	42. Continue to work to support BME bank staff into substantive employment where the individual desires this. Support and encourage BME bank workers to aspire to more regular substantive employment. • Set up system to notify bank workers and VOLUNTEERS of training opportunities • Develop provision of bank staff PDRs and clinical supervision	Lynne Pulley By end Oct with second phase launch of LMS	Dec 2017
	43. Recruitment for diversity and inclusion (also see action 27): • Trust recruitment campaigns in 2017-18 to include photos and case studies of Asian/Asian British ethnicity. • Encourage **block recruitment** whenever possible as this is proven to increase the likelihood of appointing BME staff and staff from other minority groups (evidenced to improve diversity of recruited talent). Encourage recruitment for difference.	Kerry Smith	Dec 2017

<u>END</u>

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO PUBLIC Trust Board

Enclosure No:11

Date of Meeting:	05/10/17		
Title of Report:	Finance Position Month 5		
Presented by:	Executive Director of Finance, Performance and Digital		
Author:	Assistant Director of Finance		
Executive Lead Name:	Suzanne Robinson	Approved by Exec	☒

Executive Summary:		Purpose of report	
The report summarises the finance position at month 5 (August 2017)		Approval	☒
		Information	☐
		Discussion	☒
		Assurance	☐
Seen at:	SLT ☐ Execs X	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee X • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☐ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently. X 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	None applicable		
Resource Implications: Funding Source:	None directly from the report None applicable		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	There is no direct impact on the protected characteristics as part of the completion of this report.		
Recommendations:	Receive the report noting: ▪ The reported surplus of £215k against a planned surplus of £24k. This is a favourable variance to plan of £191k.		

- The M5 CIP achievement:
  - YTD achievement of £491k (58%); an adverse variance of £357k;
  - 2017/18 forecast CIP delivery of £2,415k (76%) based on schemes identified so far; an adverse variance of £782k to plan;
  - The recurrent forecast delivery at month 5 of £2,737k representing a recurrent variance to plan of £460k.

- The cash position of the Trust as at 31st August 2017 with a balance of £6,243k; £726k better than plan.

- Year to date Capital receipts for 2017/18 is (£358k) compared to a net planned capital expenditure of £37k;
  - The original operating plan submitted to NHSI in December 2017 planned net capital expenditure of £1,106k by Month 5.

- Use of resource rating of 2.

Approve:

- The month 5 position reported to NHSI.

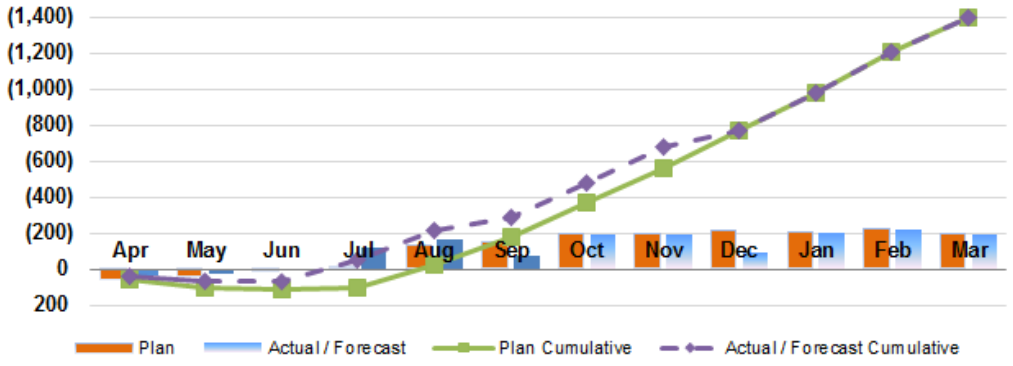
NHS
North Staffordshire
Combined Healthcare
NHS Trust

Financial Overview as at 31st August 2017

Income & Expenditure - Control Total (Surplus) / Deficit

£000	Plan	Actual	Var	%	RAG
YTD	(24)	(215)	(191)	(795)	G
FOT	(1,400)	(1,428)	(28)	2	G

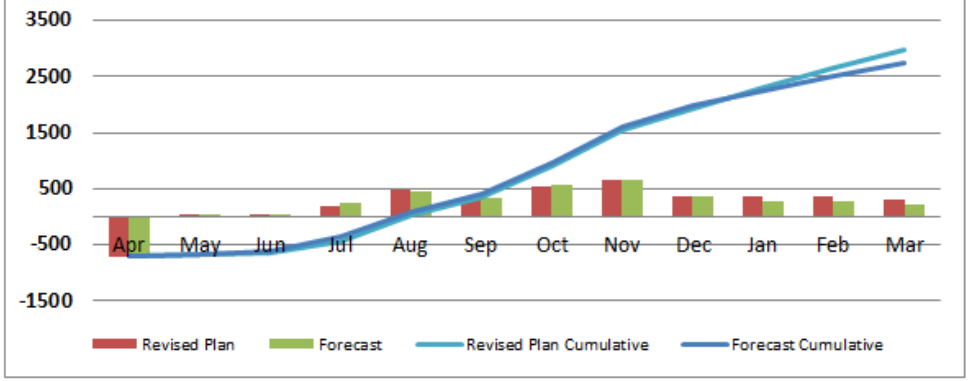
Retained (Surplus) / Deficit Run Rate 2017/18



Net Capital Expenditure / (Receipts)

£000	Plan	Actual	Var	%	RAG
YTD	37	(358)	(395)	(1,068)	G
FOT	2,979	2,731	(248)	(8)	G

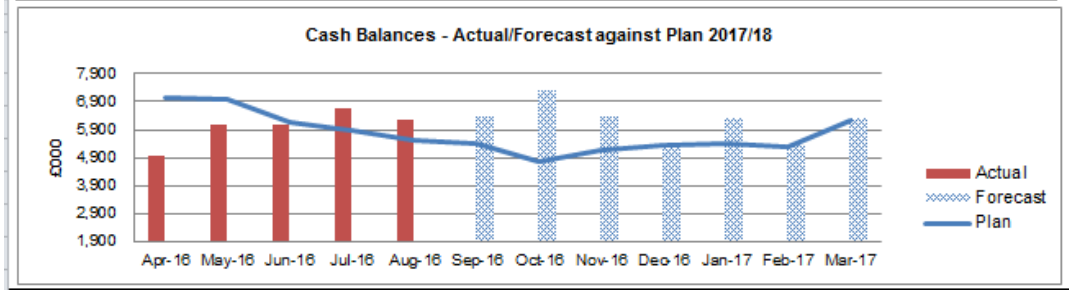
Net Capital Expenditure - Plan / Forecast 2017/18



Cash Balances

£000	Plan	Actual	Var	%	RAG
YTD	5,517	6,243	726	12	G

Cash Balances - Actual/Forecast against Plan 2017/18



Cost Improvement

£000	Plan	Actual	Var	%	Rec Var	RAG
Clinical	676	427	(249)	(37)	(760)	R
Corporate	172	64	(108)	(63)	300	G
Total	848	491	(357)	(42)	(460)	R

Use of Resource

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

1. Introduction:

The Trust's 2017/18 financial plan is to deliver a trading position of £0.9m surplus. The Trust has accepted the Control Total from NHS Improvement (NHSI) of £1.4m surplus which includes £0.5m from the Sustainability & Transformation Fund.

2. Income & Expenditure (I&E) Performance

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

- During month 5, the trust had an in month trading position of £133k surplus against a plan of £95k surplus; **a favourable variance of £38k**. Sustainability and Transformation funding has been assumed at £33k for month 5, bringing the overall trust control to a £166k surplus against plan of £128k; **a favourable variance of £38k**.

- The trust has a year to date trading position of £74k surplus against a plan of £117k deficit; **a favourable variance to plan of £191k**. After Sustainability and transformation funding (£141k), the trust has a Control Total surplus of £215k against a plan of £24k surplus; **a favourable variance to plan of £191k**.

- To reduce overall reliance on Agency and improve resilience post EPR implementation, the trust has utilised substantive staff to support the implementation of the ROSE programme. There is a benefit to the financial position of £151k YTD through not backfilling these posts during this period. This non-recurrent benefit accounts for the majority of the YTD surplus.

		Month 5			Year-to-Date			Forecast		
Table 1: Summary Performance	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
Income	(82,276)	(6,747)	(7,245)	(498)	(34,621)	(34,579)	42	(82,236)	(82,024)	212
Pay	61,973	5,152	5,204	52	26,499	25,098	(1,401)	62,072	60,566	(1,506)
Non Pay	16,739	1,272	1,680	408	7,101	8,269	1,168	16,601	17,785	1,184
EBITDA	**(3,563)**	**(323)**	**(361)**	**(38)**	**(1,021)**	**(1,212)**	**(191)**	**(3,564)**	**(3,673)**	**(110)**
Other Non-Op Costs	2,664	228	228	0	1,138	1,138	(0)	2,664	2,773	109
Trading Surplus	**(900)**	**(95)**	**(133)**	**(38)**	**117**	**(74)**	**(191)**	**(900)**	**(900)**	**(0)**
Sustainability & Transformational Funding	(500)	(33)	(33)	0	(141)	(141)	0	(500)	(500)	0
Control Total	**(1,400)**	**(128)**	**(166)**	**(38)**	**(24)**	**(215)**	**(191)**	**(1,400)**	**(1,400)**	**(0)**

3. Income

Table 2 below shows the trust income position by contract:

- The NHS Stoke-on-Trent CCG and NHS North Staffordshire CCG contracts are set on a block basis. The Trust is showing an under performance of £42k year to date on Stoke-on-Trent CCG's, relating partly to invoice disputes for 2016/17;

- Under recovery of £28k year to date on Associates Contracts is due to a reduction in indicative activity. £68k under recovery on Out of Area Treatments (OATs) is mainly due to an underperformance of the sale of substance misuse beds;

- Stoke on Trent public health is under performing by £50k, mainly due to a reduction in referrals from community service provided by lifeline to Substance Misuse Inpatients.

- STF is earned quarterly for trusts operating within its agreed control. The total for 2017/18 is £500k and is phased 15% for Q1, 20% for Q2, 30% for Q3 and for 35% Q4. **£141k is reflected at month 5**.

		Month 5			Year-to-Date			Forecast		
Table 2: Income	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
NHS Stoke-on-Trent CCG	(35,683)	(2,852)	(2,927)	(75)	(14,822)	(14,780)	42	(35,778)	(35,736)	42
NHS North Staffordshire CCG	(24,412)	(1,938)	(1,938)	(0)	(10,070)	(10,070)	(0)	(24,412)	(24,412)	(0)
Specialised Services	(3,097)	(258)	(258)	0	(1,290)	(1,333)	(42)	(3,097)	(3,139)	(42)
Stoke-on-Trent CC s75	(3,947)	(329)	(425)	(96)	(1,645)	(1,645)	(0)	(3,947)	(3,947)	(0)
Staffordshire CC s75	(1,056)	(88)	(88)	0	(440)	(440)	0	(880)	(880)	(0)
Stoke-on-Trent Public Health	(1,392)	(134)	(123)	11	(457)	(407)	50	(1,392)	(1,268)	124
Staffordshire Public Health	(613)	(51)	(51)	0	(256)	(256)	0	(613)	(613)	0
ADS/One Recovery	(1,497)	(125)	(125)	0	(624)	(624)	0	(1,497)	(1,497)	0
Associates	(756)	(63)	(59)	4	(315)	(287)	28	(756)	(701)	55
OATS	(760)	(63)	(56)	7	(317)	(249)	68	(760)	(600)	160
Total Clinical Income	**(73,214)**	**(5,901)**	**(6,050)**	**(149)**	**(30,234)**	**(30,089)**	**145**	**(73,133)**	**(72,794)**	**339**
Other Income	(9,062)	(847)	(1,195)	(349)	(4,387)	(4,490)	(103)	(9,103)	(9,230)	(127)
Total Income	**(82,276)**	**(6,747)**	**(7,245)**	**(498)**	**(34,621)**	**(34,579)**	**42**	**(82,236)**	**(82,024)**	**212**
Sustainability Transformation Funding	(500)	(33)	(33)	0	(141)	(141)	0	(500)	(500)	0
Total Income Incl. STF	**(82,776)**	**(6,780)**	**(7,278)**	**(498)**	**(34,762)**	**(34,720)**	**42**	**(82,736)**	**(82,524)**	**212**

4. Expenditure

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

		Month			Year-to-Date			Forecast		
Table 3: Expenditure	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
Medical	7,459	596	566	(31)	3,126	2,762	(364)	7,471	6,654	(816)
Nursing	27,962	2,366	2,463	97	11,781	11,355	(426)	28,179	28,075	(104)
Other Clinical	14,776	1,166	1,030	(136)	6,156	5,304	(852)	14,656	13,288	(1,368)
Non-Clinical	10,823	925	850	(75)	4,563	4,138	(426)	10,812	10,331	(481)
Non-NHS	954	99	296	197	874	1,540	667	954	2,217	1,263
Total Pay	**61,973**	**5,152**	**5,204**	**52**	**26,499**	**25,098**	**(1,401)**	**62,072**	**60,566**	**(1,506)**
Drugs & Clinical Supplies	2,378	200	188	(13)	976	927	(49)	2,378	2,369	(9)
Establishment Costs	1,749	146	146	(0)	723	607	(117)	1,729	1,563	(166)
Information Technology	526	51	49	(1)	229	357	128	526	661	135
Premises Costs	2,101	176	163	(13)	872	853	(19)	2,101	2,167	66
Private Finance Initiative	4,087	341	354	14	1,703	1,774	71	4,087	4,242	155
Services Received	3,319	270	156	(114)	1,425	1,384	(41)	3,319	3,395	76
Residential Payments	1,708	142	149	6	712	819	107	1,708	1,966	257
Consultancy & Prof Fees	255	16	55	39	106	240	134	255	437	182
Unacheived CIP	(1,750)	2	0	(2)	(365)	0	365	(1,721)	0	1,721
Other	2,365	(72)	420	493	721	1,309	588	2,219	986	(1,232)
Total Non-Pay	**16,739**	**1,272**	**1,680**	**408**	**7,101**	**8,269**	**1,168**	**16,601**	**17,785**	**1,184**
Finance Costs	1,293	108	108	0	539	539	0	1,293	1,293	0
Local Government Pension Scheme	0	0	0	0	0	0	0	0	0	0
Unwinding of Discounts	0	0	0	0	0	0	0	0	0	0
Dividends Payable on PDC	561	47	47	0	234	233	(1)	561	560	(1)
Investment Revenue	(14)	(1)	(1)	0	(6)	(4)	2	(14)	(9)	5
Fixed Asset Impairment	0	0	0	0	0	0	0	0	0	0
Depreciation (excludes IFRIC 12)	824	74	74	(0)	371	370	(1)	824	929	106
Total Non-op. Costs	**2,664**	**228**	**228**	**0**	**1,138**	**1,138**	**(0)**	**2,664**	**2,773**	**109**
Total Expenditure	**81,376**	**6,652**	**7,112**	**460**	**34,738**	**34,505**	**(233)**	**81,336**	**81,123**	**(212)**

"Unachieved CIP" is CIP not yet transacted. Until a scheme is transacted, it remains on the unachieved CIP line, including in the forecast.

4. Directorate Summary

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

	Pay			Non Pay			Income			Total		
Table 4: YTD Expenditure	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
AMH Community	7,321	6,620	(701)	1,850	1,942	93	(929)	(940)	(11)	8,242	7,623	(619)
AMH Inpatients	2,691	2,725	34	74	166	92	(57)	(59)	(2)	2,708	2,832	124
Children's Services	2,668	2,405	(263)	269	300	31	(278)	(281)	(4)	2,660	2,424	(236)
Substance Misuse	1,128	1,100	(28)	370	338	(33)	(196)	(149)	48	1,302	1,289	(13)
Learning Disabilities	2,253	2,028	(225)	158	129	(29)	(23)	(20)	3	2,388	2,137	(251)
Neuro & Old Age Psychiatry	4,538	4,460	(78)	343	252	(91)	(392)	(429)	(37)	4,489	4,283	(206)
Corporate	5,899	5,760	(140)	5,174	6,279	1,105	(32,887)	(32,842)	45	(21,814)	(20,803)	1,011
Total	**26,499**	**25,098**	**(1,401)**	**8,239**	**9,407**	**1,167**	**(34,762)**	**(34,720)**	**42**	**(24)**	**(215)**	**(191)**

5. Cost Improvement Programme

The trust target for the year is £3.2m, as reported to NHSI. This takes into account the requirement to deliver a £1.4m control surplus for 2017/18. The table below shows the achievement by Directorate towards individual targets at M5. The Trust wide CIP achievement is 58% at M5 compared to plan.

		YTD M5			Forecast					
CIP Delivery	Annual CIP Target 2017/18	Plan	Transacted	(Under)/Over Achievement	Plan	Total Schemes	(Under)/Over Achievement	RAG	Recurrent Transacted	Recurrent Forecast
	£'000	£'000	£'000	£'000	£'000	£'000	£'000		£'000	£'000
Clinical										
AMH Community	1,084	288	134	(154)	1,084	637	(447)	59%	405	613
AMH Inpatients	379	101	3	(98)	379	51	(329)	13%	12	43
Children's Services	333	88	57	(32)	333	264	(69)	79%	218	312
Learning Disabilities	256	68	82	14	256	257	1	100%	238	258
NOAP	495	131	152	20	495	474	(21)	96%	460	560
Total Clinical	**2,547**	**676**	**427**	**(249)**	**2,547**	**1,682**	**(865)**	**66%**	**1,333**	**1,786**
Corporate										
CEO	49	13	3	(10)	49	21	(28)	43%	8	38
Finance, Performance & Digital	61	16	27	11	61	69	8	112%	71	71
MACE	62	16	8	(9)	62	19	(43)	31%	20	20
Operations	29	8	13	5	29	33	4	115%	35	35
Quality & Nursing	13	3	3	0	13	13	0	100%	13	13
Strategy (Core)	10	3	5	2	10	17	7	168%	20	20
Trustwide	365	97	0	(97)	365	484	119	133%	0	673
Workforce & OD	61	16	5	(11)	61	77	16	126%	20	80
Total Corporate	**650**	**172**	**64**	**(108)**	**650**	**733**	**83**	**113%**	**187**	**950**
Total	**3,197**	**848**	**491**	**(357)**	**3,197**	**2,415**	**(782)**	**76%**	**1,521**	**2,737**

Below 75%	
Below 90%	

Target	**3,197**
Variance	**(460)**

- The 2017/18 year to date CIP achieved stands at £491k (58%)
- The recurrent value of schemes transacted is £1,521k against £3.2m target. The recurrent forecast as at M5 is £2.737m (86%); this represents a recurrent shortfall against the target of £460k (14%).

6. Statement of Financial Position

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

Table 6: SOFP	31/03/2017 £'000	30/06/2017 £'000	31/07/2017 £'000	31/08/2017 £'000
Non-Current Assets				
Property, Plant and Equipment	28,037	27,901	27,942	27,997
Intangible Assets	222	235	240	247
NCA Trade and Other Receivables	1,426	1,426	1,426	1,426
Other Financial Assets	897	897	897	897
Total Non-Current Assets	**30,581**	**30,458**	**30,505**	**30,566**
Current Assets				
Inventories	88	91	81	77
Trade and Other Receivables	5,146	6,559	5,843	6,596
Cash and Cash Equivalents	6,964	6,092	6,636	6,243
Non-Current Assets Held For Sale	0	0	0	0
Total Current Assets	**12,198**	**12,743**	**12,560**	**12,917**
Total Assets	**42,780**	**43,202**	**43,065**	**43,483**
Current Liabilities				
Trade and Other Payables	(7,472)	(8,097)	(7,891)	(8,205)
Provisions	(333)	(311)	(302)	(278)
Borrowings	(457)	(633)	(633)	(633)
Total Current Liabilities	**(8,262)**	**(9,041)**	**(8,825)**	**(9,116)**
Net Current Assets / (Liabilities)	**3,937**	**3,702**	**3,734**	**3,801**
Total Assets less Current Liabilities	**34,518**	**34,160**	**34,240**	**34,367**
Non Current Liabilities				
Provisions	(474)	(474)	(474)	(474)
Borrowings	(12,189)	(11,899)	(11,861)	(11,823)
Total Non-Current Liabilities	**(12,663)**	**(12,373)**	**(12,335)**	**(12,297)**
Total Assets Employed	**21,855**	**21,788**	**21,905**	**22,071**
Financed by Taxpayers' Equity				
Public Dividend Capital	7,648	7,648	7,648	7,648
Retained Earnings reserve	3,987	3,919	4,036	4,202
Revaluation Reserve	9,323	9,323	9,323	9,323
Other Reserves	897	897	897	897
Total Taxpayers' Equity	**21,855**	**21,788**	**21,905**	**22,071**

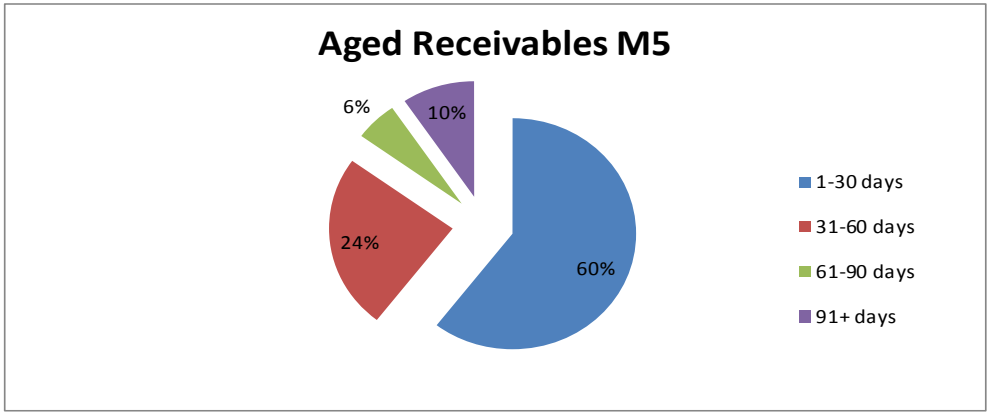
Current receivables are £6,596k

- £3,991k is based on accruals (not yet invoiced) and relates in the main to STF and income accruals paid at the end of each quarter.
- £2,605k in awaiting payment on invoice. (£367k within terms)

£1,029k is overdue by 31 Days or more and therefore subject to routine credit control processes;

- £10k has been escalated to management /solicitors;
- £14k has been formally disputed through the M12 Agreement of Balances process;
- £1,005k has not been formally disputed and full payment is anticipated.

Table 6.1 Aged Receivables/Payables	1-30 Days £'000	31-60 Days £'000	61-90 Days £'000	91+ Days £'000	Total £'000
Receivables Non NHS	510	38	4	48	600
Receivables NHS	1,065	599	141	199	2,004
Payables Non NHS	942	18	26	102	1,088
Payables NHS	512	184	40	55	791

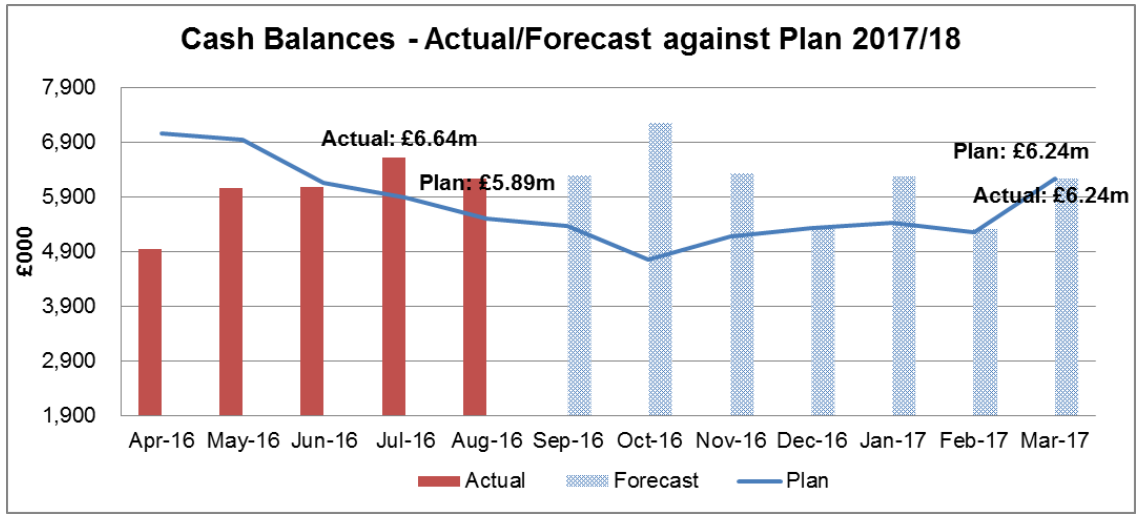


7. Cash Flow Statement

The cash balance at 31st August 2017 has decreased to **£6.243m** due to an increase in the value of receivables and a reduction in the payables; however the Trust cash position at 31st August 2017 is **£726k higher than planned.** The Trust anticipates be on plan by March 2018.

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

Table 7: Statement of Cash Flows	Apr-16 £'000	May-16 £'000	Jun-16 £'000	Jul-16 £'000	Aug-16 £'000
Net Inflows/(Outflow) from Operating Activities	(2,674)	1,184	116	702	(221)
Net Inflows/(Outflow) from Investing Activities	692	(31)	(45)	(120)	(134)
Net Inflows/(Outflow) from Financing Activities	(38)	(38)	(38)	(38)	(38)
Net Increase/(Decrease)	**(2,019)**	**1,115**	**32**	**544**	**(393)**
Opening Cash & Cash Equivalents	**6,964**	**4,945**	**6,059**	**6,092**	**6,636**
Closing Cash & Cash Equivalents	**4,945**	**6,059**	**6,092**	**6,636**	**6,243**
Plan	7,064	6,964	6,164	5,889	5,517
Variance	**2,119**	**905**	**72**	**(747)**	**(726)**



Summary of Outstanding Income		
Receivables	**£'000**	**RAG**
Invoices		
NHS Digital	672	
Stoke CCG	220	
SSSFT	315	
SSOTP	267	
Other NHS Providers	530	
Other Non NHS Providers	114	
Accruals		
STF	141	
TOTAL	**2,259**	

8. Capital Expenditure

The Trust's permitted capital expenditure agreed within the 2017/18 plan is £2.979m. Table 8 below shows the planned capital expenditure for 2017/18 as submitted to NHSI.

		Year to Date			Forecast		
Capital Expenditure	Affordability Envelope £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Place of Safety	0	0	11	11	0	11	11
Temporary Place of Safety	83	42	0	(42)	83	83	0
Psychiatric Intensive Care Unit	2,153	346	228	(118)	2,153	1,993	(160)
E-rostering	102	51	55	4	102	102	0
Information Technology	235	235	6	(229)	235	235	0
Environmental Improvements (backlog)	120	25	28	3	120	120	0
Reduced Ligature Risks	0	0	7	7	0	7	7
Ward 5 Airlock	27	0	0	0	27	27	0
Darwin	0	0	26	26	0	26	26
Ward 4 Environmental Improvements	30	15	0	(15)	30	30	0
Lymebrook MHRC	43	18	0	(18)	43	43	0
Misc	(7)	0	(7)	(7)	(7)	(7)	0
Contingency	73	0	0	0	73	0	(73)
Total Gross Capital Expenditure	**2,859**	**732**	**355**	**(377)**	**2,859**	**2,670**	**(189)**
Bucknall Hospital (Part)	(713)	(713)	(713)	0	(713)	(818)	(105)
Total Capital Receipts	**(713)**	**(713)**	**(713)**	**0**	**(713)**	**(818)**	**(105)**
Total Charge Against CRL	**2,146**	**19**	**(358)**	**(377)**	**2,146**	**1,852**	**(294)**

Net Charge to CRL	
Affordability (£2,859k - £818k)	2,041
Forecast (£2,661k - £818k)	1,852

- The **Operating Plan** as reported to NHSI forecast there would be a total charge against the CRL of £1,106k by month 5, including (£713k) Capital Receipts for the sale of Bucknall Hospital and £1,819k Capital Expenditure.
- **Actual Capital Expenditure** as at month 5 is £355k against an updated Capital Expenditure plan of £732k

9. Use of Resource Metrics

The Framework covers 5 themes, quality of care, finance and use of resource, operational performance, strategic change, leadership and improvement capability. The metrics below will be used to assess the Trust's financial performance.

Table 9: Use of Resource	Year to Date £'000	RAG Rating
Liquidity Ratio (days)		
Working Capital Balance	3,632	
Annual Operating Expenses	33,367	
Liquidity Ratio days	17	
Liquidity Ratio Metric	**1**	
Capital Servicing Capacity (times)		
Revenue Available for Debt Service	1,357	
Annual Debt Service	962	
Capital Servicing Capacity (times)	1.4	
Capital Servicing Capacity Metric	**3**	
I&E Margin		
Normalised Surplus/(Deficit)	215	
Total Income	34,720	
I&E Margin	0.6%	
I&E Margin Rating	**2**	
I&E Margin Variance from Plan		
I&E Margin Variance	0.55	
I&E Margin Variance From Plan	**1**	
Agency Spend		
Providers Cap	1,222	
Agency Spend	1,540	
Agency %	26	
Agency Spend Metric	**3**	
Use of Resource	**2**	

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

10. Better Payment Practice Code (BPPC)

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

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

	2016/17			2017/18 Month 5			2017/18 YTD		
Table 10: Better Payment Practice Code	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**
Number of Invoices									
Total Paid	508	13,183	13,691	56	866	922	272	4,467	4,739
Total Paid within Target	459	11,610	12,069	50	709	759	234	3,854	4,088
% Number of Invoices Paid	90%	88%	88%	89%	82%	82%	86%	86%	86%
% Target	95%	95%	95%	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**-4.6%**	**-6.9%**	**-6.8%**	**-5.7%**	**-13.1%**	**-12.7%**	**-9.0%**	**-8.7%**	**-8.7%**
Value of Invoices	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**
Total Value Paid (£000s)	6,860	29,380	36,240	557	2,712	3,269	3,106	12,726	15,832
Total Value Paid within Target (£000s)	6,385	27,914	34,299	460	2,652	3,112	2,887	11,769	14,656
% Value of Invoices Paid	93%	95%	95%	83%	98%	95%	93%	92%	93%
% Target	95%	95%	95%	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**-1.9%**	**0.0%**	**-0.4%**	**-12.4%**	**2.8%**	**0.2%**	**-2.1%**	**-2.5%**	**-2.4%**

11. Recommendations

The Trust Board is asked to:

Note:

- The reported surplus of **£215k against a planned surplus of £24k**. This is a favourable variance to plan of £191k.

- The M5 CIP achievement:
  - YTD achievement of £491k (58%); **an adverse variance of £357k**;
  - 2017/18 forecast CIP delivery of £2,415k (76%) based on schemes identified so far; an adverse variance of £782k to plan;
  - The recurrent forecast delivery at month 5 of £2,737k representing a **recurrent variance to plan of £460k**.

- The cash position of the Trust as at 31st August 2017 with a **balance of £6,243k**; £726k better than plan.

- Year to date Capital receipts for 2017/18 is (£358k) compared to a net planned capital expenditure of £37k;
  - The original operating plan submitted to NHSI in December 2017 planned net capital expenditure of £1,106k by Month 5.

- Use of resource rating of **2**.

Approve:

- The month 5 position reported to NHSI.

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO Public Trust Board

Enclosure No:12

Date of Meeting:	5th October 2017		
Title of Report:	Finance & Performance Committee Assurance Report		
Presented by:	Chair of Finance & Performance Committee		
Author:	Deputy Director of Finance		
Executive Lead Name:	Suzanne Robinson	Approved by Exec	☒

Executive Summary:		Purpose of report	
This paper details the issues discussed at the Finance and Performance Committee meeting on the 28th September 2017. The meeting was quorate with minutes approved from the previous meeting on the 31st August 2017. Progress was reviewed and actions confirmed taken from previous meetings.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs X Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee X • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services X☐ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.X 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	Oversees the risk relevant to the Finance & Performance Committee 932, 807, 970, 916, 931, 991, 992		
Resource Implications: Funding Source:	None applicable directly from this report		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	There are no direct impact of this report on the 10 protected characteristic of the Equality Act		
Recommendations:	The Trust Board is asked to note the contents of this report and take assurance from the review and challenge evidenced in the Committee.		

Assurance Report to the Trust Board
Thursday, 5th October 2017

Finance and Performance (F&P) Committee Report to the Trust Board – 5th October 2017

This paper details the issues discussed at the Finance and Performance Committee meeting on the 28th September 2017. The meeting was quorate with minutes approved from the previous meeting on the 31st August 2017. Progress was reviewed and actions confirmed taken from previous meetings.

Executive Director of Finance Update

The following updates were given by the Executive Director of Finance;

- A briefing on Better Payment Practice Code (BPPC) in response to queries raised by the August F&P Committee around the Trust falling short of the 95% target for "Non NHS Invoices paid within 30 days." The report analysed underperformance and diagnosed issues, recommending resolutions. The committee were assured that the mitigating actions were appropriate to resolve underperformance.

- An update from NHS Providers on Q1 Financial Performance. It painted a challenging picture for NHS Providers, with Q1 deficit of £736m, compared to £461m in Q1 of 2016/17. NHSi has increased the forecast deficit to £523m from £496m. The performance is due to slippage on efficiency schemes and a continued reliance on Agency and Bank.

- An update on the changes in the leadership team; a new programme director who is establishing a strong clinical team and working closely with Directors of Strategy to understand governance arrangements. STP plan £86m deficit, the year to date as at M5 is £3m better than plan. There is currently a piece of being completed that attempts to quantify out the inherent risk between provider and commissioner planning and forecast assumptions.

- Feedback from the Mental Health Forum where North Staffordshire Combined Healthcare shared with delegates how becoming a Mental Costing Exemplar site and winning the HFMA Annual Costing Award has helped to engage clinicians, improve decision making and identify opportunities for savings.

Finance

The Finance position was presented showing a position that is £215k better than plan. This is supported non-recurrently through benefits associated with ROSE implementation. The Trust is forecasting to meet its agreed control surplus.

Cost Improvement Programme (CIP)

The Committee received an update for Cost Improvement for month 5 and were concerned

that the total identified was still significantly short of the target. £2.737m is currently forecast to be recurrently delivered against the £3.197m target. This is a recurrent shortfall of £460k

The Committee requested in Month 4 that all CIP is transacted at Month 5 and were assured to see that significant progress had been made. The Committee were assured that all available CIP had been transacted, with only CIP in query or development still to be transacted. They noted how it provided greater visibility around the deliverability risk, of emerging schemes included in the 2017/18 forecast.

The Committee were assured that there was sufficient focus being placed on Cost Improvement but are unable to give assurance around the ability to deliver the target for 2017/18.

Agency Utilisation Report

The Committee were presented with the Agency utilisation report at M5 which showed a sharp rise compared to M4, mainly due to the extension of EPR and additional medical locum use. The trust is still expecting to remain within the Agency ceiling for 2017/18. The committee acknowledged the national shortage of medical locums but were assured that the trust were doing everything possible to recruit substantive posts.

Capital Spend and Forecast

The M5 Capital forecast was presented which factored in the new Internal Capital Resource Limit of £2.041m, which will be reviewed every quarter. The Committee were assured that the Trust had a robust understanding of the Capital Affordability through the cash management tool, but noted the challenge around the remaining contingency for the year.

Policies

The following Policies are due to expire on 30th September 2017. The Committee approved an extension to be presented at the next Finance and Performance Committee in October for ratification by Board in November.

- Cash and Treasury Management
- Anti-Bribery Policy
- Standing Orders

Performance:

- **Activity Report**

The report detailed M5 activity against plan using traditional reporting methods and care pathway clustering. There is a small over performance on Care Clusters in month, but an underperformance against traditional reporting. The Committee is not able to give assurance around the activity reported, particularly around the use of Care Clusters, due to issues with the quality of recording by operational staff. Actions are in place to improve the data quality of activity and care clustering.

- **Performance Report (PQMF)**

The report provides the Committee with a summary of performance to the end of Month 5 (August 2017)

The Trust continues to experience high bed occupancy in the Adult Inpatient and NOAP Directorates and Delayed Transfers of Care. The number of DTOC's has improved in month but remains to be an issue. It is anticipated that the Trust involvement in system wide A&E Delivery Board will support the improvement of DTOC's further.

A deep dive of Readmissions was reported to the Committee in July. A supporting action plan implemented has resulted in a significant improvement in performance. The emergency readmission rate continues to reduce from 15% in April to 4.7% in August.

Trust vacancies remain a challenge, being impacted by the recruitment of substantive posts to Ward 4, where many new starters are yet to take up posts, as well as service transformation and redesign. The trust has invested in a new system called TRAC process to be implemented in October. This is designed to streamline the recruitment time in bringing new staff in post.

Committee Oversight

The committee following changes are noted and approved:

- Digital will sit under Finance and Performance Committee. The Finance and Performance Committee will be changed to Finance, Performance and Digital.

- Estates compliance will move from Finance, Performance and Digital to Finance Committee.

- Emergency Planning will also report through Finance and Performance Committee.

The Terms of reference will be updated in terms of key risks and responsibilities of each committee.

Other Reports and Updates

The Committee received additional assurance reports as follows:

- Financial Risk Register
- CYP Waiting Times
- Business Opportunities update
- Rectification plan for Agency

Recommendation

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

On Behalf of Tony Gadsby – Chair of Finance and Performance Committee

FINANCE, PERFORMANCE & DIGITAL COMMITTEE

Terms of Reference

Membership	• Non-Executive Director (Chair) • Two other Non-Executive Directors • Executive Director of Finance, Performance & Digital • Executive Director of Leadership & Workforce • Director of Operations • Associate Director of Performance • Deputy Director of Finance • Associate Director of Governance • Deputy Director of Nursing • Chief Information Officer
Quorum	• Three Board members (one of whom to be from Finance) including at least one Executive Director and one Non-Executive Director.
In Attendance / As Required / Invited	• PA to take minutes • Assistant Director of Finance - Costing and Contracts • Chief Executive • Assistant Director Finance - Financial Management • Director of Nursing & Quality • Medical Director
Frequency of Meetings	• Monthly
Accountability and Reporting	• Accountable to the Trust Board • Assurance Report to the Trust Board after each meeting • Minutes of meetings available to all Trust Board members on request • Annual report to Trust Board on actions taken to comply with Terms of Reference
Date of Approval by Trust Board	• 5th October 2017
Review Date	• By September 2018

FINANCE, PERFORMANCE & DIGITAL COMMITTEE

TERMS OF REFERENCE

1. Constitution

The Trust Board hereby resolves to establish a Committee of the Trust Board to be known as the Finance, Performance & Digital Committee (The Committee). Its principal aim is to provide advice and assurance to the Trust Board on performance, financial risk management, and the achievement of the Trust financial and digital strategy.

The Committee has no executive powers other than those specifically delegated in these terms of reference.

2. Purpose of the Committee

The Committee is responsible for providing information and making recommendations to the Trust Board on financial, operational performance issues and digital strategy and for providing assurance that these are being managed safely.

3. Membership

The Chairman and Non-Executive members of the Committee shall be appointed by the Trust Board and the Executive members by the CEO. The Trust Board should satisfy itself that at least one Non-Executive member of the Committee has recent and relevant financial experience.

In the absence of the Chair being appointed by the Trust Board, one of the Non-Executive directors will be elected by those present to Chair the meeting.

4. Quorum, Frequency of Meetings and Required Frequency of Attendance

No business shall be transacted unless three members of the Trust Board membership are present. This must include not less than one Non Executive Board Member and one Executive Director, and in the event that this is not the Executive Director of Finance, then one senior representative from the Finance Function.

The Committee will meet as monthly to review financial performance, cost improvement delivery including performance against the NHS Improvement Single Oversight Framework metrics and key national targets. In additional the committee will provide oversight of the digital

strategy and Raising Our Service Excellence (ROSE) programme. Members of the committee are required to attend a minimum of 80% of the meetings held each financial year and not be absent for two consecutive meetings.

5. In attendance

In addition to the agreed membership, other Board members shall have the right to attend. Other directors and officers of the Trust may be asked to attend at the request of the Chairperson. Only the Committee Chairperson and relevant members are entitled to be present at a meeting of the Committee, but others may attend by invitation of the Chairperson.

6. Authority

The Committee is authorised by the Trust Board to investigate any activity within its terms of reference.

It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board to request the Chief Executive or Director of Finance, Performance & Digital to obtain reasonable outside legal or other independent professional advice but it has no delegated financial authority.

7. Duties

Finance

- To monitor the Trust's performance and the achievement of its financial plans (including the Cost Improvement Programme) and ensure that the Trust's financial strategy is aligned with the Operational Plan and in line with changing NHS systems and financial performance requirements:

- To review and recommend to the Trust Board the annual financial plan / budget, including workforce, and the associated financial budget with targets set in terms of key performance indicators including Cost Improvement.

- To recommend to the Trust Board the Long Term Financial Plan included in the Five year Integrated Business Plan.

- To ensure the Trust Board is provided with regular reports on the financial performance of the Trust including forecast performance and associated risks and make recommendations to the Trust Board on remedial actions aimed at ensuring that the Trust's financial budget and plans are achieved.

- To receive and consider the annual medium term capital plan prior to submission for approval to the Trust Board and to receive progress reports on the management of the capital programme from the Capital Investment Group (CIG) as reported within the monthly finance reporting suite along with copies of minutes of the CIG meetings.

- To keep under review issues such as reference costs and to benchmark activity and performance and to act on any learning or remedial action required.

- To monitor the development and implementation of Service Line Management and Reporting and the move towards patient level costing.

Performance

- Review the integrated performance of the Trust

- To receive and review regular updates on to ensure that effective action is taken to enable the Trust to achieve its key statutory and performance targets.

- To monitor performance against the NHSI compliance framework Board Assurance Framework (BAF) and key national targets to ensure indicators are on target.

Digital

- Oversight of the implementation of the Trust Digital Strategy

- Delivery of Benefits realisation from Digital technology

- Monitor the investment into digital technology, data security standards and cyber security

- Compliance with Digital Maturity Assessment

The committee will be responsible for approving all relevant policies outlined in the Trust policy on policies.

7. Risk Management Function

- To review the Trust's exposure to financial risk of all natures which might affect resources and the achievement of strategic objectives, and to ensure that policy decisions are taken with a full awareness of risk and to the Trust's Risk Management Committee as appropriate.

- The Committee will receive information in relation to financial risk via the

Executive Group.

- Will make recommendations on the mitigation or acceptance of identified financial, business development or related workforce risks and provide assurance on financial risk to the Risk Management Committee. The Risk Management Committee will provide assurance to the Audit Committee on the robustness of the Trust's risk management arrangements.

- Have oversight of the risk management of Financial, Operational Performance and Digital activities.

8. Accountability and Reporting Arrangements

The minutes of the Committee meetings shall be formally recorded by the PA to the Executive Director of Finance, Performance & Digital. Copies of the minutes of Committee meetings shall be available to all Trust Board members on request.

The Director of Finance, Performance & Digital or delegate shall prepare a report, to be presented by the Chair of the Committee, to the Trust Board after each meeting of the Committee.

The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full Trust Board, or require executive action whilst the Board are considering the information included within the monthly finance reporting suite and report back issues relating to financial risk to the Chair of the Risk Management Committee.

9. Sub-Committees and Reporting Arrangements

The Committee shall have the power to establish sub-committees for the purpose of addressing specific tasks or areas of responsibility. In accordance with paragraph 4.5 of the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee unless expressly authorised by the Trust Board.

The terms of reference, including the reporting procedures of any sub-committees must be approved by the Committee and regularly reviewed.

Those board reporting to Finance, Performance & Digital Include;

- Digital Board
- Capital Investment Group (finance only)
- Senior Leadership Team (as appropriate)

10. Compliance and Effectiveness

The Committee must produce an annual report to the Trust Board on the actions taken by the Committee to comply with its terms of reference.

The annual report will include information about compliance with the requirement that members should attend regularly and should not be absent for more than two consecutive meetings. The annual report will also include information about the reporting arrangements into the Committee from any sub-committees.

11. Administration

The Committee shall be supported administratively by the PA to the Director of Finance, Performance & Digital whose duties in this respect will include:

- Agreement of the agenda with the Chairperson and attendees and collation of papers
- Taking and issuing the minutes and preparing action lists in a timely way
- Keeping a record of matters arising and issues to be carried forward.

12. Requirement for Review

The Terms of Reference will be reviewed at least annually and the next review must take place before September 2018.

Finance & Performance Committee Cycle of Business 2017-18	Responsibility	No April meeting	April 17	4 May 17	1 Jun 17	6 Jul 17	3 Aug 17	31 Aug 17	28 Sep 17	2 Nov 17	28 Dec 17	31 Jan 18	1 Feb 18	1 Mar 18
Financial Planning and Management														
Monthly Financial Management Report	**Director of Finance**		X	X	X	X	X	X	X	X	X	X	X	X
Budget Setting	**Director of Finance**												X	
Year-end Timetable	**Director of Finance**										X			
Finance Strategy	**Director of Finance**			X Update	X Final									
Cost Improvement Reporting	**Director of Finance**		X	X	X	X	X	X	X	X	X	X	X	X
Operational Plan	**Director of Finance**										X	X		
Business Planning – as required	**Director of Finance**													
Contract Negotiations	**Director of Finance**									X	X	X		
Year End Analysis	**Director of Finance**			X	X									
Patient Level Information Costing System (PLICS) as required	**Director of Finance**													
Review Finance Policies – Annual overview	**Director of Finance**						X							

Finance & Performance Committee Cycle of Business 2017- 18	Responsibility	No April meeting		4 May 17	1 Jun 17	6 Jul 17	3 Aug 17	31 Aug 17	28 Sep 17	2 Nov 17	28 Dec 17	31 Jan 18	1 Feb 18	1 Mar 18
Quarterly Deep Dive	Director of Finance						X			X			X	
Market Assessment/Tenders (monthly) – for information	Director of Strategy		X	X	X	X	X	X	X	X	X	X	X	X
Finance and Performance Committee Risk Register	Governance		X	X	X	X	X	X	X	X	X	X	X	X
Director of Finance Update	Director of Finance		X	X	X	X	X	X	X	X	X	X	X	X
Performance Report	Director of Finance		X	X	X	X	X	X	X	X	X	X	X	X
Monthly Activity Reporting	Director of Finance		X	X	X	X	X	X	X	X	X	X	X	X
Reference Costs	Director of Finance					X				X				
Digital Update	Director of Finance		X			x			X			X		
BAF (Month after quarter end)	Associate Director of Governance			X		X				X			X	
Committee Minutes – Business Development Group Digital Board	Director of Finance		X	X	X	X	X	X	X	X	X	X	X	X

Finance & Performance Committee Cycle of Business 2017- 18	Responsibility	No April meeting		4 May 17	1 Jun 17	6 Jul 17	3 Aug 17	31 Aug 17	28 Sep 17	2 Nov 17	28 Dec 17	31 Jan 18	1 Feb 18	1 Mar 18
Workforce Information														
Annual Statement of Protected Pay	**Director of Leadership & Workforce**				**X**									

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REPORT TO Public Trust Board

Enclosure No:13

Date of Meeting:	5th October 2017		
Title of Report:	Cyber Security: Levels of Assurance		
Presented by:	Executive Director of Finance, Performance & Digital		
Author:	Chief Information Officer		
Executive Lead Name:	Suzanne Robinson	Approved by Exec	☒

Executive Summary:	Purpose of report	
The purpose of this paper is to provide an update of the Trust's approach to cyber security following the Wannacry incident in May 2017, and to provide the Board with assurance that future attacks are mitigated against. This paper does not directly address the operational response lessons learnt from the Wannacry attack in May 2017 (which has been received at Audit Committee), but focuses on the wider cyber security controls that the Trust must ensure are in place if it is to remain safe from future cyber-attacks.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs X Date:	Document Version No.	

Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board X☐
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services X☐ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.X 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐
Risk / legal implications: Risk Register Ref	The risk of a cyber-attack is recorded on the Digital Board Risk Register generating a score of 9. Mitigations outlined within this paper have reduced this risk below those reported to committees of the Board. (12)
Resource Implications: Funding Source:	None applicable directly from this report
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	There are no direct impact of this report on the 10 protected characteristic of the Equality Act
Recommendations:	The Trust Board is asked to; Receive the report for information and assurance

Cyber Security: Levels of Assurance
Public Trust Board
5th October 2017

1. Introduction

The purpose of this paper is to provide an update of the Trust's approach to cyber security following the Wannacry incident in May 2017, and to provide the Board with assurance that future attacks are mitigated against. This paper does not directly address the operational response lessons learnt from the Wannacry attack in May 2017 (which has been received at Audit Committee), but focuses on the wider cyber security controls that the Trust must ensure are in place if it is to remain safe from future cyber-attacks.

2. Context

Every second, billions of bits and bytes are shared across the digital ecosystem, helping organisations manage employees, fulfil orders, support customers and communicate across offices and borders. In a digitally enabled world, hackers pose a significant threat to business viability and economic prosperity.

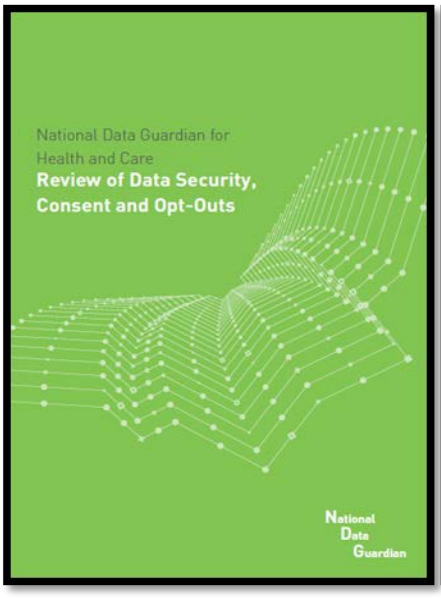
Cybercrime has evolved from a relatively unsophisticated threat to one of the greatest risks facing organisations today. Malicious hacking, identity theft and cyber disruption are now common events in the business environment. Yet in some organisations defences are down, with many companies failing to adopt basic security measures.

Complacency leaves organisations hugely vulnerable. While day-to-day operational challenges remain a significant management focus the risk of cybercrime must not be overlooked. In additional with fines for data breaches set to increase significantly, the costs of doing nothing should not be underestimated.

3. Wannacry

On the 17th May the world fell victim to the Wannacry cyber-attack which resulted in a reported 300,000 computers being infected while the countries most affected by WannaCry were Russia, Taiwan, Ukraine and India. Many of the UK's NHS Trusts were taken back to pen and paper after the much publicized cyber-attack that saw IT systems infected with Ransomware and others taken offline to prevent infection.

The Trust was one of the organisations affected and although Emergency Plans were proven to be robust with the attack contained resulting in no harm to patient care or permanent loss of patient data, there were lessons to be a learnt and agreement across the Trust that we should plan on the basis of "when the next attack will take place and not if".
To this end we must ensure that good information underpins good care. Recent



publications from Dame Fiona Caldicott and the CQC outline the key principles of where patient and service user safety is supported by Confidentiality, Integrity and Accessibility. Patients / service users must feel assured that their information is used appropriately. This is the approach adopted by the Trust.

4. Cyber Attack Learning

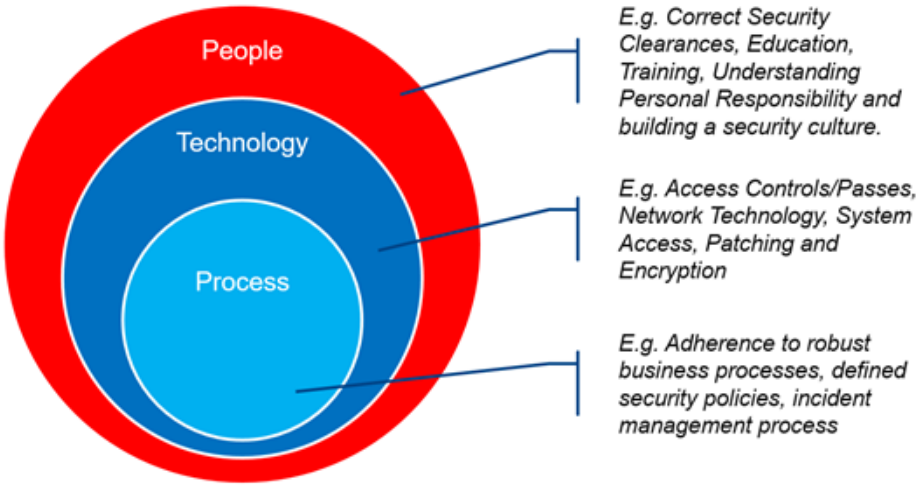
What this latest attack has taught us is;

- Ransomware is indiscriminate
- It's no good thinking that "it won't happen to me".
- Keep systems up-to-date with patches for the Operating System
- Training and education
- Protect your perimeter

This is on the basis that there are a number of known **Data Security Challenges** nationally including;

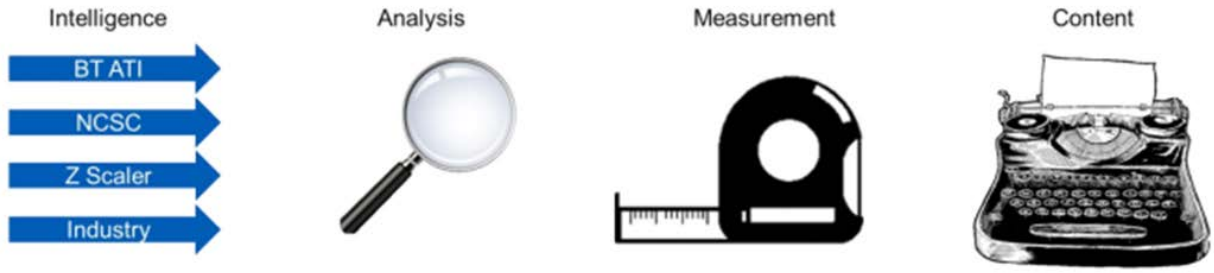
- Unsupported Operating System (OS) Browsers
- Inappropriate Staff Training
- Poor leavers, movers and changes process for staff
- Too many privileged system accesses
- Significantly reduced investment funding
- Limited situational awareness of cyber preparedness locally
- Social Engineering - Sophisticated Spear Phishing

Effective and robust cyber security requires an information security management regime built on three pillars: people, processes and technology.



5. Trust Response

The Trust has already taken steps to reduce the risks posed by cyber-attacks. The Trust is a participant in the Career service provided through NHS Digital. CareCERT is a national service providing expert advice and guidance on cyber security threats and best practice to the NHS and other health and care organisations. CareCERT (Care Computing Emergency Response Team) is run by experts at the Health and Social Care Information Centre and aims to enhance cyber resilience across the health and social care system.



The Trust Digital team works with the Staffordshire and Shropshire Health Informatics Service to implement controls to improve cyber resilience and adhere to the recommendations from NHS Digital via the CareCERT process. These actions have included;

- **Testing** - Undertaking security penetration tests (reported via Audit Committee).
- **Patching** - Keep systems up-to-date with patches for the Operating System, applications and for other security measures such as anti-virus and anti-spam. The Trust in partnership with S&SHIS has put a much more aggressive patching strategy in place with weekly patches mandated for all devices, following a testing process**.**
- **Training** - The Trust is required to provide annual training on topics such as: The Data Protection Act, the Freedom of Information Act, the adoption of technology – building and maintaining public trust in how we use and share information, information security policy and procedure.
- **Policies and procedures** - The Trust and S&SHIS had policies and processes in place should a cyber-attack happen. These were put into action and it has meant that in most cases services were restored relatively quickly.
- **Perimeter Security** - The latest security technology enables the Trust to stop attacks at the boundary, before they enter the network, by removing the source of an attack (active code) from documents and attachments via the web and email.
- **Device Replacement** - Old, out-of-date hardware and applications need to have a replacement program put in place and acted upon. For the Trust 250 devices were replaced last year (2016/17), another 200 this year (2017/18).

- **Security and Access Controls** –
    - **Usernames & Passwords**. NHS hospitals are at risk of further devastating cyber-attacks because staff are using “very weak” passwords, a new report reveals. It found that in “practically all” organisations, any staff member was entitled to access a huge wealth of patient data, backup files and passwords.
    - **Starters and leavers** - The survey also revealed that 17 per cent of active staff accounts had been unused in the previous 12 months, indicating departing staff members’ accounts are not being deactivated once they leave. The Trusts process is linked to ESR so accounts are automatically deactivated.
    - **Smartcards** - Smartcards and access control are secure measures by which clinical and personal information is accessed by only those that have a valid reason to do so. The Trust use smartcard to protect the Lorenzo EPR, NHS smartcards are similar to chip and PIN bank cards and enable healthcare professionals to access clinical and personal information appropriate to their role.
    - **Central control** - Since WannaCry, the government has taken steps to impose more central control and oversight of NHS data security, in the face of the growing cyber threat, including forcing health service leaders to demonstrate how they were protecting their organisation’s data.

Summary

The controls outlined in this report and monitored via the Information Governance Steering Group, the Digital Board and Audit Committee.

Recommendations

The Trust Board is asked to;

- Receive the report for information and assurance

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REPORT TO (Trust Board)

Enclosure No:14

Date of Meeting:	5th October 2017		
Title of Report:	CAMHS Assurance Report		
Presented by:	Dr Nasreen Fazal-Short		
Author:	Dr Matthew Johnson: Clinical Director CYP Directorate		
Executive Lead Name:	Dr Nasreen Fazal-Short – Acting Director of Operations	Approved by Exec	☒

Executive Summary:		Purpose of report	
The Assurance Report provides detail on the substantial progress that has been made by the CYP Directorate in meeting the needs of Children and Young People. It details the level of access through waiting time data to a range of interventions that promote recovery. It also highlights improved performance on clinical areas that were highlighted by CQC. Additionally, it describes future developments to promote sustainability.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☒ Date: 19.09.17	Document Version No.	
Committee Approval / Review	• Quality Committee ☒ • Finance & Performance Committee ☒ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	✓ To enhance service user and carer involvement.☒ ✓ To provide the highest quality services ☒ ✓ Create a learning culture to continually improve.☒ ✓ Encourage, inspire and implement research & innovation at all levels.☐ ✓ Maximise and use our resources intelligently and efficiently. ☒ ✓ Attract and inspire the best people to work here.☒ ✓ Continually improve our partnership working. ☒		
Risk / legal implications: Risk Register Ref	Implementation of the transformation plan will ensure sustainability and reduce the risk of recurrence of waits.		
Resource Implications: Funding Source:	N/A		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	Data on helpfulness of interventions will be monitored against accessibility for particular groups of young people and their families and utilise the data to target support where there is an access problem.		
Recommendations:	The Board is asked to note the significant improvement in supporting children and young people with timely access to treatment and also to note the systems in place to monitor and maintain improved performance.		

CAMHS Assurance Report

Dr Matthew Johnson: Clinical Director Children and Young People's Directorate

1. Introduction

Historically the Children and Young People (CYP) Directorate faced demand for services that exceeded resources and capacity; this affected the timeliness of access to services. The CQC Inspection in September 2015 highlighted the under-resourcing of services and included the requirement to increase staffing. Funding was secured from our CCGs to support the appointment of 20 WTE additional multi-disciplinary staff. This has supported a number of initiatives to reduce waiting times and the development of the service. These include measures to ensure that children and young people referred to our services are assessed in a timely way together with ensuring that, following assessment, children and young people proceed without delay to evidence based intervention. The CQC visit in 2015 also highlighted the need to improve care planning and risk assessment for children and young people. In the return inspection in September 2016 the CQC noted improvement in both areas however further improvement in the management of waiting lists was identified.

2. Service Model

From 2010 the CYP directorate used the Choice & Partnership Approach (CAPA) model, whilst this model offered some advantages an unintended consequence was a lack of clarity, in some cases, as to what further assessment or intervention was required for young people. Following a review, an improved model has been established. The current model includes a detailed assessment that results in a clear formulation and care plan being agreed with the young person and their family at their first point of contact with the service. This indicates the intervention required which may involve signposting to another service or the CYP is accepted onto one of our evidence based clinical pathways. The most appropriate intervention is always determined in partnership with the young person and their family.

2.1 Emergency and Urgent Referrals

We have established processes in place for managing emergency (including crisis) referrals and urgent referrals. Emergency referrals are seen on the same day and urgent referrals are seen within a week. Emergency and urgent referrals are seen by our Priority Team who are based at the Central Referral Hub.

2.2 Assessment to Treatment

A number of additional interventions were established to improve waiting time from assessment to treatment. These include the following:

Group Interventions for Young People

A number of group interventions have been established to improve timely access to evidence based treatment for the young person. Evidence of effectiveness is being collected routinely and will be reviewed to develop these interventions further.

Education Workshops

A workshop model has been piloted and implemented with great success to expedite assessment of young people waiting for assessments and intervention for specific neurodevelopmental disorders namely Attention Deficit Hyperactive Disorder (ADHD), and Autism Spectrum Disorder (ASD). The workshop model includes aspects of education about the respective diagnoses including presenting symptoms and treatment options. Screening questionnaires are completed and appointments offered for further assessment (where indicated) and intervention.

3. Waiting List Protocol

Historically, the number of referrals received by the CYP Directorate exceeded capacity to allocate Children and Young People who met criteria for routine treatment in a timely way. These children and young people were held on a waiting list for allocation. A protocol is in place to support Service Managers to monitor waiting lists and ensure that any changing needs or escalation of risk of young people is monitored and addressed. This protocol was shared with commissioners and the CQC. At the 2016 CQC inspection, the service could not provide assurance that this protocol was applied systematically. To address this issue, the protocol has been strengthened and regular audits (both internal and external) are completed to ensure that it is systematically applied across all CYP teams. There has also been a strengthening of the processes of ensuring all children and young people have an allocated care co-ordinator so that there is continuous care.

As capacity in the Directorate has increased, the number of children and young people waiting (i.e. those who have received an assessment but are not yet in receipt of any intervention) has reduced significantly (see section 4). However, this protocol remains in place and is monitored by the Service Managers ensuring that CYP and their families receive regular contact and intervention and family support from their allocated care co-ordinator whilst they are waiting for some additional treatments.

There are internal processes in place to monitor any further waits for specialist psychological interventions or other specialist treatment packages that may occur while the service user is being care co-ordinated by one of the CAMHS teams.

Going forward Lorenzo is being developed to enable us to track CYP who are waiting for specific interventions (e.g. ASD, ADHD, trauma / attachment, medical, psychological). When this is implemented we will no longer need to maintain the team databases.

4. Waiting List Progress

The service has refined its systems and processes and has implemented a comprehensive action plan to ensure that all children and young people, who were identified as waiting for specialist interventions following assessment, will be in treatment by the end of October 2017. All children and young people have an allocated care co-ordinator who is responsible for facilitating the delivery of their care and maintaining regular contact with them.

The table below illustrates the significant progress made in reducing the number of Children and Young People waiting to start treatment in mainstream CAMHS services

and the position as at 26th September 2017 is that all previous legacy waits have now been allocated.

All Waits	Waits June 2017	Waits End July 2017	Waits End August 2017	Waits 06 Sept 2017	Waits 08 Sept 2017	Waits 26 Sept 2017
North Staffs	35		9	2	2	0
North Stoke	94		29	24	13	0
South Stoke	95		30	8	2	0
Total	224		68	34	17	0

On 1st December 2016, the CAMHS Learning Disability Team moved from the Children and Young People's Directorate to the Learning Disabilities Directorate to ensure there was a joined up, life-span approach to the national Transforming Care agenda.

The table below illustrates the significant progress made in reducing the number of CYP waiting to start treatment in the CAMHS Learning Disability Team over this period and the position as at 8th September:

CAMHS-LD Team	Waits End January 2017	Waits 08 Sept 2017
TOTAL	**90**	**15**

All children and young people identified as waiting are in contact with their care co-ordinator and have appointments booked for individual treatment and/or will be attending one of the new group based interventions developed by the team. It is anticipated that all children and young people waiting will have accessed treatment by the end of October 2017.

Following to move to the EPR system in May, there is further work to validate the waiting time information with the CAMHS Learning Disability Team in respect of the Referral to Treatment (RTT) 18 week target.

5. Performance

Performance against the KPIs is monitored on a monthly basis at the Directorate performance meeting as well as at the Executive Team Meeting. Reports on performance are provided to Finance and Performance Committee, Quality Committee, Senior Leadership Team and Executives.

5.1 Trust performance Measures

In the absence of any nationally recognised metrics, the Trust has developed local KPIs to provide further assurance that children and young people are seen for assessment and treatment in a timely manner:

- 4 week wait from referral to assessment (all CYP services excl. ASD) - This will be measured by the presence of the first face to face or telephone/ digital (Skype) contact.

- 18 week from referral to treatment (all CYP services excl. ASD) - This will be measured by the presence of the second face to face or telephone / digital (Skype) contact.

It should be noted that key performance targets are being developed nationally to improve access to CAMHS and treatment times are likely to be defined as referral to treatment time within 6 weeks for routine clinical pathways.

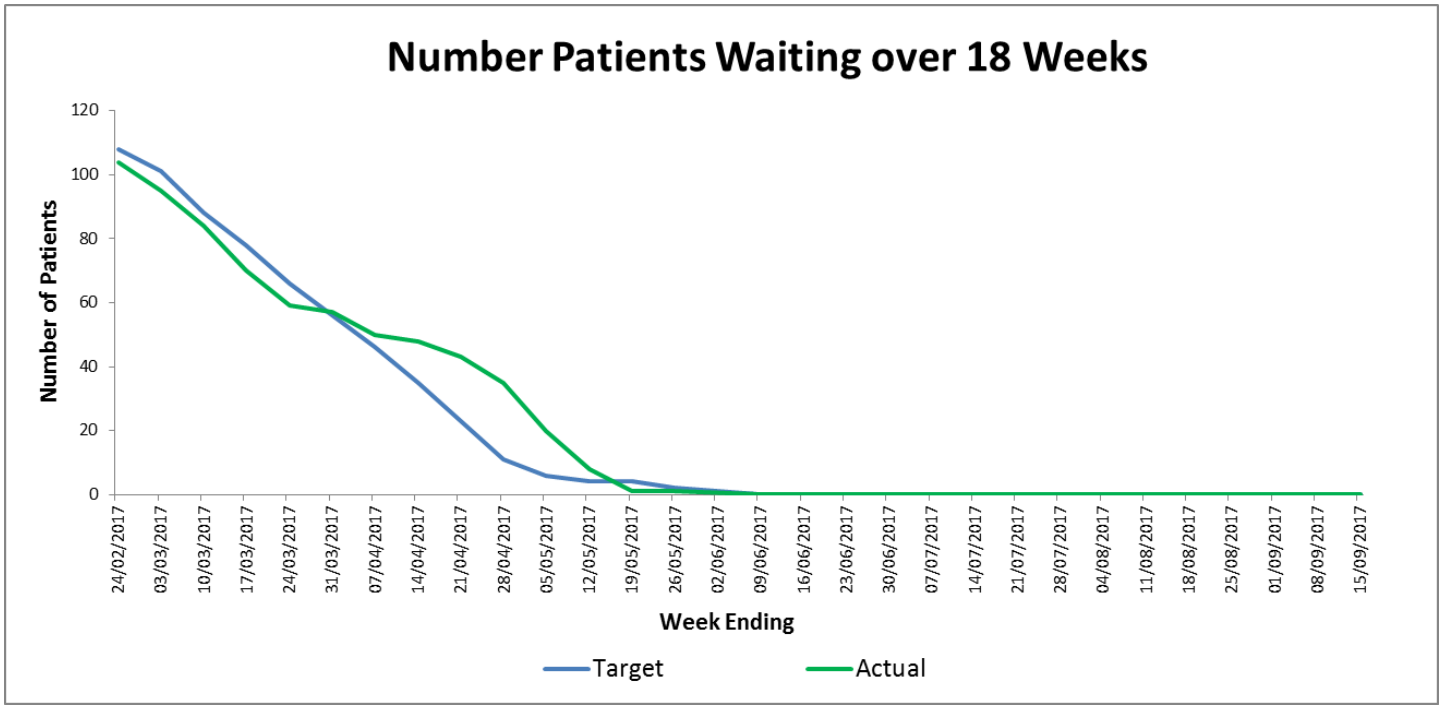
The table below illustrates the performance of the mainstream CAMHS teams (excluding CAMHS ASD) in meeting the current Referral to Treatment (RTT) 18 week target:

18 Weeks Referral to Treatment (2 Contacts) in 18 Weeks

	28-Apr	05-May	12-May	19-May	26-May	02-Jun	09-Jun	16-Jun	23-Jun	30-Jun	07-Jul	14-Jul	21-Jul	28-Jul	04-Aug	11-Aug	18-Aug	25-Aug	01-Sep	08-Sep	15-Sep
Target	80%	82%	83%	85%	87%	88%	90%	92%	93%	95%	97%	98%	99%	100%	100%	100%	100%	100%	100%	100%	100%
Actual	80%	83%	86%					97%		97%		100%		100%	100%	100%	97%	99%	96%	96%	95%
Variance	**0%**	**1%**	**3%**					**5%**		**2%**		**2%**		**0%**	**0%**	**0%**	**-3%**	**-1%**	**-4%**	**-4%**	**-5%**

"People on WL for treatment have been waiting <18 weeks for treatment"

The figure below illustrates the performance of the CAMHS ASD Team in meeting the current Referral to Treatment (RTT) 18 week target:



All children and young people referred to the CAMHS ASD Team are in treatment within 18 weeks.

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Patients Waiting Over 18 Weeks	07/04/2017	14/04/2017	21/04/2017	28/04/2017	05/05/2017	12/05/2017	19/05/2017	26/05/2017	09/06/2017	16/06/2017	29/06/2017	07/07/2017	14/07/2017	21/07/2017	28/07/2017	04/08/2017	11/08/2017	18/08/2017	25/08/2017	01/09/2017	08/09/2017
Target	46	35	23	11	6	4	4	2	0	0	0	0	0	0	0	0	0	0	0	0	0
Actual	50	48	43	35	20	8	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Over / (Under) performance	-4	-13	-20	-24	-14	-4	3	1	0	0	0	0	0	0	0	0	0	0	0	0	0

% seen within 18 Weeks	07/04/2017	14/04/2017	21/04/2017	28/04/2017	05/05/2017	12/05/2017	19/05/2017	26/05/2017	09/06/2017	16/06/2017	29/06/2017	07/07/2017	14/07/2017	21/07/2017	28/07/2017	04/08/2017	11/08/2017	18/08/2017	25/08/2017	01/09/2017	08/09/2017
Target	57.0%	64.6%	74.7%	86.7%	91.9%	93.8%	92.7%	95.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Actual	49.0%	48.9%	51.1%	64.6%	78.3%	90.2%	98.6%	98.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Over / (Under) performance	-8.0%	-15.7%	-23.6%	-22.1%	-13.6%	-3.6%	5.8%	2.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

6. Assurance

An action plan was established which addressed the feedback from the CQC inspection in September 2015. This action plan was refreshed following the 2016 CQC inspection and a programme of audit and assurance was implemented.

The key areas to monitor compliance with the action plan and provide assurance to the Board via Quality Committee include:

6.1 Care Planning and Risk Assessment

The service carries out a monthly care plan and risk assessment audit in line with the Trust's protocol. Each team audits a random selection of ten care records each month. Audit includes checking for patient and carer involvement, individual's preferences, strengths and goals and that reviews are carried out as scheduled. Any care plans and risk assessments which indicate that improvements could be made are discussed directly with the responsible clinician in management supervision sessions and guidance offered about how improvements can be made at the next appointment with the individual patient.

The most recent audit in August indicates good compliance with key parameters of risk assessment and care assessment as below:

Risk assessment reviewed as per policy	%
North Staffs	90%
North Stoke	100%
South Stoke	90%
ASD	100%
Paed Psych	100%

Care plan goals are Recovery focussed	%
North Staffs	100%
North Stoke	100%
South Stoke	100%
ASD	100%
Paed Psych	100%

Service user involved with risk assessment	%
North Staffs	100%
North Stoke	100%
South Stoke	100%
ASD	100%
Paed Psych	100%

Service user involved with care plan	%
North Staffs	100%
North Stoke	100%
South Stoke	87%
ASD	100%
Paed Psych	100%

Carer involved with risk assessment	%
North Staffs	100%
North Stoke	90%
South Stoke	100%
ASD	100%
Paed Psych	100%

Carer involved with care plan	%
North Staffs	100%
North Stoke	80%
South Stoke	100%
ASD	100%
Paed Psych	90%

6.2 Monitoring the Performance of the Waiting List

The CAMHS Service Managers meet on a weekly basis with the Head of Service to review performance data. There is a clear trajectory, the data is validated and actions are taken forward on a case by case basis by the Service Managers each week. Performance is monitored for assurance via Directorate performance reviews and PQMF to appropriate committees and the Board.

6.3 Compliance with CQC Action Plan

The governance team attend meetings with the service managers to review progress against the CQC action plan. The CQC action plan is monitored at monthly performance reviews where progress is discussed and assurance sought. In addition unannounced compliance visits are also undertaken to provide added assurance that the progress is being maintained and sustained.

7. Future Developments

Having made significant and sustained progress in reducing the waiting lists across the Directorate, the service is now beginning a transformation project to further develop the Central Referral Hub. This will be achieved through reconfiguration of existing resource and the introduction of an evidence based, brief intervention clinical pathway. Building on the existing model of care provided by the Central Referral Hub, this transformation will improve the front door experience for children, young people and their families - working in partnership to deliver an integrated, recovery based, preventative model that is flexible in meeting the needs of children and young people.

The proposed development of the Central Referral Hub is underpinned by the following principles:

- Timely access to a responsive service (no wrong door approach)
- The centralising of a timely, comprehensive, assessment with an enhanced access to clinical pathways
- Standardisation of approach with enhanced governance
- Equity of service
- Early intervention by an appropriately skilled professional
- Improved CYP and family / carer experience and outcomes
- Reduced length of stay in treatment
- Compliance with new anticipated waiting time targets

8. Conclusion

- The Board to note the significant improvement in supporting children and young people with timely access to treatment.
- To note the systems in place to monitor and maintain improved performance.

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REPORT TO Trust Board

Enclosure No:15

Date of Meeting:	5th October 2017		
Title of Report:	Towards Outstanding Engagement – Pulse Survey Baseline results and programme update Report		
Presented by:	Paul Draycott		
Author:	Kerry Smith, Associate Director of Workforce		
Executive Lead Name:	Paul Draycott, Director of Leadership and Workforce	Approved by Exec	☐

Executive Summary:	Purpose of report	
This paper provides a high level summary of the Trust's Towards Outstanding Engagement Programme in response to the initial Pulse Survey conducted in May 2017 which will inform our baseline position from which we can benchmark our performance and improvement. Initial results from the Trust's first Pulse Survey on balance provide for a favourable staff engagement result. With some identified areas requiring focus and improvement. The second pulse check will allow the Trust to benchmark and review progress providing more timely and meaningful staff engagement and cultural feedback. Further, discussions and monitoring to take place at the Trusts PCD and JNCC. The first Cohort of 16 Teams on the Towards outstanding engagement programme are progressing well and as planned. The first cohort will conclude in January 2018 and a celebration event will be held on 26th February 2018 to review the progress, celebrate the team's successes and share organisational learning.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	1
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☒ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☐ 3. Create a learning culture to continually improve.√ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.√ 6. Attract and inspire the best people to work here.☒ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	N/A		
Resource Implications:	Ongoing costs of Go Engage, management time to oversee and run the programme and release of staff to participate in the programme.		

Funding Source:	
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	All staff are actively encouraged to participate in the Pulse Surveys which are entirely anonymous. The Towards Outstanding Engagement Programme is also a fully inclusive programme.
Recommendations:	The Trust Board are asked to accept the results of the first Pulse survey and note the favourable results. Additionally the Board are asked to continue to support the 'Toward Outstanding Engagement' for future cohorts as part of the long term strategy to improve staff engagement and attend the Celebration event on 26th February 2017.

Towards Outstanding Engagement – Trust Board Paper

Pulse Survey Baseline Position and Programme Progress Report
September 2017

1. Purpose of the Report

This paper provides a high level summary of the Trust's Towards Outstanding Engagement Programme in response to the initial Pulse Survey conducted in May 2017 which will inform our baseline position from which we can benchmark our performance and improvement.

It also provides an update on the 'Towards Outstanding Engagement' programme, supporting OD (organisational development) interventions and progress made to date with regards to Cohort One.

2. Introduction

In May 2017 the Trust commenced the Go Engage programme known internally as Towards Outstanding Engagement Programme. This programme uses the Go Engage tool which has been developed by Wrightington, Wigan and Leigh NHS Foundation Trust to better understand the NHS Trusts culture and engagement both at a Trust and more local level and provides results on a quarterly basis using a Pulse Survey.

The programme also brings the Trusts OD interventions and practises together helping teams to undertake a more targeted approach and enabling a tailored programme to maximise impact.

Based on the initial Trusts Pulse Survey a high level summary of the results is given detailing:

- Current good practice within the Trust
- Suggested areas for improvement
- Friends and Family Test
- Response Rate
- Recommendations

There is vast research evidence to suggest that increasing staff engagement can lead to outcomes such as reduction in sickness absence, reduction in staff turnover, increase is staff performance, improvement in quality of patient care and improvements in safe practice. In future reports it will be possible to measure whether trends in these outcomes vary with the results from the quarterly pulse check survey.

3. Pulse Survey Results - Baseline position

The information contained within this report is based upon the responses to a 47 question survey and is conducted on a quarterly basis (undertaken in May 2017). The main aim of the survey is to periodically review levels and trends of staff engagement across the organisation and identify the factors that may be enabling or inhibiting staff engagement. By frequently obtaining and acting upon this cultural data, the Trust will be able to continuously improve staff experience, involvement and well-being.

It should be noted that this survey excludes the data of the 16 teams who are currently taking their own pulse surveys as part of Cohort One Towards outstanding engagement

programme. Their data will be compared to the trust wide data, as they embark on a 6 month engagement journey in their teams.

The main headline based on the results for the Trust currently indicate experiences a 'moderate to positive' in all level of engagement enablers with an overall score of 3.96 out of 5.

This overall figure now forms the benchmark and baseline in which we can track staff engagement levels going forward. The staff engagement model underpinning this survey measures the cultural enablers, feelings and behaviors associated with engagement for which the key and notable findings for combined are detailed in the sections below. It should be noted that no negative engagement enablers are reported. Results from the dashboard are detailed below:

Results Dashboard

Enablers of Staff Engagement	Engagement Feelings
Work Relationships 4.19	Dedication 4.19
Trust 4.08	Focus 4.11
Resources 3.86	Energy 3.52
Clarity 3.83	
Personal Development 3.76	**Engagement Behaviors**
Mindset 3.71	Discretionary Effort 4.14
Influence 3.62	Persistence 4.07
Recognition 3.57	Adaptability 3.94
Perceived Fairness 3.53	Advocacy 3.73

Scale				
1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

	Scores on average positively
	Scores on average moderately
	Scores on average negatively

The overall engagement score for this quarter is 3.96 out of 5.

3.1 Current Good Practise Enablers

- **'Work Relationships'** is the highest scoring engagement enabler scoring positively at 4.19 out of 5, suggesting that staff have positive relationships with line managers and colleagues and feel there is the social support available in order to work effectively. This is likely to be a key driver of engagement for the Trust;

- **'Trust'** also scored positively at 4.08 out of 5 and highlights a potential area of strength for the Trust, with staff indicating they are satisfied with their freedom to act, opportunity take responsibility and make decisions for themselves and the autonomy to engage with their work and the team:

- **'Dedication, Focus, Persistence and Discretionary Effort'** attained a positive score (+4 out of 5), and are areas of engagement which are strengths for the Trust.

Comparisons against the Trust norm indicated that staff in **Nursing & Quality** scored significantly higher on a number of engagement areas including Clarity, Influence,

Mindset, Recognition and Focus. This staff group also reported the highest overall score for engagement within the Trust with an overall score of 85.66% (4.23 out of 5);

3.2 Suggested Areas for improvement Enablers

- **'Perceived Fairness'** was found to be the lowest scoring engagement enabler with a score of 3.53 out of 5, suggesting that staff are only moderately satisfied with the fairness of processes, decisions and treatment;

- **'Recognition'** (the extent to which staff feel the organisation and/or manager recognises and values their work) also score moderately at 3.58 out of 5 and is the second lowest scoring enabler, indicating another key area for improvement within the Trust;

- **'Energy'** was the lowest scoring engagement measure (3.52 out of 5), which suggests that staff may be displaying dedication and going the extra mile for the Trust at their own expense, and may be at high risk of burnout;

- **'Mindset'**, the extent to which staff feel that they are encouraged to believe in themselves, believe in moving forwards, and have a positive state of mind, scored moderately at 3.71 out of 5, however scored more negatively by the item 'staff confidence in the future of the Trust' which scored 3.18 out of 5. This suggests that staff have a low level of optimism and hope for the future direction of the organisation.

Comparison data also found that staff in **Estates & Ancillary** scored significantly lower on the majority of staff engagement enablers, feelings and behaviours, with several areas scoring negatively (>3 out of 5) including Clarity, Influence, Mindset, Perceived Fairness, Recognition, Dedication, Energy and Advocacy;

3.3 Friends and Family Test

The Staff Friends and Family Test has shown that staff are experiencing moderate levels of 'Advocacy' for the Trust, with 60.15% of staff indicating they would be likely to recommend the Trust to friends and family as a place to work and 67.82% indicating they would be likely to recommend the Trust to friends and family if they needed care or treatment.

3.4 Response Rate

The response rate for this survey was 23.14% (261 staff completed it out of 1128 invited). This response rate does not meet the recommended response level of 30% and therefore some caution must be adopted in the interpretation of the results. The low response rate is largely due to technical issues and staff caution of external mail following the cyber-attack. Technical issues have since been addressed and as we share results and actions with staff we are confident of enhancing responses in Q2 due in mid-October 2017.

3.5 Recommendations taken from the Pulse Survey

Based on the results, recommendations have been suggested by Go-Engage. These recommendations will be reviewed, agreed and monitored at the People and Culture Development committee in October 2017:

Broadly they relate to suggestions:

1. To improve response rate
Update: Actions have already been taken to increase trust wide communications regarding this point
2. Relating to perceived Fairness responses
Update: To be discussed and reviewed at PCD and JNCC.
3. Recognition is also an important area of development
Update: To be discussed and reviewed at PCD and JNCC.
4. Relating to Estates & Ancillary reporting significantly lower scores for the majority of engagement areas
Update: Supportive action has been taken to support this staff group, a Team from this group is part of the Cohort One programme and further planned engagement work is ongoing. A new Associate Director of Estates has recently commenced in post.
5. Mindset (the extent to which staff are encouraged to believe in themselves, believe in moving forwards, and have a positive state of mind) is a strong predictor of Energy, which is an area of prioritisation for the trust as the lowest scoring engagement feeling.
Update: To be discussed and reviewed at PCD and JNCC.

The second pulse check questionnaire is currently in operation and results will be available by mid October 2017. Results will be shared with the Trust's PCD, JNCC and Trust Board in due course for further review and assurance.

4. Towards Outstanding Engagement Programme Update (Cohort One)

The 16 Teams which form the Trusts first Cohort have now commenced their 6 month Towards Outstanding Engagement journey and attended a 2 day initiation workshop July 2017. The workshop supported the teams to analyse their reports and select which OD tools are likely to have the most impact.

Cohort One Consists of the following teams:

Training and Education Team	Darwin Team
South Stoke CAMHS Team	North Staffs CAMHS Team
North Stoke CAMHS Team	Assessment and Treatment Team
Estates Team	Performance Team
Finance Team	Greenfields Team
Pharmacy Team	Community Learning Disability Team
Ward 6 Team	Ward 1 Team

Initial feedback suggests that the majority of teams are progressing well and working through their agreed action plans. Two clinical teams are experiencing some delays as a result of staffing issues and a high acuity. Additional support has been put in place to support these teams. Mentors have also been assigned to each of the teams providing support and guidance to each team.

The 6 month programme for Cohort one is due to end in January and will require each team to undertake a Team Pulse Check. A Towards Outstanding Engagement celebration Event will be held on 26th February 2018 to review the progress, celebrate the team's successes and share organisational learning.

Wave 2 promotion and selection of teams for Cohort 2 is due to commence in December 2017 and will run as detailed above.

5. Programme OD Interventions update

A mapping activity of tools, approaches and progress made by each team is currently underway.

5.1 Mentoring

The first mentor networking meeting has taken place, reviewing progress and identifying barriers, constraints or support needed.

5.2 Coaching

The coaching programme is an essential part of the Towards Outstanding Engagement programme and an introductory Coaching session has been delivered at the Leadership Academy on 6th May 2017. The aim is to identify existing trained coaches, create a register and promote the service available across the Trust. A further coaching assessment day will be held on 31st October to develop a cohort of 17 trained coaches across the Trust.

5.3 Action learning sets

Action learning sets are providing shared learning and further support for Cohort One teams. Sessions are planned for delivery in September, October and November.

5.4 Listening into Action

It is planned to deliver two listening into actions sessions which will be held in November 2017.

6. Conclusion

Initial results from the Trust's first Pulse Survey on balance provide for a favourable staff engagement result. With some identified areas requiring focus and improvement. The second pulse check will allow the Trust to benchmark and review progress providing more timely and meaningful staff engagement and cultural feedback. Further, discussions and monitoring to take place at the Trusts PCD and JNCC.

The first Cohort of 16 Teams on the Towards outstanding engagement programme are in the aim progressing well and as planned. The first cohort will conclude in January 2018 and a celebration event will be held on 26th February 2018 to review the progress, celebrate the teams successes and share organisational learning.

7. Recommendation

The Trust Board are asked to note the results of the first Pulse survey and the favourable results.

Additionally the Board are asked to note the progress to date of the 'Toward Outstanding Engagement' Programme and are invited to attend the Celebration event on 26th February 2018.

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO TRUST BOARD

Enclosure No:16

Date of Meeting:	5 October 2017		
Title of Report:	Partnership Strategic Plan		
Presented by:	Andrew Hughes, Joint Director of Strategy and Development		
Author:	Andy Oakes – Head of Partnerships and Karen Day – Business Development Manager		
Executive Lead Name:	Andrew Hughes	Approved by Exec	☒

Executive Summary:	Purpose of report	
The report aims to outline a plan for partnership for the Trust. It focuses on the maintenance of existing partnerships and the development of new partnership opportunities. It provides structure and governance to all partnership arrangements and offers a structure to all levels of partnership engagement. Partnership will be a theme of the business planning process and this is offers a toolkit for those discussions.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☒ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☐ 3. Create a learning culture to continually improve ☒ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently. ☒ 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☒		
Risk / legal implications	None specifically identified although some partnerships need to be covered by formal Partnership Agreements or Memoranda of Understanding.		
Resource Implications:	None specifically identified although management of effective partnerships will need attention and governance.		
Diversity & Inclusion Implications	None specifically identified although partnership need to be developed that respect and reflect protected characteristics.		
Recommendations:	The Trust Board is asked to: • RECEIVE the document and DEBATE any issues that it raises. • NOTE the process that is being followed as part of the business planning process. • BE ASSURED that the Directorate of Strategy and Development is gaining further grip and insight regarding partnerships.		

Partnership Strategic Plan

1. INTRODUCTION

The development, maintenance and governance of Partnerships in all NHS Trusts are crucial for their future and the future of the health and social care economy. Increasingly over the past five years the prevailing understanding inherent in the commissioning of new services has been that organisations need to approach the delivery of services with partnership at the core of the service planning.

Outstanding organisations do not view partnerships as a threat or partners as completion but rather they embrace all forms of partners who share their values.

Together, we and our partners gain from working together by widening the available market for their services. Working in Partnership strengthens our position, helps us to secure the business for local third sector partners and improves the services we deliver.

Partnership is also critical to our Alliance approach, as positivity and proactivity are essential for all organisations that aspire to lead in the development and delivery of new models of care.

2. PARTNERSHIP STRATEGIC PLAN

The attached Partnership Strategic Plan provides the framework and toolkit that will be used with Directorates and our Partners to bring clarity and ambition to our partnership arrangements.

The Plan was received by the Business Development Committee at its September meeting. It was acknowledged as a largely academic and theoretical document but also welcomed as an evidence-based approach to better governance.

The Directorate of Strategy and Development will be launching this year's planning process at the Leadership Academy on 4 October 2017. Over the coming quarter (and beyond) the aim will be to complete a comprehensive review and compile a detailed review of all existing partnership. The work will provide a baseline assessment of the nature of our partnerships and, even more critically, of the resource that is currently being used – often in informal or unseen ways – to manage those relationships.

This will allow us to consider and reflect on how me identify and manage partnerships in the future, focusing on the key themes of capacity, capability and priority.

3. RECOMMENDATIONS

The Trust Board is asked to:

- **RECEIVE** the document and **DEBATE** any issues that it raises.
- **NOTE** the process that is being followed as part of the business planning process.
- **BE ASSURED** that the Directorate of Strategy and Development is gaining further grip and insight regarding the Trust's partnerships.

North Staffordshire Combined Healthcare NHS Trust

Partnership Strategic Plan (Draft)

2017 – 2018

Version 2 – September 2017

Through partnerships to improve lives and deliver quality of care

Version Control

The following table details the document version changes:

Version	Date	Author	Description of Change

Document Distribution

The table below details the distribution of the Strategic Business Plan:

Version	Date of Issue	Name	Notes
1	25.08.17		First draft. (KD)

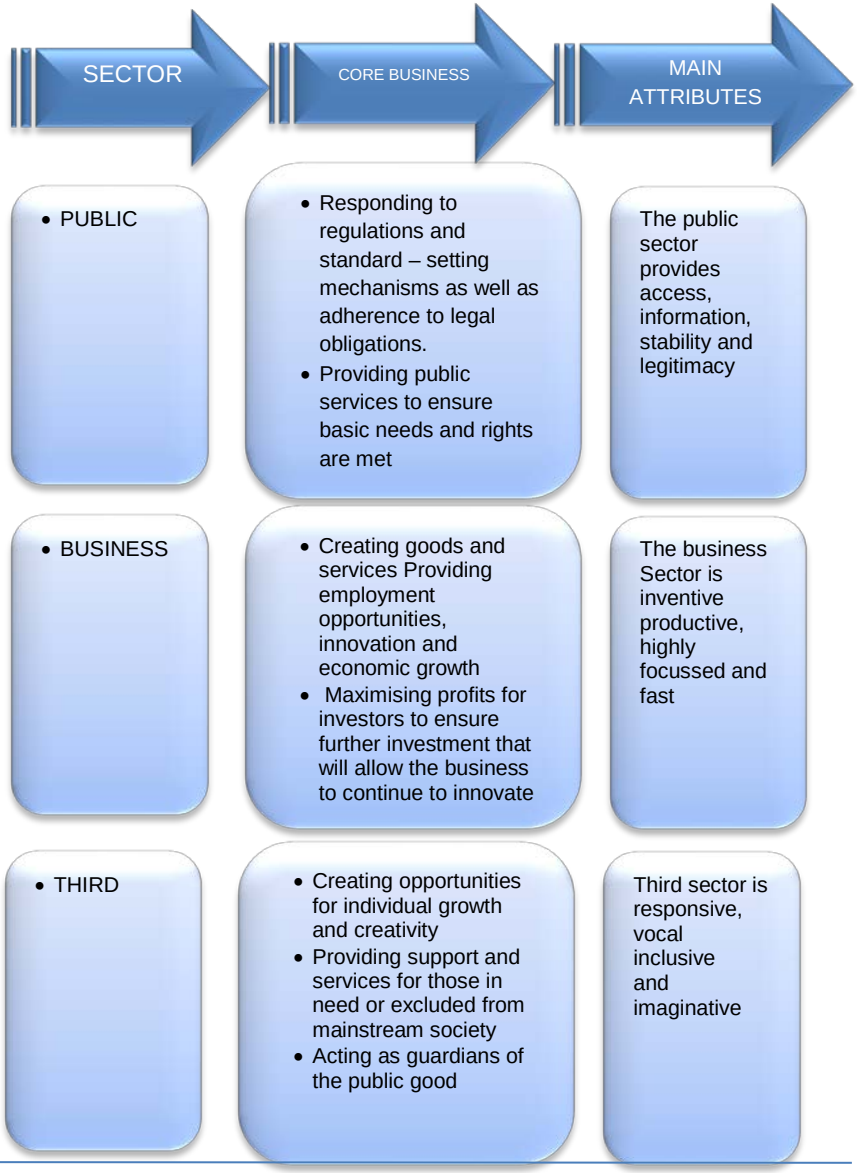
Table of Contents

Section One: Introduction

The hypothesis underpinning a partnership approach is that only with comprehensive and widespread cross-sector collaboration can we ensure that sustainable development initiatives are imaginative, coherent and integrated enough to tackle the most intractable problems. Single sector approaches have been tried and have proved disappointing. Working separately, different sectors have developed activities in isolation - sometimes competing with each other and/or duplicating effort and wasting valuable resources. Working separately has all too often led to the development of a 'blame culture' in which chaos or neglect is always regarded as someone else's fault.

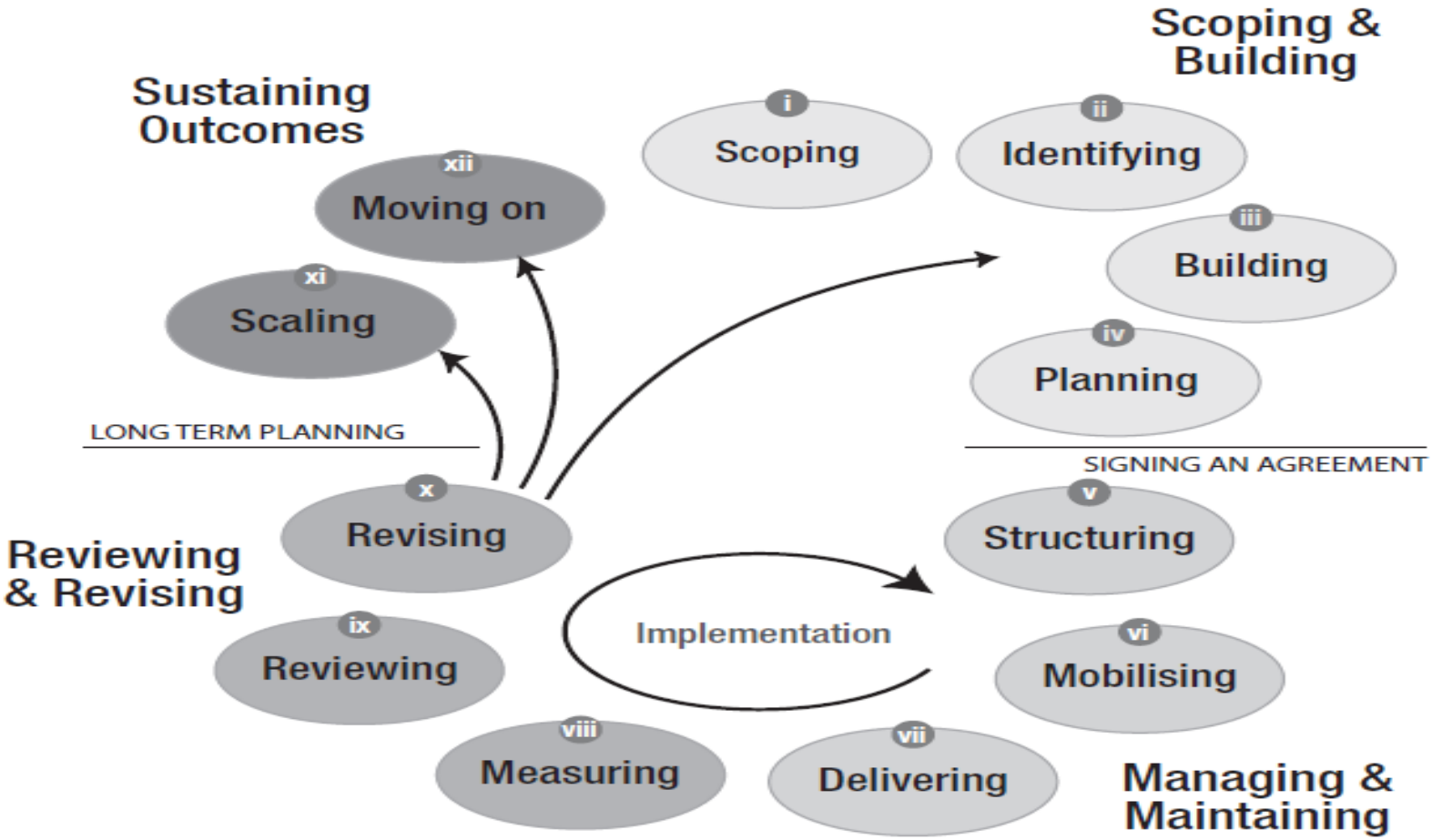
Partnership provides a new opportunity for doing development better - by recognising the qualities and competencies of each sector and finding new ways of harnessing these for the common good.

What each sector does - whether the public sector, business sector or charitable third sector - bring? The 'core business' of each sector leads to quite different priorities, values and attributes which provides the basis of delivering dynamic and innovative results. These are summarised in the diagram opposite:



Section Two: Phases in the partnering process

Each partnership will follow its own unique development pathway. The important thing is to be aware that each of the 'phases' outlined in the diagram is important and should not be neglected if the partnership is to remain balanced and on course to achieve its goals.



Section Three: Obstacles in Partnerships

Although there may be many good reasons for creating partnerships to tackle major development issues, it is not always obvious to all that this is the best way forward. It is also not always easy to promote collaboration in particularly unsympathetic cultural, political or economic contexts. Obstacles to partnering can, therefore, take many forms:

SOURCE OF OBSTACLE	EXAMPLE
• PUBLIC	• Prevailing attitude of scepticism • Rigid / preconceived attitudes about specific sectors / partners • Inflated expectations of what is possible
• NEGATIVE SECTOR CHARACTERISTICIS (Actual or Perceived)	• Public sector: bureaucratic and intransigent • Business sector: single-minded and competitive • Third Sector: combative and territorial
• PERSONAL LIMITATIONS (of Individuals Leading the Partnerships)	• Inadequate partnering skills • Restricted internal / external authority • Too narrowly focussed role / job • Lack of belief in the effectiveness of partnering
• ORGANISATIONAL LIMITATIONS (of partner organisations)	• Conflicting priorities • Competiveness (within sector) • Intolerance for other sectors
• WIDER EXTERNAL CONSTRAINTS	• Local social / political / economic climate • Scale of challenge(s) / speed of change • Inability to access external resources

When too many obstacles are stacked against a partnership it may be best to abandon the idea and wait for better times. But most obstacles are surmountable with enough patience, commitment and effort. And even those that challenge the partnership to the point of break-down can be used to transform it into something better and stronger. Some argue (and many partnerships have experienced this as a reality) that a break-down or crisis can generate an unexpected and original response because it forces those involved to pay renewed attention and to see things more imaginatively. From this perspective an obstacle can, in fact, provide the partnership with an invaluable turning point.

Section Four: Key partnering challenges

As well as a commonly agreed goal, all partnerships face some key challenges and will need some guiding principles to address these effectively.
Each sector will have its own priorities and may struggle to accept the different priorities of others, but robust discussion may go a long way to reconciling apparent differences and to achieving compromise. Three core challenges that have recurred time and again in cross-sector partnerships in many different parts of the world are:

- Power Imbalance
- Hidden Agendas
- Winning at all costs

For partners to be able to work together they need to work with a number of agreed principles; Equity, Transparency and Mutual Benefit:

- Equity because it leads to Respect: for the added value each party brings
- Transparency because it leads to Trust: with partners more willing to innovate and take risks
- Mutual Benefit because it leads to Engagement: more likely to sustain and build relationships over time.

These principles should be worked out as part of the partnership-building process and agreed by all partners. If they provide the foundation upon which the partnership is built, then as things progress they continue to provide the 'cement' that holds the partnership together over time. Exploring these key values can be a useful starting point for discussion between potential partners prior to formalising the partnership, even if they are subsequently replaced by different values developed by the group. What is important is that all partners accept and agree to abide by whatever the group itself decides is appropriate.

Leadership Challenge:

Dealing with obstacles to partnering and ensuring that agreed values are continuously respected, constitute some of the major leadership challenges in a partnership. Other challenges are related to the day-to-day management tasks of the partnership's project and activities. Above all, what individuals operating in a partnership think about each other (do they feel connected to a common purpose?) and how they feel about the partnership (do they share a commitment to working together?) is of paramount importance. Partnering requires the right attitude and strong commitment just as much as the right structures, skills and actions. And the challenge of leadership within a partnership relates to all of these things.

It is important to remember Partnerships take a lot of effort from all those involved - in particular they often take a considerable investment of time to build the quality working relationships that underpin effective collaboration. The risk here is that sometimes this can lead to a focus on the partnership for its own sake rather than for its capacity to deliver a useful programme of work. Partnering is a mechanism for sustainable social, environmental and/or economic development - it is not an end in itself.

Section Five: Building Partnerships

Identifying Partners

The strongest partnerships are those that have drawn together the best set of partner organisations. At an early stage after 'scoping' a partnership, it is therefore critical to:

- Identify what types of partner organisations would add value
- Explore the range of options available either by building on existing and proven contacts or by seeking new ones
- Select the most appropriate partners and secure their active involvement

It is worth taking time over this and locating as much information as possible in order to arrive at an appropriate decision, including undertaking research to confirm the organisation's 'track record'. This can be done by reading their annual reports, looking at their web-site, undertaking a 'fact-finding' visit and /or asking others who know of the organisation's history for their views. A preliminary dialogue can then be arranged with a senior member of staff from the prospective partner organisation. This does not commit either side to a partnership - but it can provide a useful opportunity for both parties to assess at an early stage whether or not to proceed. At its best, it can address either party's concerns and clarify any potential conflicts of interest.
It may be necessary to explain the idea of partnership and to make a sound case for why this particular organisation would have something to contribute and how it would be able itself to benefit. It may take time to persuade enough people in the prospective partner organisation that this partnership will be worth the time and effort involved.

There may also be some value in organising special activities (workshops, site visits, exchanges) between several potential partner organisations to explore the idea of partnering more fully and collaboratively before any firm commitments are agreed. And it is a good idea to allocate some follow-up work to individuals to assess their capacity to actually turn a verbal commitment into action.

In some instances there may be little or no choice about partners. If it is important to work with a local government department, for example, then effort will need to be dedicated to persuading them to become actively involved by showing how they too can benefit (have their own goals met) by working in constructive collaboration with other sectors.
In all situations, however, it is important to be realistic about what the partnership is likely to be able to achieve and to be open about the challenges involved.

Equally it is important to remember no partner (including you and your organisation!) is perfect - what you are seeking is a partner organisation that will provide as good a match as you can find to enable the partnership to achieve its objectives. Essentially, you are looking for partners that have many of the appropriate attributes and the clear potential to grow more fully into the role of partner over time.

Appendix 1 – (P1) Partner Assessment Form should be used as a check-list of question to ask about any prospective partner. This information will be held on by the Strategy and Development Directorate on each partner formed within the Trust.

Assessing Risk and Rewards

Each partner needs to assess the risks and rewards that may arise from being involved in a cross-sector initiative. In fact, each partner will need to understand the potential risks and rewards of their fellow partner organisations almost as deeply as their own if they are to really commit themselves to genuine collaboration and the principle of 'mutual benefit'. While it is common for each partner to believe the risks to their organisation are greater than to any other, it is interesting to note that most categories of risk apply equally to all partners. Organisational risk for each of the sectors may arise in any of the following areas:

- **Reputational impact** - all organisations and institutions value their reputation and will rightly be concerned about whether that reputation can be damaged either by the fact of the partnership itself or by any fall-out in future should the partnership fail
- **Loss of autonomy** - working in collaboration inevitably means less independence for each organisation in the areas of joint work
- **Conflicts of interest** - whether at strategic or operational levels, partnership commitments can give rise to split loyalties and / or to feeling pushed to settle for uncomfortable compromise
- **Drain on resources** - partnerships typically require a heavy 'front end' investment (especially of time), in advance of any appropriate level of 'return'
- **Implementation challenges** - once a partnership is established and resources procured there will be a fresh set of commitments and other challenges for each partner organisation as the partnership moves into project implementation

Risk assessment is important and sometimes easily ignored in the enthusiasm for potential benefits from collaboration. Partners should encourage each other to undertake such assessments at an early stage of their collaboration and - wherever possible - find opportunities for addressing any concerns together as a partner group in an open and non-judgemental atmosphere.

But of course all partners anticipate that the rewards will outweigh the potential risks and here too there are many areas of benefit that may be common to all partners. These include:

- Professional development of key personnel
- Better access to information and different networks
- Greater 'reach'
- Improved operational efficiency
- More appropriate and effective products and services
- Greater innovation
- Enhanced credibility
- Increased access to resources

In addition to these common benefits, there are likely to be a range of further rewards that are specific to individual partners. Ideally these too would be acknowledged and shared at an early stage of the partnership to enable mutual appreciation of each other' specific priorities and to ensure that all partners understand completely the expectations each partner has from the partnership.

Resource Mapping

Prior to formalising a partnership, it is important for the partners to consider what resources will be needed for the agreed project or programme of work. Typically this is worked out in terms of funding requirement, but one of the real benefits of working cross-sectional is the potential access to a wide range of non-cash resources that the partners can bring to the partnership. Apart from the very tangible contributions this will yield, the process is also invaluable in building respect, understanding and teamwork between partners - all important pre-conditions of successful collaboration.

Appendix 2 – (P2) Resource Mapping tool should be used to support this process.

Securing Partner Commitment

Partnerships are little more than dialogues until those involved have made a tangible commitment to collaboration. Such a commitment is typically recorded in some form of Partnering Agreement or Memorandum of Understanding. The difference between an agreement and a contract is that an agreement is usually:

- Not legally binding
- Developed and agreed between the parties as equals
- Readily re-negotiable
- Open-ended (though sometimes a series of short-term agreements is more appropriate than an open-ended one)
- Entered into voluntarily

Effectively partners are creating an 'agreement to co-operate' and this may be all that they need to start working well together. At a later stage it may be necessary to create legally binding contracts in order to undertake a large-scale or complex project; to handle larger amounts of funding or to register as a new form of 'institution'. But a Partnering Agreement is usually the first step and in many instances it may be sufficient to confirm and consolidate the partnership medium to long-term.

Existing commitments include:

- North Staffs GP Federation.
- North Staffs Alliance Board Principles
- Addiction Dependency Solutions – Community Substance Misuse
- Rapt – Substance Misuse Prison (Stoke Heath)
- Mitie – Mental Health and Learning Disabilities Prisons (Whatton and Gartree).
- Addaction and BAC O'Connor – Community Substance Misuse
- Brighter Futures – Residential Detoxification and stabilisation for Substance Misuse

Interest-Based Negotiation

Securing agreement requires negotiation - but in a partnering arrangement this is not negotiation in the sense of a 'hard-nosed' business deal. What is required is the opportunity for the underlying interests of all parties to be drawn out and discussed in a purposeful way that aims at building consensus and complementarity out of diverse aspirations.

Partners going through this form of negotiation need to exercise considerable patience, tact and flexibility - but if just one individual demonstrates their willingness to do this others will follow their lead.

Interest-based negotiation is best served when those involved:

- Listen carefully
- Ask open (rather than closed) questions
- Summarise what has been said to see if they have understood correctly and Agree to disagree when necessary in order to move the discussion forward

Appendix 3 – (P3) formal versa informal structures tool should be used to support this process.

Governance and accountability

Even at an early stage, partnerships will need to have governance structures in place to ensure that decision-making, management and development arrangements are appropriate and operate effectively. Partners often find themselves accountable to a number of different 'stakeholders' including:

- Partnership project beneficiaries
- External (non-partner) donors(who will each have their own reporting requirements)
- Individual partner organisations (which will each have their own accountability and governance systems)
- Each other as partnering colleagues

It is likely that accountability is much more a driver of a partnership than is commonly recognised and for this reason, governance and accountability procedures need to be agreed and put at the heart of the Partnering Agreement.

To some extent, partners will have choices about what they do and how they do it. They may want to consider a range of options from completely informal arrangements (e.g., an ad hoc collection of individuals), to those that are highly formal (e.g., a new legally registered organisation with independent governance and accountability procedures) before choosing the most appropriate for their needs; but however informal a partnership, a Partnering Agreement is always necessary to avoid later misunderstandings and conflict. Most partnerships start informally and grow increasingly formalised over time as their programme of work becomes more complex and more resource intensive

Appendix 4 (P4) Stakeholder Mapping – should be used to flag up the key questions partners should ask to checkout their own and others intentions, attitudes and commitments to the partnership.

Appendix 5 – (P5) Partnering Agreements offers a simple template for initial partnering agreements. All agreements must be approved through the contracting department.

Section Seven: Managing the Partnering Process

Once a partnership is in place and a Partnering Agreement is signed, there are new challenges to face.

Partnering Roles

Many people will be involved in the partnership in its different phases, taking on a range of roles as required. It is important to recognise the differences and to understand which roles are needed, at what stage and for what purpose. It is equally important to ensure that the best person is allocated to a particular role. Roles may change often during the life of a partnership and partners may 'grow' into new roles as they become more experienced in partnering.

Role	Notes
Champion	An individual (or several individuals) who promote the partnership using their personal / professional reputation and / or role to give the partnership greater authority or profile
Broker/Intermediary	An individual selected (either from one of the partner organisations or from outside the partnership) to act on behalf of the partners to build and strengthen the partnership especially in its early stages
Manager	An individual appointed by the partnership on a paid basis to manage the partnership and / or the partnership project – especially once the partnership is established and is at the stage of project implementation
Facilitator	An individual (usually external to the partnership) appointed to manage a specific aspect of the partnering process (e.g. a meeting set up to deal with a particular issue facing the partner group).
Promoter	An individual, most likely a member of the partnership, who acts as an advocate for the partnership to others – a "champion" who argues the merits of the partnership on the basis of its track record rather than their own personal reputation.

Partners as Leaders

Partnerships raise interesting issues about leadership. What is the role of a 'leader' in a paradigm that is essentially collaborative and based on a notion of equity between the key players? Is collaboration between equals and the notion of strong leadership incompatible? How does leadership emerge and find expression in a partnership paradigm without undermining the principle of shared responsibility? How do partners carry the necessary leadership roles on behalf of the partnership within their organisation as well as the other way round?

Naturally, at different stages over the course of the partnering process one or other partner will take a more pro-active, more exposed and more public leadership role - and will be responsible and accountable to their partner colleagues for their actions. What kind of leadership style is chosen at a given moment largely depends on the type of partnership, the complexity of the current issue, the urgency of the required action, and the personalities of the people involved. Ideally, partnerships will include people with diverse leadership competencies, so that all the challenges the partnership faces over the course of its existence can be tackled by strong leadership, shared - as appropriate - between the different partners.

There are other leadership roles likely to be required during the partnering process including:

- Acting as 'guardian' of the partnership's mission (internally and externally) and being prepared to stand up for its values
- Coaching each other (directly and indirectly) in good partnering behaviour and partnership / project management
- Challenging each other's ways of looking at the world, of doing things, and of approaching difficult or contentious issues
- Empowering other members of the partnership to be pro-active, to innovate and to be allowed to make mistakes
- Creating hope and optimism when the process seems to be stuck.

In the early stages of the partnering process, it may be very useful to select an individual - either from one of the partner organisations or from outside the partnership - to act as broker or intermediary on behalf of the partners to build and strengthen the partnership. In his/her ability to combine a compelling vision with day-to-day practical implementation, the partnership broker epitomises a new style of leadership, operating as a catalyst for change by 'guiding' rather than 'directing'.

For any partnership to be effective and to deal successfully with challenges, it needs to be built on a strong foundation of individual commitment to partnering and on the conviction that a partnership approach is necessary to achieve the desired goal.

Partnering Skills

Successful partnering takes a range of skills - some may come naturally and others may need to be acquired – but those required for negotiation and mediation, facilitation and coaching of others, and the ability to work in teams, are crucial for all individuals who want to work together effectively and to achieve outstanding results.

They may find themselves negotiating agreements or mediating between different partners or facilitating an awkward meeting. They will almost certainly need to assimilate record and disseminate a lot of information. They may need to coach or capacity-build other partners, key players or project staff. Their remit on behalf of the partnership to deepen the involvement of their own organisation may well require skills in building institutional engagement or institutional-strengthening. Last, but not least, each partner will carry some responsibility for evaluating and reviewing the partnership and its impacts.

Of course, no one has all these skills in equal measure and in a partnership tasks can be distributed to take account of professional strengths and weaknesses. Individuals from each sector will bring different skills and professional competencies to the partnership and at an early stage tasks can be allocated to those who demonstrate that they are good at a particular kind of activity. But working in a partnership also offers the opportunity for individuals to develop their skills and to build their own capacities - indeed it is one of the aspects of partnering that makes it attractive as a new area of work for those ready for a change in their professional life.

During the process of professional skills and capacity development, individuals often discover that the partnering process has not only taken them on a professional journey, but also on a personal adventure of self-discovery and development.

Partnering skills, however, are most easily acquired by those who already have a level of self-awareness and self-management. In other words, effective partnering requires people who can read and control their own emotions, who are quite confident, and who embody qualities such as empathy, optimism, imagination, open-ness and modesty. Partnerships also crucially require partners who are good at taking initiative.

Appendix 6 – **(P6)** Partnering roles and skills questionnaire enables individuals involved in partnering to assess their own competencies and how they might develop their professional capacities to be even better partners in the future.

Appendix 7 – Enables you to consider the management and mandate options.

Good Partnering Practice

Using Language as a Partnership-Building Tool:

The way in which partners use language can make or break a partnership. Each sector is riddled with its own 'jargon' that can be completely alienating to those who simply don't understand it. At least, partners need to be sensitive to how they are using language - consciously and conscientiously speaking in language that is appropriate, clear and concise. A few words well selected and communicated is worth far more than a lot of words that are obscure and confusing. At best, well-chosen words can be used as tools to build consensus rather than allowing careless use of language to reinforce divisions. Some examples of useful distinctions in language can be drawn from partnership experience to date:

Difficult concepts partnership-building for partners' alternative:

Trust	Transparency
Profit	Benefit
Common objectives	Complementary objectives
Contract	Agreement
Business plan	Action plan
Funding	Resourcing
Sectoral priorities	Sectoral values
Committee	Focus / Working / Task group

Evaluation	Review
Market analysis	Scoping exercise
Consultation	Participation
Exit strategy	Moving on strategy

Distinctions are about how we understand and relate to the world. The ability to make distinctions is extremely important for effective partnering. It gives people greater freedom of thinking and acting, and leads to greater personal and professional success and satisfaction. A few more useful distinctions for individuals working in partnership are mentioned below:

Working from facts:

The ability to distinguish between facts and the interpretation of those facts is extremely important for any life situation. It can be detrimental to any partnership if people's action is based on their interpretation of events rather than on the evidence of the events themselves.

Break-through not Break-down:

Break-downs can occur during any stage of the partnering process. Indeed, break-downs are natural by-products of any challenging process. In spite of this, break-downs can be de-motivating and are often seen as insurmountable hindrances. A break-**down** is not necessarily a bad thing but rather the interruption of a process which is trying to achieve something different. The challenge for partners is to see a break-down as an opportunity for a break-through.

Requesting VS Complaining:

Making requests is a feature of all partnering. Usually people don't make enough requests, instead, they simply complain. But there is a big difference between the two. Complaints put people on the offensive. They are therefore disempowering and often lead to animosity rather than problem-solving. Requests, on the other hand, create a completely different situation. A request invites a response and action.

Creating Quality Partnering Conversations:

Partnerships are, at one level, networks of conversations. And the quality of the conversations between partners will largely determine the effectiveness of the partnership. In conversations partners create the future. They are jointly creating a vision of where they want to go. They discuss what they stand for, what each of them is accountable for, and create an understanding of how they can rely on each other. Conversations are one of the most powerful tools for building transparency and subsequently trust among partners. It is in conversation with each other that problems can be turned into opportunities and practical activity is generated.

Managing Meetings Well

Partnerships rely - especially in the early phases - on people meeting each other either on a one-to-one basis or as a partner group. Meetings easily become repetitive, tedious and un-productive if they are not highly focussed and well-managed. It is a particular skill to create a good meeting environment and to ensure that any meeting:

- Achieves its goals
- Keeps all parties actively engaged throughout
- Concludes all the items on the agenda
- Allocates follow-up tasks and timetables for completion
- Agrees decision-making procedures that will operate between meetings
- Alerts those present to issues to be addressed at a future meeting
- Summarises all decisions taken and, above all,
- Ends at the pre-agreed time

This comprehensive approach to meetings (whether formal or informal) will engender a sense that everyone's input is valued and their time constraints are respected.

At their best, meetings will also be able to operate as a partnership-building tool - through the way in which responsibilities for managing the meeting, such as chairing / facilitating / record-keeping, are shared. Other ways of making meetings meaningful and lively include:

- Allowing opportunities for social interaction
- Brainstorming a new and topical issue
- Inviting a very interesting guest speaker
- Sharing a relevant experience - perhaps a visit to a project or holding the meeting at the premises of a new partner organisation and seeing their work at first hand
- Using the meeting for enhancing learning, by ending with a review of what worked well and what could be improved in the way the participants interacted.

If attendance at partner meetings begins to drop off, it should be taken as a sign that the meetings are no longer engaging or important enough for partners to make the effort to come - some drastic measures should be taken!

Appendix 8 – **(P8)** Guidelines for Partnering Conversations explores in more detail the importance of creative conversations as a basis for good partnerships.

Keeping Records:

Keeping good records of meetings and of the partnership's progress is an art - it is a bad idea to give the role of record-keeper to the least experienced or most junior person available. The great challenge is whether to record everything or simply the bare minimum. Each partnership will have to decide what it requires but some basic considerations include:

- Deciding in advance who needs what kind of information and in what form and then adapting the information appropriately for different purposes
- Reducing notes from meetings to a) decisions b) areas needing further discussion c) agreed action points
- Keeping a lively record of the partnership's 'history' (including illustrations / photographs) so that newcomers to the partnership will be able to understand what has been achieved and how
- Making as many of the written records as openly available as possible so that the partnership is recognised as efficient and transparent

Creating A 'Learning' Culture:

Most of those involved in partnerships agree that the partnerships that endure are ones that are most open to learning from their own and other's mistakes. Every partnership can be seen as a form of 'action learning' where the partners are learning by doing. To see all partnership activity as a form of research (in addition to being a delivery mechanism for achieving a task) is to give partners the opportunity for deepening and enhancing their knowledge, skills and professional practice. True collaboration transforms the individuals that engage in it consciously: partners' help each other grow personally and professionally while accomplishing the objectives of the partnership.

In addition, every partnership will have much to teach others who aspire to creating collaborative approaches to sustainable development in their own areas of work. Many partnerships - even those that seem to be well established - have benefited from being part of a 'learning network' where experiences, good and bad, are shared.

Setting Ground Rules:

Some simple 'base-line' rules agreed between partners can be very helpful when the partnership is new and different partners feel the need to assert themselves and their 'agendas' at the expense of giving space to others. Some partners, from the business and public sector especially, may find it strange to set rules for behaviour whereas their third sector colleagues are likely to think this quite natural and acceptable (an early encounter with sectoral diversity!).

Ground rules might include:

- Active listening
- Not interrupting
- Speaking briefly and to the point
- Dealing with facts not rumour
- Respecting those not present

Typically, in the early phases partners may need to remind each other about the agreed ground rules - it can take a while to break behaviour patterns! But over time the partnership will naturally adopt these new methods and the ground rules are simply there in the background as a gentle reminder. Newcomers to the partnership then quickly adapt to a modus operandi that they see working well. Ground rules can even be written into the Partnering Agreement.

Partnerships work well when:

- There are clear decision-making protocols / procedures agreed and in place
- Most day-to-day decisions are carried by individuals or small groups on behalf of the partnership
- Only major decisions (for example, of policy or expenditure) are brought to the partners as a whole group
- There is regular, easily accessible and succinct information-sharing between the partner

Section Eight: Delivering Successful Projects

Managing the Transition

Once the partnership is established and a Partnering Agreement in place, the partners will turn their attention to the development of their proposed project / programme of work or joint activities. This is the partnership getting down to business and marks a significant transition from a focus on partnership building to project development and implementation. Some partners will be far more comfortable with this phase because they like to get on with practical tasks and may have found the earlier phases irksome. Others will be anxious that the partnership is not yet robust enough to move from talk to action. As with all projects, considerable attention will need to be paid to working out the details and a clear Action Plan is important to give a framework and milestones that all can agree on

Keeping to the Task:

The most successful partnerships are those that are highly task-focussed - where all partners are actively engaged in delivering tangible and practical results. At this point it may be that a Co-ordinator or a Manager needs to be appointed to manage the project on behalf of the partners who are unlikely to have the time to do this on a day-to-day basis. One person certainly needs to have an overview of the delivery process and to ensure that project staff and partners are fulfilling their commitments well and on time. It is a measure of how far the partners have grown to trust each other if they can let go of the day-to-day details confident that the partnership-initiated programme of work is operating smoothly. Appendix 9 – **(P9)** Action Planning Template.

Reporting, Reviewing and Revising:

Once the project or programme of work is up and running, the partners may decide to meet less frequently and, when they do meet, operate more as a review panel. A regular cycle of reporting will need to be in place to ensure the partners are informed of progress (and challenges). These reports, written or verbal, can form the basis of reviews both of the project and the partnership itself. The partners may want to review their own Partnering Agreement (say once a year) and alter it if necessary to reflect new priorities and aspirations.

Appendix 10 – (P10) Partnership Review template suggests a range of ways to approach partnership reviews depending on what the aims of the review are.

Section Nine: Sustaining Partnerships

Securing Greater Engagement

Partners will always need to work hard to secure greater engagement from partner organisations and often also from other non-partner organisations. With regard to partner organisations - it is not uncommon for a partnership to be quite peripheral to the very organisations in whose name it is operating.

Why might this matter? Failure to engage partner organisations can mean (at best) a less vigorous and comprehensive involvement from the organisation and (at worst) the collapse of the partner relationship if one or two key players move on. It may well be that the active involvement of partner organisations is far more important than is generally realised.

And what of other non-partner institutions?

There are several other institutions or agencies for whom the partnership may be important and who therefore need to understand and become more engaged with the partners in a number of ways. These include:

- INSTITUTIONS OPERATING AT STRATEGIC / POLICY LEVELS (e.g., government departments, political parties, international agencies)

- ORGANISATIONS AT OPERATIONAL LEVELS (e.g., other companies, public sector agencies and third sector organisations)

Partners will need to assess how important each of these different relationships is, either in terms of enabling the partnership to have more impact, or in terms of being influenced by the partnership in the way they operate.

Building Institutional Capacity:

How do partners help to build the capacity of those institutions involved? It is a question of helping institutions to internalise the partnership's lessons. Sometimes it is simply a matter of time, but more often it is a case of combating active or passive resistance. There are several different approaches partners can employ to build greater institutional capacity in the institutions and organisations involved directly or indirectly in the partnership. These can include bringing their experiences of cross-sector collaboration into the institutions in order to build:

Organisational Culture Change	• Demonstrating that other organisations do things differently (and sometimes more effectively) • Providing evidence of the value of an organisational 'learning' culture • Promoting more values-based organisational approaches • Persuading managers that more participatory approaches can work efficiently
Human Resource Development	• Demonstrating that cross-sector collaboration can improve professional performance • Engaging employees in practical ways in the partnership initiative(s) • Persuading managers that the organisation can benefit from their employees involvement in cross-sector collaboration
Dynamic Networks	• Demonstrating the value to the organisation of these new relationships and the diversity of their reach and influence • Illustrating the potential for new relationships / ideas / areas of work • Bringing key others into the organisation in creative and useful ways
Better Communication	• Endorsing the organisation through good publicity for the partnership's achievements • Using internal communications systems to keep people engaged and informed • Creating special events for other people to illustrate the benefits of the partnership (especially to organisational sceptics) • Providing opportunities
Opportunities for getting 'Out of the Box'	• Providing opportunities for key players to have a direct, first-hand experience of the partnership's work • Setting up and managing encounters between key people who do not usually meet (and may have a record of mutual dislike or suspicion) • Creating new 'experiential learning' opportunities (e.g., job swaps, secondments, internships, partnering workshops)

In some situations it may be appropriate to create a completely new kind of institution to take over the role of the partners medium to long-term as described in **Appendix 11** – **(P11)** seven different types of partnership 'institution' that have evolved over the past decade - formalising to a greater or lesser extent the different models of cross-sector engagement outlined in **Appendix 3 (P3)**

So partners need to address whether their efforts are best spent engaging institutions more effectively; building the capacity of existing institutions or creating a new institutional structure. In fact, a partnership may - over time - need to do all three things.

And - ultimately - it may become more a question of institutional reform.

We turn to a cross-sector partnership to create an approach to sustainable development that will be more innovative and far-reaching in social, economic and / or environmental terms than single sector approaches. But if the partnership fails to challenge and ultimately change entrenched institutional / sectoral behaviour then it is likely that its impacts will be merely transitory or superficial.

At some stage it will become clear that partnerships have a potentially major role to play in, directly or indirectly, reviewing and revising the central values, roles and primary activities of the different sectors - whether public, private or third sector.

Institutional reform may be a more important outcome of the partnership than any other. In other words, if the partnership leads to a government department functioning more creatively or efficiently; or to a corporation contributing more rigorously and systematically to sustainable development in all aspects of its operations; or to having much larger-scale and more credible impact as an organisation then the 'outcomes' of the partnership will have become significantly more substantial that its 'outputs'.

The Alliance could very well evolve along these lines.

Section Ten: Successful Partnering

Defining Success

What does a successful partnership look like? Who defines 'success'? How is it measured? Partnering and partnership-based projects are invariably complex and can therefore be very challenging to evaluate. Outputs, outcomes and impacts are usually diverse, sometimes quite subtle and often unexpected. We will address the specific issue of assessing the partnership, we assume that the projects will be evaluated in the way that all development projects are - according to criteria laid down by partners at the beginning. Our primary concern here is the effectiveness of the partnership from the perspective of the partnering organisations.

Partners are likely to need to measure or assess three things. These are:

- Impacts of their partnership project on society
- Value of the partnership to the individual partner organisations
- Actual costs and benefits of the partnership approach

Only by looking at all three will it be possible to evaluate whether the:

- Partnership has been effective in achieving its aims
- Partners have truly benefited from their involvement
- Partnership approach was the best / most appropriate choice

Collecting the information on which to make a judgement about the partnership's effectiveness is in itself a challenging process. Most partnerships that have reached the stage of being evaluated tend to distinguish between measuring the impacts of the partnership projects and assessing the value of the partnership to the partner organisations.

It is reasonable to expect that the projects and activities can be evaluated using fairly conventional methods based on outputs and statistics, but assessing the value of the partnership itself demands a somewhat different approach. To assess a collaborative and participatory venture requires a collaborative and participatory research process, if the integrity of the partnership itself is to be respected and maintained.

So what would a successful partnership look like? A successful partnership might have any, several or all of the following characteristics:

- **The partnership is doing what it set out to do -** the project or programme of activities has achieved pre-agreed objectives
- **The partnership is having impact beyond its immediate stakeholder group -** there is some recognition of achievement from project beneficiaries, key others and / or the wider community
- **The partnership is sustainable and self-managing –** either through the continuing engagement of partner organisations or through a self-sustaining mechanism that has replaced the partnership, enabling partners to move on to other things
- **The partnership has had 'added value' in which individual partners have gained significant benefits -** partner organisations have established new ways of working with other sectors and / or have had their own systems and operational styles improved.

The important thing here is that, at an early stage of their partnership, partners agree on a number of indicators (both tangible 'deliverables' and broader 'process' indicators) and use these as a basis for tracking the effectiveness of their partnership over time. Ideally, indicators should cover partner-specific as well as shared goals.

Sharing Good Experiences

If your partnership has been successful and productive then spread the word - but make sure you wait until you have a convincing and real story to tell.

When you do decide to 'go public' tell the story well **Appendix 12 (P12)** will support and make sure you select the best 'story-tellers' from your partnership's network.
Who is it that might be interested in whether or not the partnership has been successful?

Appendix 13 – (P13) Case Study Template provides a simple format for collecting case study material with a view to disseminating the experience.

There are a number of potential 'internal' and 'external' audiences for this information:

Internal Audiences:

- Partnership project beneficiaries
- Partners and staff involved in the partnership
- Their respective line managers
- Senior management within the partner organisations
- Selected departments within the partner organisations
- Operational staff facing similar challenges elsewhere

External Audiences:

- Policy makers
- Bi-lateral regional or multi-lateral agencies
- Relevant 'umbrella' organisations
- Media / general public
- Key others – including those who might join the partnership or who might develop their own partnership inspired by this one

It is important to impart information in the right way for the different audiences. The public will want a story with a personal dimension. Policy makers will like statistics. Potential partners will want to know how current partners have benefited from their involvement. A successful partnership will understand who needs what kind of information and will find methods for communicating to different audiences in many different ways. **Appendix 14 – (P14) Communication Check-list** will provide some suggestions about potential audiences, communications option and messages for your partnering stories.

Collaboration in a Competitive World

Partnerships offer a real alternative approach to sustainable development by substituting collaboration for competition.

No partnership is ever easy, comfortable, secure, safe, quick or cheap. But with a lot of good management, some good will and a little determination, cross-sector partnerships for sustainable development can work well and may achieve a great deal more than single sector approaches to the same issue.

Finally, there are just three 'golden rules' that should help to keep partnering on track when the going gets tough…

Golden Rule 1 – Build on Shared Values (because successful partnerships are values-driven)

Golden Rule 2 - Be Creative (because very partnership is unique).

Golden Rule 3 - Be Courageous (because all partnerships involve risk)

Section Eleven: Trust Oversight

The resources required to support successful partnership working as described in the partnering phased process (Section One) is significant and crosses a number of our directorates both clinically and corporately.

To ensure we have a level of understanding and decisions on the best use of our resources to support partnership development the Business Development Committee will provide the governance and will actively challenge, monitor and review throughout the business year by receiving regular reports and updates of our partnership activity.

Similar to the Business Planning Cycle we feel partnerships are intrinsic to our business plans and will therefore include dedicated time in ensuring partnerships are reflected in our plans.

Appendix 1 - (P1) – Partner Assessment Form

A 'prompter' enabling those creating a partnership to ask systematic questions of any potential partner to ensure a good fit with the goals / needs of the partnership. This tool should be used as a starting point for exploring a potential relationship by providing a basis for frank discussions with the key players involved at both senior and operational levels. It is designed to raise appropriate questions - not to provide definitive 'screening'.

Does the Prospective Partner Organisation have…	**Current Status** **A review of:** • **What you know so far** • **The reliability of our sources of information** • **Whether you have enough information upon which to base a decision**	**Further Actions** **A note for:** • **Further information required** • **Remaining concerns** • **Timetable and criteria for making a decision about suitability**
1. A good track Record		
2. Reasonable standing / respect within their own sector		
3. Reasonable standing / respect from other sector and other key players?		
4. Wide-ranging and useful contacts they are willing to share?		
5. Access to relevant information / resources / experience?		
6. Skills and competencies that complement those of your organisation and / or other partners?		
7. Sound management and governance structures?		
8. A record of financial stability and reliability?		
9. A stable staff group?		
10. Sticking power when things get tough?		
Are the Staff in the Prospective Partner Organisations		
11. Experienced and reliable in the development of projects?		
12. Successful at mobilising and managing resources?		
13. Good communicators and team players?		

Appendix 2 – (P2) – Building a Resource Map

All sectors have human, technical and knowledge resources of one kind or another. They are often very different and highly complementary and when pooled they can provide much of the resource needed for the planned activities. It is important evidence resource contributions from partners - and many non-cash contributions can be given a financial value as 'matched funding'. Money should therefore always be seen as a last rather than a first requirement!

Appendix 3 – (P3) – Informal VS Formal Structures

TYPE OF STRUCTURE	ADVANTAGES	DISADVANTAGES
INFORMAL		
WORKING GROUP A small number of people who agree to explore a partnership initiative on behalf of a wider group	• Greater freedom to explore ideas / intentions and to build newre lationships	• Not being taken seriously enough by external agencies or other key players
FOCUS GROUP A small number of people who agree to take forward one specific aspect of a partnership's development	• Cheaper – the major resource demand is time rather than cash	• Too easily neglected when those involved are diverted by their other priorities
TASK GROUP Mandated by a larger group to complete a specific task (e.g., procure resources; manage a registration process)	• Non-bureaucratic	• Not structured enough for the co-ordination and management of resources
MORE FORMAL		
NETWORK A communications arrangement linking people who are engaged in similar activities	• Developing a greater profile	• Needs greater co-ordination
FORUM A meeting place for open debate and new ideas	• Providing an 'umbrella' for a wide range of loosely linked activities	• Requires more agreement on policies and operational principles
SOCIETY A membership organisation with a dedicated focus of activity	• Building commitment from a wider constituency	• More complex decision-making processes
FORMAL		
ASSOCIATION A more formal, registered version of a society	• Increased authority and capacity to exert influence	• Subject to legislative restrictions on action
FOUNDATION An association that mobilises and disseminates resources	• More focused activities and greater likelihood of sustainability	• Tendency to become over-bureaucratic and impersonal
AGENCY An independent organisation established to act on behalf of others	• Enhanced ability to mobilise and manage large-scale resources	• Increasingly high administrative (as opposed to project) costs

Appendix 4 – (P4) – Stakeholder Mapping

The stakeholder mapping exercise provides a systematic approach to identifying all interested / interesting parties and begins to help to distinguish the roles each of these might take in relation to a new partnership project. Initially, the information available will be limited and the mappings will need to be adjusted as more intelligence comes in.

Stakeholders can be defined as:

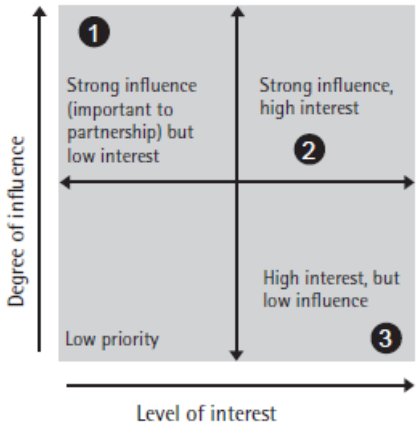
- those whose interests are affected by the issue or those whose activities strongly affect the issue;
- those who possess resources of all kinds (financial, influence, expertise) needed for strategy formulation and implementation;
- those who control relevant implementation
-

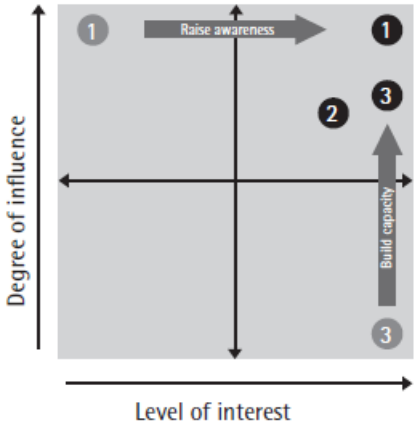
Mapping 1: Initial sweep
In the first stage, as many organisations and individuals from across the sectors are identified and mapped in a grid similar to that below, with their specific interest detailed in the relevant box:

Stakeholder	Affecting	Affected by	Resources	Implementation
Name 1				
Name 2				
Name 3				

Mapping 2: Influence against interest:

Stakeholders are mapped within a 'Boston Square' to capture the degree to which each stakeholder has influence over the relevant issues / possible partnership objectives, and their level of interest. Ideal partners will have both a strong influence over and high interest in the objectives of the partnership. However, it is rarely so clear cut. By classifying stakeholders in this way, one can determine cases where: 1) significant awareness-raising is required to turn a highly-influential but low-interest stakeholder into an interested potential partner or 2) significant capacity development is required to turn a stakeholder with high interest but low influence into a stronger potential partner.





Mapping 3: Roles and degree of engagement

Multiple different organisations and individuals might play roles in a partnership project, but not necessarily as partners. This mapping of stakeholders begins to outline the role and level of engagement of the various stakeholders. As the partnership is developed and relationships are built, stakeholders might well change their roles.

Role	Stakeholder
Partner	
Contractor	
Influencer / Champion	
Disseminator	
Funder	
Informer / consultation	
Knowledge provider	
Regulator	
Beneficiary	
Other	

Appendix 5 – (P5) – Sample Partnering Agreement

There are a number of versions of agreements within the Trust to be discussed with the Contracts Team

1.0 PARTNER ORGANISATIONS

1.1 Partner A
Contact details
Contact person

1.2 Partner B
Contact details
Contact person

1.3 Partner C
Contact details
Contact person

2.0 STATEMENT OF INTENT

2.1 We, the undersigned, acknowledge a common commitment to / concern About...

2.2 By working together as partners, we see the added value each of us can bring to fulfil this commitment / address this concern

2.3 Specifically we expect each partner to contribute to the project in the following way(s):
Partner A...
Partner B...
Partner C...
All partners...

3.0 STRUCTURES AND PROCEDURES

3.1 Partner roles and responsibilities...

3.2 Co-ordination and administration...

3.3 Working groups / committee(s) / advisory group(s)...

3.4 Decision-making processes...

3.5 Accountability arrangements...

4.0 RESOURCES

4.1 We will provide the following resources to
a) the partnership and
b) the project...

5.0 AUDITS / REVIEWS / REVISIONS

5.1 We agree to make available all information relevant to this partnership to partners as necessary

5.2 We agree to review the partnership every ... months

5.3 An independent audit of the financial arrangements of the partnership (and any projects resulting from the partnership) will be undertaken on an annual basis

5.4 We agree to make adjustments to the partnership (including re-writing this agreement) should either a review or an audit indicate that this is necessary for the partnership to achieve its objectives

6.0 CAVEATS

6.1 This agreement does not permit the use of copyright materials (including logos) or the dissemination of confidential information to any third party without the written permission of the partner(s) concerned

6.2 This agreement does not bind partner organisations or their staff / officers to any financial or other liability without further formal documentation

SIGNED

_____ on behalf of Partner A

_____ on behalf of Partner B

_____ on behalf of Partner C

DATE _____

PLACE _____

Appendix 6 – (P6) – Partnering Roles and Skills Questionnaire

This questionnaire is designed for individuals involved in partnerships to assess their own partnering skills – in order to build confidence about skills strengths and strategies to address any skills weaknesses. It can be used by the partners as a group to build a picture of the competencies within the partnership and to identify which individual is best equipped to undertake which tasks / roles. It can also be a tool for enabling partners to recognise when specific skills might need to be brought in from outside the partnership. Skills can be developed and roles can change over the lifetime of a partnership. The more each individual can develop their professional capacities and take on new tasks, the more they will feel engaged and valued within the partnership. Partnerships can work well because they provide new opportunities and allow individuals to get 'out of the box' of their day-to-day operational style.

ROLES ASSESSMENT (1 = low, 5 = high)

Key Roles in Partnerships	Assessment of current capacity in this area	Strategy for improvement (if necessary)
Partnership / project 'championship'	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	
Awareness raising	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	
Co-ordination / Administration	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	
Relationship management	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	
Resource mobilisation	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	
Project / programme planning	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	
Project / programme management	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	
Communication	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	
Monitoring	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	
Other (specify)	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	

SKILL ASSESSMENT (1 = low, 5 = high)

Key Roles in Partnerships	Assessment of current capacity in this area	Strategy for improvement (if necessary)
Negotiation	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	
Mediation	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	
Facilitation	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	
Synthesising information	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	
Coaching / capacity-building	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	
Institutional engagement	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	
Institution-strengthening	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	
Evaluating / reviewing	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	
Other (specify)	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	

Appendix 7 – (P7) – Management and Mandate Options

Appendix 8 – (P8) – Guidelines for Partnering Conversations

Conversation for Generating Possibility

A Conversation for Generating Possibility is a conversation to envisage the future as a rich scenario of inspiring possibilities. It is about sharing creative and imaginative ideas. Questions of feasibility are of no concern at this stage. Rather, a Conversation for Possibility is intended to bring out intuitive and aspirational views of how the best possible future might appear.

A Conversation for Generating Possibility will be most appropriate during the early stages of the Partnering Process, when partners are working together to create a vision, but it can also be applied later on as the partnership is being renewed. It should be conducted as a brain-storming session around a set of specific strategic and open questions that encourage reflection and imagination, and do not elicit simple 'yes' and 'no' answers.

A Conversation for Possibility should continue for at least 15 minutes, although it could last up to an hour. Examples of suitable 'open' questions include:

What would a break-through in ... (insert theme or desired outcome) mean?
What would a break-through in ... (insert theme or desired outcome) make possible?
What are you / we building with this initiative?

Conversation for Generating Opportunity

A Conversation for Opportunity is concerned with generating concrete joint commitment for break-through action. It is a conversation about shared accountabilities. It is through such a conversation that partners arrive at agreement about which of the possibilities that have been created earlier constitute concrete opportunities for the future and could be realistically pursued by the partners.

A Conversation for Opportunity invites people to answer the following question:

What can you declare that at the end of this initiative would be a break-through?

Once this question has been discussed for at least fifteen minutes, partners can move on to develop a shared Partnership Commitment Statement (not to be confused with a Partnering Agreement). The Statement might begin with an opening statement such as:

We are / Our partnership is… committed to ...

Each partner is asked to write down what he/she thinks that the commitment statement should be. This is then shared with the other partners and the strengths (not the weaknesses) of each statement are discussed. The group will choose the statement they consider best to work on further and then continue to amend it together as a group until it adequately reflects the commitment of all partners, and everybody is fully satisfied.

Conversation for Action

A Conversation for Generating Action can be held at all stages of the Partnering Process, whenever joint or individual action is required. It helps to clarify individual responsibilities and to create a common understanding of who is accountable for what. It also helps to take the Partnering Process a step further, turning possibilities and opportunities into concrete activities. The key opening question might be: *Who will take what actions, by when?*

It is recommended that written notes are kept of the individual commitments made and that these are copied to each partner. This will enable the partners to hold each other accountable later on.

Conversation for Completion

Being ‘complete’ with something means being ‘whole’ with it. Completion not only applies when terminating a certain process, but it is equally important that partnerships are complete on an on-going basis. This helps to promote understanding and create alignment between the partners. A Conversation for Completion can therefore be conducted at all stages of the Partnering Process. Partners can usefully ask themselves (and each other) the following questions and undertake further activities based on the answers given:

What is left to accomplish in order for us to say that the partnership has been successful or is finished?

What actions do we need to take to achieve this?

Who will do what, by when?

What promises or commitments have we made but not yet delivered on?

Who will do what actions, by when, to complete these?

Who wants/needs to be apprised of the status/outcome of the partnership?

What will we do to communicate this to them?

Who might be angry, annoyed, irritated or disappointed with us or with our activities?

How will we complete this with them?

Who has contributed to the partnership and its activities?

How will we acknowledge them and their contribution?

What else will we do to be complete (i.e., whole) with our initiative?

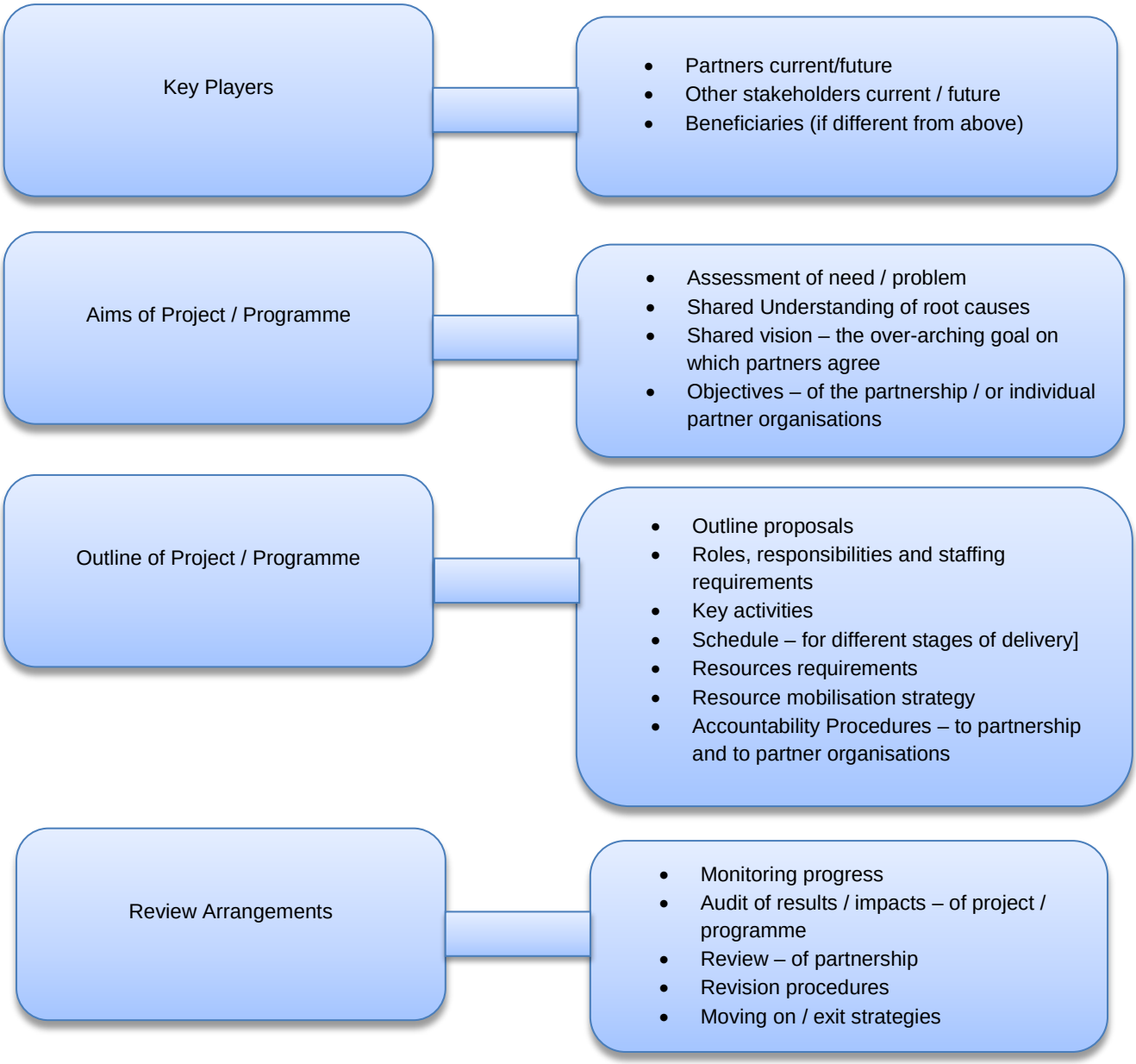
Appendix 9 – (P9) – Action Planning

Action planning (sometimes known as Development Planning or Business Planning) is a familiar process to most professionals and there are many ways of approaching the task. In a partnership it is particularly important to remember that:

- All partners must be involved in the action planning process to feel a sense of commitment and 'ownership'
- Each individual will bring different skills and expectations to the task - managing this diversity may be time consuming but - at its best - it will add considerable value
- Each individual will need to consider the implications of the action plan for their own organisation and for their organisation's own planning process and priorities.

Action planning represents a significant point in a partnership - where the partnership relationship has been established and the focus of attention is moving from building the partnership to designing and delivering a collaborative programme of work. It is therefore vital it is done well or the partnership itself will be undermined.

Sample Action Planning Framework



Appendix 10 – (P10) – Partnership Review Template

This is designed as a tool for reviewing the partnership to assess whether it is achieving the goals / expectations of the individual partner organisations. It is essentially a 'health check' of the partnership rather than a more formal audit of the project or programme the partners have undertaken.

An assertive external reviewer who imposes their opinions can be highly destructive to partner relationships. Partners are likely to know best what is - and is not - working from their perspective. They are most likely to be honest in expressing their views and more open to the possibility of change when they feel 'safe'. A partnership review should therefore be seen as an internal process where any external reviewer is appointed to operate as a facilitator rather than an assessor.

AIMS	POSSIBLE ACTIVITIES
To offer partners an opportunity to reflect on the value of the partnership from their own organisation's perspective	• **1:1 conversations** with key players from each partner organisation undertaken by a nominated 'reviewer' that are then written up as a narrative for partners to discuss • **Group workshop** – run separately within each partner organisation – undertaking a SWOT analysis (exploring Strengths, Weaknesses, Opportunities and Threats in the partnership) which are then 'matched' across the different partner organisations • **Meetings in pairs** (2 individuals from different partner organisations meeting as 'critical friends') for a frank exchange of views that are then shared at a partners' meeting / workshop
To assess what – if any – changes would improve the effectiveness of the partnership	• **Change of focus** – can be explored through a 'futures workshop' or a 'scenario planning exercise' where partners are invited to do some 'blue skies' thinking • **Re-definition of roles and responsibilities** – partners invited to undertake a roles / skills re-assessment and re-assigning responsibilities between partners to tackle new tasks differently • **Institutionalisation** – engaging a larger number of people from the partner organisations in the partnership in new ways
To agree as a group to any revisions to the partnership agreement to take account of the findings of the review process	• **Re-writing the Partnering Agreement** to reflect new goals; changes of focus or new activities • **Expanding the partnership** – either by incorporating new partners or by publicising its activities and achievements and supporting others in creating similar initiatives • **Developing an exit or moving on strategy** – for the project, or the partnership, or one or more of the partner organisations. Moving on can mean 'job well done' it does not have to be interpreted as failure. A healthy partnership copes with closure / changes / departures in a creative and positive way

Appendix 11 – (P11) – Building New Partnership Institutions

TYPE	CHARACTERISTICS	STRENGTHS
LOCAL ALLIANCE	Partners from all main sectors given equity of involvement and decision-making responsibility within an independent formal structure operating locally	• Strong sense of local ownership and self-determination • Builds and institutionalises local collaboration
GLOBAL ALLIANCE	As above but operating internationally	• Economies of scale • Builds strategic links between players who together bring power, resources and influence
DISPERSED	Partners have agreed a common aim but they rarely meet face-to-face. Instead they operate by different partners (or sub-groups of partners) being mandated to complete tasks on behalf of the partnership to which they are ultimately accountable	• Maximum flexibility • Freedom of operation and self-determination for partners
TEMPORARY	The partnership structure is designed for obsolescence. It is time-specific and therefore dispensed with once the agreed programme of work is completed	• Intensity of involvement • Focus on immediate and visible results
CONSULTATIVE	The 'task' of the partnership institution is to provide advice and / or a sounding board for new ideas rather than to develop and implement a project	• Built into the political process • Authority drawn from consensus rather than power base
INTERMEDIARY	An organisation operating between and on behalf of partners and many other players. Essentially it supports the development of a number of independent partnership initiatives rather than being a partnership itself	• A highly 'empowering' model • Helps to build a 'culture' of collaboration • Creates appropriate and flexible support structures
LEARNING	The partnership is established with the primary goal of learning and sharing information arising from partnership experiences	• Flexible • Building knowledge and capacity as a primary aim

Appendix 12 – (P12) –Telling the Story

Once upon a time…

Partnerships start out as stories inside our heads, and end up as stories out in the world. In the voyage from the ideal to the real, we begin with the imagination. While we imaginatively conceive an initiative, we must also be able to share the story in a way that engenders lively interest and enthusiasm in others.

Sharing our experience without recourse to imagination can make partnering sound like a painting-by-numbers exercise. The process is reduced to a series of strategic manoeuvrings, to statistical descriptions, to factual analysis. While such stories have their place, they offer little by way of inspiration. To be truly moved, we need to know that something meaningful is at stake and that in trying to bring a vision to life we run real risks.

To tell the story of a partnership is to recount an adventure, a quest to achieve something both unique and universal; Unique because no one has made this particular journey before; Universal because every partnership sets sail upon an unknown sea, seeking a destination that is far from safe or certain. There is indeed a prize to be won, but there is also the very real danger that the partnership will founder long before the end is reached.

In communicating this journey it is important not to skip over the obstacles faced - be they half-submerged problems that surfaced early on, stone-throwing cynics who argued for a less co-operative approach, or monstrous errors of judgement which had to be faced and worked through. The most engaging stories maintain a tension between good and evil, between the possibility of success and the possibility of failure. Ensure that mistakes as much as successes are allowed to appear as fully-fledged characters. We – the audience - desperately want to hear about the near misses, the last minute cliff-hanging efforts to secure agreement.

If there is one key piece of advice, it is this: allow for the heroic. It is easy to be modest; to discount what has been achieved. Cross-Sector Partnerships, however, are far from commonplace. True partnerships are the stuff of legends. Think of the Fellowship of the Ring. In making a conscious choice to operate as a partnership, to overcome barriers, to do what it takes to achieve the goal – all this is still a rarity, unusual, exceptional

.

This doesn't mean using flowery language or overly dramatic phrases. It does mean not reducing achievements to just the facts. Allow us to marvel at what's been accomplished. Equally, help us to see that partnership is truly an ideal worth aspiring to.

In the end, having stayed the course fought the dragons, sailed triumphantly home; no-one is ever the same again. The experience has left its mark. Confronting doubts and working through the difficulties has brought new learning, new strength and new understanding. In practising the art and craft of partnering we have transformed our organisations and ourselves - in other words - our world.

This is always a story worth telling.

Appendix 13 – (P13) –Case Study Template

In conducting interviews with key people in order to access information don't forget to:

- Tell the interviewee(s) who you are and why you are asking these questions
- Use 'open' rather than 'closed' questions – open questions invite a description; closed questions invite a 'yes' or 'no' response
- Be an active listener – listen attentively and don't be mentally preparing your next question
- Write your notes during a break in conversation so that you are looking at the interviewee(s) and not at your notebook while they are speaking
- Feedback what you have heard to make sure you have understood correctly and to enable the interviewee(s) to add anything they may have forgotten.

INFORMATION	Name of initiative, partner details, other stakeholder details, key dates, location
HISTORY	What key issues led to the partnership initiative? Who started it? What were the agreed core values / values underpinning it? What were its aims and objectives? What were the first steps?
ACTIVITIES	What has the partnership undertaken? How were activities managed? What have been the outcomes and outputs to date? What more is anticipated?
ROLES	Who were the key individuals involved and what were their roles? How did they change over time?
ACCOUNTABILITY	In what ways is the initiative accountable? How is its impact / effectiveness measures assessed? How is the partnership reviewed? What is the process for making key decisions – including changes?
CHALLENGES	What have been the main challenges encountered during the partnership's lifetime? How have they been dealt with? What challenges remain?
RESOURCES	How is the initiative resourced (cash and non-cash in-puts)? Is there funding from any external source(s)? If so, from where and what proportion of the budget does this represent? To what extent are resources renewable and / or is the initiative sustainable? Now? At some stage in the future?
THE FUTURE	What are the immediate development plans? Are there longer-term plans in place? Do partners have a 'moving on' strategy? Does the initiative have a finite term of operation? What time-scale is envisaged for moving on or termination strategies?
ACHIEVEMENTS	What are the main achievements?
CONTACT DETAILS	Who can be contacted for further information and how?

Appendix 14 – (P14) –Communication Check List

It may be important for a number of reasons to publicise a partnership and / or its activities and these reasons need to be taken into account, but 'going public' too soon can put a lot of pressure on a partnership and can have some unexpectedly negative impacts. Partners need to assess the risks and benefits of publicising their work and ensure that all partners concur with and adhere to an agreed strategy.

POTENTIAL AUDIENCES	COMMUNICATIONS OPTIONS	POTENTIAL MESSAGES
Partners ☐	Conversations ☐	"We have learnt the value of working collaboratively – you should try it!" ☐
Project staff ☐	Public meetings ☐	
Other staff in partner organisations ☐	Workshops ☐	"We have tackled a major issue and been more effective than other approaches that have been tried in the past " ☐
Project stakeholders ☐	Capacity-building activities ☐	
Project beneficiaries ☐	High profile events ☐	
Community group(s) ☐	Site visits ☐	"Our evidence demonstrates that this intervention has had real and positive impacts on those who need it most " ☐
Non-partner donors ☐	Print media ☐	
Public figures ☐	Radio / TV ☐	"It is all a question of leadership and a determination to work together to make a difference" ☐
Policy makers ☐	Video / DVD ☐	
Local / regional / national government ☐	Internet ☐	"This approach is cost effective and sustainable" ☐
Potential new partners ☐	CD Rom ☐	
National organisations ☐	Written case studies ☐	"This is a local solution to a local challenge" ☐
Academic institutions ☐	Newsletters ☐	
International agencies ☐	Publications ☐	"This form of collaboration allows for greater participation and empowerment for those we seek to help" ☐
Other? ☐	Other? ☐	
		Other? ☐

NHS
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REPORT TO: Trust Board

Enclosure No:17

Date of Meeting:	5th October 2017		
Title of Report:	Assurance Report from the Quality Committee		
Presented by:	Patrick Sullivan Non-Executive Director and Chair of Quality Committee		
Author:	Sandra Storey, Associate Director Medical & Clinical Effectiveness		
Executive Lead Name:	Dr Buki Adeyemo, Executive Medical Director	Approved by Exec	☒

Executive Summary:		Purpose of report	
This report provides a high level summary of the work of the committee during September 2017 and request for the Trust Board to ratifiy policies and endorse recommendations in the report.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	Approved by Chair of Quality Committee and Executive Lead	Document Version No.	
Committee Approval / Review			
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement. 2. To provide the highest quality services 3. Create a learning culture to continually improve. 4. Encourage, inspire and implement research & innovation at all levels. 5. Maximise and use our resources intelligently and efficiently. 6. Attract and inspire the best people to work here. 7. Continually improve our partnership working. The business of the Quality Committee is applicable to all strategic objectives.		
Risk / legal implications: Risk Register Ref	None identified		
Resource Implications: Funding Source:	N/A N/A		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	None identified		
Recommendations:	To note policy approval		

North Staffordshire Combined Healthcare NHS
NHS Trust

Outputs from the Quality Committee
for the Trust Board meeting on 5 October 2017

1. Introduction

During the month of September 2017, the Quality Committee were asked to consider a number of policies. This was undertaken by virtual review in the absence of a meeting. The purpose of this report is to notify the Trust Board of the outcome of this work and to recommend ratification of policies and procedures as follows:

2. Policy report – the recommendations were supported by the Committee for ratification of policies by the Trust Board for 3 years or otherwise stated as follows:

- ✓ 1.02 Professional Registration – extend to 31.12.2017
- ✓ 5.40 Transport Policy – updated and approve for 3 years
- ✓ 1.25 Food & Waste Guidelines – reviewed – extend to 28.02.2018
- ✓ 4.27 Protected mealtimes – reviewed – extend to 28.02.2018
- ✓ 1.67 Smoking policy – extend to 31.12.2017
- ✓ All Infection Control (IC) policies to have same review date 31.01.2018
- ✓ 1.12b Staffs and Stoke Safeguarding Adult Partnership Board Procedure - remove procedure from SID. Overarching policy remains in place.

3. Next meeting:
Thursday 26 October 2017 2.00pm

On behalf of the Committee Chair, Mr Patrick Sullivan, Non-Executive Director
Sandra Storey Associate Director Medical and Clinical Effectiveness

28 September 2017