North Staffordshire Combined Healthcare NHS Trust

MEETING OF THE TRUST BOARD

TO BE HELD IN PUBLIC
ON THURSDAY, 8 JUNE 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.	**DECLARATION OF INTERESTS RELATING TO AGENDA ITEMS**	Note
3.	**DECLARATIONS OF INTERESTS RELATING TO ANY OTHER BUSINESS**	Note
4.	**MINUTES OF THE OPEN AGENDA – 11 May 2017** *To APPROVE the minutes of the meeting held on 11 May 2017*	Approve Enclosure
5.	**ACTION MONITORING SCHEDULE & MATTERS ARISING FROM THE MINUTES** *To CONSIDER any matters arising from the minutes*	Note Enclosure
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
	QUESTIONS FROM MEMBERS OF THE PUBLIC	
8	*To RECEIVE questions from members of the public*	Verbal
	TO PROVIDE THE HIGHEST QUALITY SERVICES	
9.	**STAFF RETIREMENTS** *To EXPRESS our gratitude and recognize staff who are retiring* To be introduced and presented by the Chair **STAFF BEREAVEMENT**	Verbal Verbal

10.	**REACH RECOGNITION AWARD ON EXCELLENCE** *To PRESENT the REACH Recognition Team Award* To be introduced by the Chief Executive and presented by the Chair	Verbal
11.	**PATIENT STORY – RECOVERY FOCUSSED CARE COORDINATION** *To RECEIVE the Patient Story from Jane Lamb, Service User and Jane Simner, Care Coordinator for Early Intervention Team* *To be introduced by Ms M Nelligan, Executive Director of Nursing & Quality*	Verbal / Presentation
12.	**NURSE STAFFING MONTHLY REPORT - April 2017** *To RECEIVE the assurance report on the planned versus actual staff variances from Ms M Nelligan, Executive Director of Nursing & Quality*	Assurance Enclosure
13.	**NURSE STAFFING SIX MONTHLY REPORT** *To RECEIVE the Six Month Staffing report from Ms M Nelligan, Executive Director of Nursing & Quality*	Approval Enclosure
14.	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 1** *To RECEIVE the Month 1 Performance Report from Miss S Robinson, Director of Finance and Performance*	Assurance Enclosure
15.	**UK ALERT LEVEL CRITICAL TRUST BOARD REPORT** *To RECEIVE the UK Alert Level Critical Trust Board Paper from Dr Nasreen Fazal-Short, Acting Directors of Operations*	Assurance Enclosure
	TO ENHANCE SERVICE USER AND CARER INVOLVEMENT	
16.	**SERVICE USER AND CARER COUNCIL** *To RECEIVE an update from, Ms W Dutton, Vice Chair of the Service User and Carer Council*	Assurance Enclosure
17.	**FEEDBACK FROM SERVICE USER CARER COUNCIL OPEN SPACE / QUALITY PRIORITIES** *To NOTE the Trust Quality Priorities from the Service User Open Space Event from Ms M Nelligan, Executive Director of Nursing & Quality*	Note Enclosure
	CREATE A LEARNING CULTURE TO CONTINUALLY IMPROVE	
	Received as Item 11 PATIENT STORY – RECOVERY FOCUSSED CARE COORDINATION	
	ENCOURAGE, INSPIRE AND IMPLEMENT RESEARCH AND INNOVATION AT ALL LEVELS	

18.	**RAISING OUR SERVICE EXCELLENCE (ROSE) 'GO LIVE' UPDATE** *To RECEIVE an update for Raising Our Service Excellence (ROSE) from Mr G Thomas, Digital Strategic Advisor to be in attendance for this item.*	Assurance Enclosure
	MAXIMISE AND USE OUR RESOURCES INTELLIGENTLY AND EFFICIENTLY	
19.	**FINANCE REPORT – MONTH 1 (2017/18)** *To RECEIVE for discussion the Month 1 financial position from Miss S Robinson, Director of Finance and Performance*	Assurance Enclosure
20.	**ASSURANCE REPORT FROM THE FINANCE & PERFORMANCE COMMITTEE** *To RECEIVE the Finance & Performance Committee Assurance report from the meeting held 1st June 2017 from Mr T Gadsby, Chair/Non-Executive Director*	Assurance Enclosure
21.	**ASSURANCE REPORT FROM THE AUDIT COMMITTEE** *To RECEIVE the Finance & Performance Committee Assurance report from the meeting held 31st May 2017 from Mrs B Johnson, Chair/Non-Executive Director*	Assurance Enclosure
22.	**TRUST SELF CERTIFICATION – CONDITION FT4** *To RECEIVE and SIGN OFF the Trust Self Certification – Condition FT4 from Mrs L Wrench , Associate Director of Governance*	Approval Enclosure
	ATTRACT AND INSPIRE THE BEST PEOPLE TO WORK HERE	
	CONTINUALLY IMPROVE OUR PARTNERSHIP WORKING	
	DATE AND TIME OF THE NEXT MEETING	
	The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday, 13 July 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	

North Staffordshire Combined Healthcare NHS Trust

Enclosure

TRUST BOARD

Minutes of the open section of the North Staffordshire Combined Healthcare NHS Trust Board meeting held on Thursday, 11 May 2017 At 10:00am in the Boardroom, Trust Headquarters, Lawton House Bellringer Road, Trentham, Stoke on Trent, ST4 8HH

Present:

Chairman:

Mr D Rogers
Chairman

Directors:

Mrs C Donovan
Chief Executive

Dr B Adeyemo
Medical Director

Mr P Sullivan
Non-Executive Director

Mr A Rogers
Director of Operations

Mr T Gadsby
Non-Executive Director

Mr P Draycott
Executive Director of Leadership &Workforce

Mrs B Johnson
Non-Executive Director

Mr A Hughes (part)
Joint Director of Strategy and Development

Ms M Nelligan
Executive Director of Nursing and Quality

Dr K Tattum
GP Associate Director

Ms J Walley
Non-Executive Director

Miss S Robinson (part)
Director of Finance and Performance

In attendance:

Mrs L Wrench
Associate Director of Governance

Mrs J Scotcher
Executive PA

Mr M Fletcher
Communications Officer

Dr N Fazal-Short
Clinical Director – ADMH Inpatient

Mr G Thomas
Digital Strategic Advisor

REACH Individual Recognition Award - Stephanie Zahorodnyj

Members of the public:
Mr G Williams
Hilda Johnson
Phil Smith

Staff Retirements
Penny McDonagh
Jeff Smith

The meeting commenced at 10:00am.

6932017	**Apologies for Absence** Apologies were received Miss Barber, Non-Executive Director, Ms Jenny Harvey, UNISON, Mr McCrea, Head of Communications and Ms W Dutton, Vice Chair Service User and Carer Council, Mr Hughes, Joint Director of Strategy and Development and	**Action**

	Miss Robinson, Director of Finance will be joining the meeting later on today due to other commitments. Mr D Rogers acknowledged that Mr A Rogers was leaving the Trust and thanked him for his dedication and contribution during his time with the Trust. He further welcomed Dr Fazal-Short who will be taking over as Acting Director of Operations.	
694/2017	**Declaration of Interest relating to agenda items** There were no declarations of interest relating to agenda items.	
695/2017	**Declarations of interest relating to any other business** There were no declarations of interest relating to any other business.	
696/2017	**Minutes of the Open Agenda –6 April 2017** The minutes of the open session of the meeting held on 6 April 2017 were approved.	
697/2017	**Matters arising** The Board reviewed the action monitoring schedule and agreed the following: ***446/16 - Briefing on Staffordshire Budget Reductions in response to Better Care Fund shortfall*** - The Board continue to pursue these matters with support from our Clinical Care Commissioning Groups and will be kept informed of progress. ***Mrs Donovan commented that this service is now up and running with a new model of care. The service will be monitored for any negative impact.*** ***In addition, Mr A Rogers commented there is further investment of £160k although this is limited to community detox.*** ***Mr Draycott stated that it is important that the Trust carries out an Equality Impact assessment to ensure that there is no adverse impact.*** ***Ms Walley urged that the Trust continues with the joint and pro-active working*** ***Remove from schedule***	

	666/17 Safe Staffing Monthly Report – February 2017 The Six month Safe Staffing report for the period only July – December 2016 will be submitted to the next Trust Board in May 2017. ***Ms Nelligan confirmed this had been shared with the Quality Committee, however this requires further work, but will be submitted to the next Trust Board.*** ***668/17 ROSE Update*** – Mr Thomas urged that the Trust carry out a business contingency exercise led by our Emergency Planning lead. It was agreed to take forward. ***Mr Rogers confirmed that there has been some desk top testing and scenarios carried out. The good news is CHIPs will remain as a back-up whilst the Trust transfers to ROSE. The Trust has also deployed paper packs out to services, if there should be a total failure. IT are helping the Trust to develop a back-up into the data warehouse. However, there are developments for 'read only' reports into the data warehouse. The Trust will 'go live' this weekend and has a command and control centre in operation during this period.*** ***668/17 ROSE Update*** – a Benefits realisation process will be fed through to the Finance and Performance Committee and this will help give Non-Execs further assurance purposes ***This will be submitted to the Trust Board in June 2017*** ***671/17 Developing People Improving Care*** – the Board supported review of this via the People and Culture Development Committee in 6 months time. ***This will be submitted to the Trust Board in October 2017.***	**Ms Nelligan** **Mr Thomas** **Mr Draycott**
698/2017	**Chair's Report** The Chair commented that the national and local agenda is difficult to predict. The STP difficulties are continuing, however the plan seems to be improving and the Trust is at the centre of this. ***Received***	
699/2017	**Chief Executive's Report** Mrs Donovan, Chief Executive, presented this report which provides an update on the activities undertaken since the last meeting in April 2017 and draws the Board's attention to any other issues of significance or interest.	

	Launch of the New Behaviours Framework Following extensive engagement with staff, service users and carers through a Listening into Action (LiA) project team, the Trust launched our new values of Proud to CARE – Compassionate, Approachable, Responsible, Excellent. To support these values we have created a behaviour framework that highlights how we should behave as staff. The framework was developed through a further wave of engagement ensuring the behaviours include the thoughts and views of staff about what is important to our future success as a Trust. It highlights how we should behave and can be used to educate and encourage staff to behave in a particular way, and hold people to account. Thanks to Mr Draycott and his team. **Striving Towards Outstanding Levels of Staff** The Trust has launched 'Go Engage - Towards Outstanding Engagement' – a dedicated programme for improving staff engagement and culture. This programme will provide teams the opportunity to better understand their current internal culture, whilst also equipping them with new tools to be able to improve things for the better. Thanks to Mr Draycott and his team. **Raising our Service Excellence (ROSE)** Following months of hard work and preparation, our 'Go live' for our new electronic patient record (EPR) system ROSE takes place on 13 May 2017. Teams are being supported as we migrate to the new system over the go-live weekend, while staff have been busy completing their e-learning and attending face-to-face training sessions to ensure they are fully prepared for what promises to be an exciting new chapter in our journey Towards Outstanding. **Ward 4 Harplands** The Trust is delighted that the ward has now been permanently commissioned as a shared care service with UHNM from June 2017 and will provide 15 beds for patients with dementia and physical health needs. This is very positive news most importantly for service users and carers and the resilience of our staff. The Trust has used agency staff before, but will be recruiting staff through our forthcoming campaigns. **Recruitment Campaign** The Trust is now focussing on continuing with the Recruitment Campaigns with 10 events scheduled between May – September 2017, (including evenings). Plus an incentive for introducing a friend with £50 Amazon voucher. The events are for registered nurses mental health (RNMHs), registered nurses learning disability (RNLDs) and registered nurses adults (RNAs) and will take place at Harplands Hospital,	

	starting on Tuesday 23 May and Wednesday 24 May. Those applying will have the opportunity to apply for available posts on the day, be interviewed by a panel and potentially leave with a job offer. **Strong Year-end Financial Performance** The Trust ended 2016/17 with a £1.45m surplus against a planned surplus of £1.4m – the 18th consecutive year we have demonstrated strong financial performance. As a result, the Trust received a further £600,000 of sustainability and transformation funding, which is earned by trusts that operate within their agreed financial limits. Our staff deserve a big thank you for helping us to achieve this position in spite of the extremely challenging financial climate. **Celebrating and Nurturing Nursing Excellence Conference** Tomorrow is International Nurses day and following the success of last year's Nursing at its Best @ Combined conference, we will be marking the day with another Trust event – Celebrating & Nurturing Nursing Excellence. **Open Day for Psychological Services** The Trust will be holding a second Open Day for Psychological Services on Friday, 9 June 2017 from 9am-5pm at North Staffs Medical Institute, Everyone is welcome and there will be talks throughout the day from psychologists and therapists about the services we offer throughout the Trust to support people with their psychological care. **Religion and Mental Health meeting** The Trust held a Religion and Mental Health event where we welcomed representatives of the Sikh community and a representative from Sanctus, a charity supporting asylum seekers and refugees as they go through their assessment process for right to remain. **Staffordshire and Stoke-on-Trent Sustainability and Transformation Plan (STP)** The Staffordshire STP has now been identified as the most financially challenged health economy in the country. The Trust has had more focus nationally around the significant challenges in the health economy. The STP has approx £130m in year deficit, which is being driven by UHNM - £120m, £12.7m - SSOTP. UHNM have now been put in special measures. Within Northern Staffordshire, the Trust continues to define and plan for a Multi-specialty community provider as a solution. There has now been three meetings of the Alliance Board which has been set up to plan and align our services with the MCP approach and localities.	

	All trusts have been written to by NHS Improvement and NHS England flagging up the publication of an NHS Five Year Forward View Delivery Plan. **Director of Operations** Mrs Donovan personally thanked Mr A Rogers for his contribution and wished him all the best, he will be leaving the Trust at the end of May to take up a new opportunity as Chief Operating Officer at Camden and Islington NHS Foundation Trust. This is a great opportunity for Andy and we are delighted to see him continue to progress his career leading NHS mental health services. ***Received***	
700/2017	**Questions from the public** Mr Williams raised issues regarding out of hours and a recent incident involving a family member suffering from mental health issues, who was detained in a police cell. He also informed the Board that he had been interviewed on the radio this week with the police commissioner, Mathew Ellis. Mr A Rogers referred to the Place of Safety and that the Trust is in total agreement with Mr Williams' concerns. The Trust has made improvements and progress with the Community Triage service, including a designated Place of Safety at the Harplands site 24/7. The Trust also has capacity sharing with Staffordshire and Shropshire to use their Place of Safety when the one at the Harplands is in use. Mr A Rogers gave assurance that the Trust is working towards an additional Place of Safety. The Trust has developed plans for a Psychiatric Intensive Care Unit and this will be based at the Harplands early next year. However, there is still a requirement for further revenue funding from commissioners. The Trust is aware that this is an issue and we are continuing to do all we can to minimise these events. Mrs Donovan reiterated these comments and that the Trust has made improvements, but this is an ongoing challenge. Ms Walley thanked Mr Williams for raising these issues. She urged that the Trust look at strategic partnerships going forward and that we need to understand more clearly what opportunities we have. It is important that Non-Executives keep a close watch on how we understand the situation and that individuals are not sent outside of the county. Mr Sullivan queried that if somebody is detained for a considerable time – is this reported as a serious incident? Dr Adeyemo stated that it would be, as per the Trust protocol.	

	Another member of the public, Mr Smith, North Staffs Voice, recalled a similar incident he had with a family member and that it is also about the police supporting the individual. The Trust needs to ensure the police engage and inform us appropriately. Mrs Donovan commented that the Trust would be supporting Mr Williams and thanked him for highlighting these issues. It was agreed to bring back a report on the Place of Safety capacity and performance.	**Dr Fazal-Short**
701/2017	**Staff Retirements** Mrs Donovan recognised those staff who are retiring this month as follows, **Jeff Smith (EMT Maintenance Joiner)** In 1979 Jeff joined the NHS working at St Edwards Hospital. Since that time Jeff has been based at various hospitals across North Staffordshire including St Edwards, Bucknall, Cheadle, and presently Bradwell Hospital. Jeff is a true team player. His work as a Joiner has been varied including working within the workshops with numerous wood working machines. Over the years he has help maintain fire doors, provided anti-ligature support, make windows, and has even made bespoke furniture to support services. He has also made an important contribution to supporting the Trust through being part of the On-Call Team. Amongst Jeff's passions, which we're sure he'll continue after his retirement, are cars and he has a reputation having lost count how many he cars he has owned over the years! Thank you for all your hard work over the last 38 Years and all the best for your retirement. **Penny McDonagh – Ward Manager** Penny started her nursing career as a cadet nurse back in 1979 (another one) progressing her career to become a Staff Nurse, Deputy Ward Manager and then Ward Manager. In 2002 Penny also completed her registration as a general nursing and became a dual registered practitioner. Throughout her career Penny has worked within various in-patient settings and realised that her passion lay with older adults, where she been practicing with dedication and compassion for the past 20 years. Penny is passionate and dedicated in her role and has always	

	been keen to share her knowledge and experience with more junior members of staff, as well as being an excellent role model to ensure patients receive the highest standard of care. Penny is an extremely valued and well respected member of the NOAP Directorate and will be missed by all her colleagues and many friends she has formed over the years. We wish you all the best in your retirement. Unable to attend - Sue Whitehurst, Community Nurse Broom Street Community Unit, Learning Disabilities Directorate ***Received***	
702/2017	**REACH Recognition Award** **Individual Award May 2017** **Stephanie Zahorodnyj Team Leader, County Community Mental Health Team, Neuro and Old Age Psychiatry (NOAP) Directorate** The County Community Mental Health Team in NOAP are at the front line of the directorate's community services and, as Team Leader, Stephanie ensures that high quality patient care is delivered throughout North Staffordshire. Stephanie's has great leadership and managerial skills, calm manner and ability to manage change rapidly. These were all recognised by the CQC last year and were instrumental in the NOAP Community services achieving an 'Outstanding' rating. She is a natural leader who supports everyone through good times and bad and has developed others within the directorate – raising the bar for care of the elderly in the community. Her caring nature, can do attitude and commitment are inspiring. Whether it supporting a colleague or on occasion being out at 9 o'clock at night to deal with an urgent referral that came in at 5pm; her energy, drive and commitment to service users is immense and she is recognised as the heartbeat of the team. The value that best represents Stephanie is 'Excellent'. Her contribution to the Trust has been enormous and her manager says of her that "every member of the team would walk over hot coals for her!" Thank you and congratulations.	
703/2017	**Assurance Report from the Quality Committee** Mr Sullivan, Chair of the Quality Committee/Non-Executive Director, presented the summary of the Quality Committee held on 27 April 2017 for assurance purposes.	

	The following policies were approved for 3 years or otherwise stated: 7.07 Records Management 4.42 Research and Development Commercial Research 1.44 Dual Diagnosis – extension to 31 August 2017 ***Ratified*** Mr Sullivan highlighted the following reports which were scrutinised and received by the Quality Committee: • Safe Staffing Report – February and March 2017 • Performance and Quality Management Framework Month 11 2016/17 • Serious Incident Q4 2016/17 • Risks to Quality services M11 2016/17 In terms of assurances, the Quality Committee received the following: • Quality Impact Assessment of Cost Improvement Programme CIP • Clinical Effectiveness Report • Serious Incident Thematic review Board Assurance Framework 2016/17 Q4 and BAF 2017/18 • Directorate Performance Reviews • NCIS Scorecard project In terms of information, the Quality Committee received the following: • Director of Quality Report • Unannounced Assurance Visits • Learning from deaths – National Quality Board – March 2017 • Parent and Baby Unit Review and Action Plan The Quality Committee approved: • Terms of Reference for the Infection, Prevention and Control	

	Furthermore, Mr Sullivan reported that the Quality Committee intend to make some changes to their structure. This is to ensure the committee receives better information with increased focus for each of the Clinical Directorates and to analyse and make more use of a consent based agenda. The committee will also receive patient stories. In respect of the National Confidential Inquiry into Suicides and Homicide, Ms Walley queried if the Trust was involved and how we compare. Mr Sullivan responded that in respect of the scorecard, there is nothing that makes the Trust an outlier and that all organisations provide information on an annual basis. The value of the National Confidential Inquiry is that the Trust can review and take on board recommendations which allow us to improve. Dr Adeyemo echoed these points; in particular one of the recommendations is to improve the follow- up after 7 days, as it has been identified that suicides often occur post discharge in the first 3 days. ***Received***	
704/2017	**Safe Staffing Monthly report –March 2017** Ms Nelligan, Executive Director of Nursing and Quality, presented the assurance report. This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during the data collection period (1 – 31 March 2017) in line with the National Quality Board expectation that: The performance relating to fill rate (actual numbers of staff deployed vs numbers planned) during March 2017 was 80% for registered staff and 103% for care staff on day shifts and 84% and 107% respectively on night shifts. 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 Ms Nelligan further reported that the ward staff are supported by the Multi-disciplinary Team. Fill rates are still a challenge, but to note there has been no harm arising from any incidents; these are noted within the content of the report. Fill rate for Ward 1 has decreased from the previous month.	

	The difficulties with Ward 1 are set out in the report; these being secondments and sickness. In a previous Board we received Ward 5 position and the fill rate had risen by 10%. As stated earlier in the meeting, the Trust is holding 8 one stop recruitment shops. The main focus is to recruit to Ward 4 and an advert has recently been placed with 25 applicants applying. It is our desire to fill and appoint all those people, assuming they meet the competencies that we require. The Trust has implemented the E-rostering system in April 2017 and we will also be introducing Safe Care Module, to enable us to benchmark ourselves with other Trusts. Next steps are for the ADMH Inpatient Directorate, to refresh the Admission criteria, in line with the Service Specification, to address our acuity and occupancy. As noted in the CEO report, at tomorrow's Nursing Conference, to celebrate International Nurses Day, we will be launching: • 'Retire and return' - Colleagues in Human Resources are supporting this launch. • Combined Nursing Badge – To help build the morale of the workforce • Recognition to our preceptorship nurses – To hold an Award Ceremony The Trust is also working with universities and collaborating with UHNM for HCSW opportunities and building our workforce with RGN roles. Mr Gadsby requested that Ward 4 be incorporated into the Safe Staffing report. Ms Nelligan advised this would be included going forward. Ms Walley raised Mental Health awareness in schools with the apprenticeship levy. Ms Nelligan stated that it is crucial to raise the profile of Mental Health in general. The Trust needs to promote this and this also links into the prevention work. Mr Draycott commented that it is the Trust's intention to train our own nurses. Mrs H Johnson thanked Ms Nelligan for the Safe Staffing report and queried whether there was an impact on the community with admissions to acute wards? As eluded to previously, Ms Nelligan stated that the Trust will be refreshing the Admission criteria and the development of our Acute Care pathway. The Trust is reviewing safer staffing in the Access Team presently; the community will be reviewed, when	

	there is capacity to do so. Finally, Ms Nelligan confirmed that a meeting with CCGs is due to be held in respect of acuity and bed occupancy. ***Received***	
705/2017	**Serious Incident Q4 report** Dr Adeyemo, Medical Director, presented this report which provides an overview of the Serious Incidents reported during Q4 2016/17, from 1 January to 31 March 2017. There were 13 serious incidents during Q4 with 2 being downgraded on review. The key points highlighted; • 3 unexpected deaths in the Substance Misuse Directorate • 5 incidents reported from the Adult Community Directorate • 3 incidents reported from the NOAP Directorate (-0ut of 3 incidents 2 were falls) In terms of the learning from serious incidents, key points are as follows: • Clarity regarding re-referrals to CMHTs • Strengthened communication with clinical staff from Royal Stoke, when transferring patients to our care • Improved clinical documentation. • Identifying other interventions that have been tried before medication has been prescribed. • Strengthen our Dementia training. The Trust is maintaining good practice around risk assessments, care planning documentation and collaboration with families and carers during incident reviews. With regard to Duty of Candour, all incidents that have met the criteria and have been progressed in line with Trust's policy The Serious Incident Annual Report will be submitted to the next Trust Board. ***Received***	**Dr Adeyemo**

706/2017	**Performance and Quality Management Framework Report (PQMF) Month 12** Miss Robinson, Director of Finance, presented this report. The report provides the Board with a summary of performance to the end of Month 12. At Month 12 there are 2 metrics rated as Red and 1 as Amber. The following performance highlights were noted; • 94.3% of patients Trust wide were assessed within 18 weeks of referral against a target of 92% • 99.5% of CAMHS patients (excluding ASD) have been seen for assessment within 18 weeks • 100% data sets submitted to SUS has an NHS number field completed • Our DNA rate has remained consistently below target throughout the year 96.2% of service users on CPA have received a review within 12 months and 96.6% have a care plan in place • The response rates to all categories of RAID referrals have been consistently met in Quarter 4 Exceptions were reported as follows: • Agency Spend - Reduced to 5.7% • Core Agency - Increased slightly to 2.9% • Rose Agency - Reduced to 2.3% • Delayed Transfers of care – Increased to 12.9% The delays relate to accessing health and social care funding and placements and patients choice. The Trust is piloting the Red to Green approach developed by the Emergency Care Improvement Programme (ECIP) which focuses on eliminating patient time wasted in the pathway (red days) and focussing on days which are of value to the patient (Green days). • Readmissions – increased to 8.8%, a deep dive is being undertaken. • 7 Day follow up - Target reduced to 91% ***Received***	
707/2017	**Raising our Service Excellence** Mr Thomas, Digital Strategic Advisor, was in attendance for this item only and highlighted that the Trust is scheduled to 'Go live'	

	on 13 May 2017, with all Trust services established by 15 May 2017. The launch is on track and continuing to progress well. The Safety Report was signed off by NHS Digital and necessary approval signatures have been obtained. Mr Thomas gave further assurance that the implementation of ROSE is not posing any unacceptable risks to patients. NHS Digital will issue a Change Control notice, should there be any problems. It was noted that the Trust still has an issue with the electronic prescribing module, this is a high risk but is being addressed. The Trust has now trained 95% of staff. During the first 3 months, there will be some further updates and tasks to complete i.e. interface with UHNM, pathology. It was agreed for a Benefits Realisation plan to be delivered at the next Trust Board. Going forward, the Digital by Choice Strategy will require revision. Mr Sullivan asked what would be the critical timeframe where we could have serious problems. Mr Thomas stated that the Trust will be aware within hours/minutes of 'go live'. In respect of information reporting there may be some issues with the Trust's data accuracy and this will be evident by early June 2017. Mrs B Johnson raised has there been consideration for new starters to be trained on the new system? Mr Draycott gave assurance that plans have been developed for new staff and there is also training on-line. Mrs Donovan thanked Mr Thomas for his support and contribution. This has been a momentous achievement and will make a huge difference to our patients and staff. .***Received***	**Mr Thomas**
708/2017	**Board Assurance Framework Q4 2016/17** Mrs L Wrench, Associate Director of Governance, presented the Board Assurance Framework, which provides an update and RAG rating for those actions due during quarter 4 2016/17. The Board Assurance Framework (BAF) aligns the Trust strategic objectives to our quality priorities and key risks including the	

	Board's level of risk appetite. The BAF Q4 has been received and discussed by all sub-committees of the Board in detail. In summary, there are 50 controls within the BAF, with 108 different assurances. The key successes were noted; • CQC outcomes • Development of Nursing Strategy • Implementation of Patient Safety Matrix • Unannounced Visits Assurance programme • Healthwatch/CCG Visits programme • CQUIN 100% achievement • Early Intervention and IAPT Target • GP Federation • Development and implementation of the Values and Behaviours Framework The Trust is continuing with ongoing work in terms of some of the red areas; • Estates Review • Partnership working alongside social care – issues with S75 agreement ***Received*** **Board Assurance Framework 2017/18** The BAF 2017/18 has again been received at the sub-committees of the Board and the actions have been agreed. It was noted that there are 7 high level priorities. The BAF 2017/18 will now be launched and agreed going forward. The BAF Q1 2017/18 will be submitted to the Trust Board in July 2017. ***Received***	**Mrs Wrench**
709/2017	**Service User and Carer Council** Ms Nelligan, Director of Nursing and Quality, updated the Board in respect of the Service User Carer Council on meeting activity and achievements to-date on behalf of Ms Dutton. A Workshop had been held on 27 April 2017, following the Open Space Event to look at service/quality improvement initiatives the Council wished to prioritise. Feedback has since been collated and Board members reviewed this in the content of the	

	report. Mr Sullivan raised his frustrations regarding the point; *That Clinical notes are read prior to service user attending appointments to avoid having to repeat* Ms Nelligan stated that we need to review whether this is an isolated case or a regular occurrence. The Trust may look at introducing a Secret Shopper Model, in order to see how we assure ourselves. It was noted that the next steps would be for a review of the Terms of Reference and arrangements for the election of a new Chair for the Service User and Carer Council, together with encouraging the increase in membership. Ms Nelligan agreed to submit a briefing FROM THE Service User Carer Council Open Space Event around Quality priorities to the next Trust Board. ***Received***	**Ms Nelligan**
710/2017	**Second Citizen's Jury to examine Mental Health Service Provision (NSCHT and SOT CCG)** Ms Nelligan, Director of Nursing and Quality, presented this report regarding the development of a Citizens Jury, by North Staffs CCG. The Citizens Jury puts patients, carers and the interested public at the heart of healthcare commissioning in order to give a real opportunity for patients to shape future services. The concept for a Citizen`s Jury arises from the NHS Constitution and the Francis report and links to the principles of National Voices, a coalition of Health and Social Care charities in England. The jury will look at access to current mental health service provision, will be able to call for evidence and will then develop recommendations to inform and improve the commissioning of mental health services in the future. ***Received***	
711/2017	**People and Culture Development Assurance Report – 2 May 2017** Mrs B Johnson, Non-Executive Director presented this report on behalf of Miss Barber Chair/Non-Executive Director of the People and Culture Development Committee. This is the assurance report to the Trust Board from the meeting held on 2 May 2017.	

	The following policies were approved: • Acting down for Medical Staff Policy • Employee Travel • On-call Policy - Extend to end of August 2017 ***Ratified*** The Committee received the following: • Staff Story • Workforce Directorate Performance and Rectification Plans • Board Assurance Framework • Health Education England Mental Health • Workforce Strategy • PDR Audit • Workforce and OD risks It was noted that the Trust had been shortlisted for the forthcoming Healthcare People Management Association (HPMA) Awards with the Feel Good Friday health and wellbeing initiative which has been chosen as a finalist in the Social Partnership Forum Award for partnership working between employers and trade unions. In addition the Trust has also been shortlisted in the Academic Wales Award for Excellence in Organisational Development for the Leading with Compassion scheme where staff, patients and carers are able to recognise someone who they believe has demonstrated compassion. Shortlisted ***Received***	
712/2017	**Monthly Finance Reporting Suite – Month 12** Miss Robinson, Director of Finance, presented this report which contains the financial position at Month 12. The Trust Board is asked to note: • Month 12 the Trust reported a surplus of £2,051k against a plan of £1,400k surplus; • CIP achievement in month 12 is o 74% achieved in year of £1,923k, with an adverse variance of £677k from plan o 93% recurrent achievement of £2.425m, with an adverse variance of £175k from plan	

	• The cash position of the Trust as at 31st March 2017 with a balance of £6,964k; £137k above plan. • Capital expenditure for 2016/17 is £2,594k compared to a plan of £2,743k. This an underspend against the capital plan of £149k; and • Use of resource rating of 3. Approved. The Board congratulated Miss Robinson and the Finance Team for the achievements with the financial position. ***Received***	
713/2017	**Finance and Performance Committee Assurance Report – 4 May 2017** Mr Gadsby, Chair of the Finance and Performance Committee/Non-Executive Director, presented the assurance report to the Trust Board from the Finance and Performance Committee held on 2 May 2017. The Finance and Performance Committee were updated as follows: • Annual Accounts - This had been reviewed in detail at the recent presentation to the Audit Committee on 25 April 2017 and assurance provided • Capital outturn - The Trust is spending capital and investing appropriately. • Cost Improvement Programme • Agency Report – Received and the committee are comfortable this is under control • Corporate benchmarking • Performance Report (PQMF) • Waiting times in CAHMS • Risk Register • Board Assurance Framework ***Received***	
714/2017	**Audit Committee Assurance Report –2017** Miss Robinson, Director of Finance and Performance, gave verbal assurance in respect of the Annual Accounts overview. The draft Accounts were submitted on 26 April 2017. The final Accounts will be submitted by 1 June 2017 and the financial successes were noted. Miss Robinson requested that the Audit Committee have delegated authority to approve the Accounts.	

	Approved	
715/2017	**Trust Self Certification - Condition G6 – Systems for compliance with license conditions** Mrs Wrench, Associate Director of Governance, presented this report for approval. NHS trusts are required to self-certify that they can meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that they have complied with governance requirements. Trust Board must self-certify and confirm compliance against condition G6 to NHS Improvement by 31 May 2017 ***Approved*** It was further noted that there will be another Condition FT4 for submission by the end of June 2017. This will be submitted to the June Trust Board. ***Received***	**Mrs Wrench**
716/2017	**Register of Board Members – Declarations of Interest** Mrs Wrench, Associate Director of Governance, presented this report to provide an update as at 30 April 2017 of current member's interests. It was noted there were some further revisions to be made in respect of Mrs Donovan and Ms Walley. Mrs Wrench to update accordingly.	**Mrs Wrench**
717/2017	**Any other business** None	
718/2017	**Date and time of next meeting** The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday, 8 June 2017 at 10:00am, in the Boardroom, Lawton House, Trust HQ.	

719/2017	*** 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 1.45pm

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
06-Apr-17	666/2017	Safe Staffing Monthly report – February 2017 -The Six month Safe staffing repo	Ms M Nelligan	08-Jun-17	Ms Nelligan confirmed this had been shared with Quality Committee, however this requires further work but will be submitted to the next Trust Board
06-Apr-17	668/2017	ROSE Update - Mr Thomas urged that the Trust carry out a Business Contingency exercise led by our Emergency Planning lead. It was agreed to take this forward.	Mr Thomas	08-Jun-17	This will be submitted to the Trust Board in June 2017
11-May-17	709/2017	Service User and Carer Council - Ms Nelligan agreed to submit a briefing from the Service User Carer Council Open Space Event around Quality priorities to the next Trust Board.	Ms Nelligan	08-Jun-17	Agenda item for June 2017 Trust Board
11-May-17	715/2017	Trust Self Certification - Condition G6 – Systems for compliance with license conditions It was further noted that there will be another Condition FT4 for submission by the end of June 2017. This will be submitted to the June Trust Board.	Mrs Wrench	30-Jun-17	Agenda item for June 2017 Trust Board
11-May-17	716/2017	Register of Board Members – Declarations of Interest - It was noted there were some further revisions to be made in respect of Mrs Donovan and Ms Walley. Mrs Wrench to update accordingly.	Mrs Wrench	08-Jun-17	Action complete
11-May-17	700/2017	Questions from the public - Mrs Donovan commented that the Trust would be supporting Mr Williams and thanked him for highlighting these issues. It was agreed to bring back a report on Place of Safety capacity and performance	Dr Fazal-Short	13-Jul-17	
11-May-17	705/2017	Serious Incident Q4 Report - The Serious Incident Annual report will be submitted to the next Trust Board	Dr Adeyemo	13-Jul-17	
11-May-17	707/2017	Raising our Service Excellence - It was agreed for a Benefits Realisation presentation to be delivered at the next Trust Board.	Mr Thomas	13-Jul-17	
11-May-17	708/2017	Board Assurance Framework - 2017/18 - The BAF Q1 2017/18 will be submitted to the Trust Board in July 2017.	Mrs Wrench	13-Jul-17	

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REPORT TO TRUST BOARD

Enclosure No:4

Date of Meeting:	8th June 2017		
Title of Report:	Chief Executives Report to the Trust Board		
Presented by:	Mrs Caroline Donovan		
Author:	Mrs Caroline Donovan		
Executive Lead Name:	Mrs Caroline Donovan	Approved by Exec	☐

Executive Summary:	Purpose of report	
This report updates the Board on activities undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☐

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☐ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☐ 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	n/a		
Resource Implications: Funding Source:	n/a		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	n/a		
Recommendations:	To receive this report for information		

Chief Executive's Report to the Trust Board
8 June 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. NHS CYBER ATTACK

As you will be aware, the entire NHS was the victim of a cyberattack of ransomware on Friday 13th May demanding payment in virtual bitcoins. We were one of the 48 NHS organisations that were infected.

Our staff worked tirelessly and professionally over the weekend of 13th – 15th May to continue to provide the highest quality care, to manage the impact and to resolve the problems. It seems unfair to pick out individuals from a considerable team effort, but David Hewitt, Ben Boyd, Joe McCrea, Darryl Gwinnett, Andrew Hughes and the duty senior nurses really did go above and beyond.

We worked with colleagues across the health economy to ensure that patient care was not compromised and I am pleased to report that no data was lost or illegally accessed. We also were able to use our social media channels and new website to very good effect to ensure local patients and the local media were kept informed and reassured and we were able to answer any questions that arose

As a result, the attack was dealt with calmly and effectively.

The attack came just hours before we were due to 'Go Live' with our new Electronic Patient Record (ROSE). However, the careful planning we had put in place to prepare for the migration of our records from the old CHIP system to the new Lorenzo system put us in good stead to deal with the cyber attack.

2. RAISING OUR SERVICE EXCELLENCE (ROSE) LAUNCHES

A decision to reschedule the ROSE launch for 19th May was made in consultation with both NHS Digital and DXC, the suppliers of the Lorenzo system we are using.

The initial roll out of ROSE has gone extremely well, with no unanticipated issues and plenty of which we can be proud. We have received some great feedback from NHS Digital who told us that they thought the way in which we had prepared and mobilised for the launch was among the best they'd seen and would be held up as an exemplar to other NHS organisations.

Highlights from the first few days included:

- Day to day operations were busier than normal, as we expected, but there were no major incidents;
- We were able to review the distribution of floor walkers based feedback from community managers;
- Some minor system configuration issues were identified as more staff began to use the system and we were able to work through these to distinguish between issues rather than misunderstanding
- By the end of the first weekday, 529 staff had logged into Lorenzo since Saturday and we had over 256 staff on system at one time today

Our staff deserve a tremendous amount of praise, both for the preparations they put in leading up to go live and the work that is ongoing to make ROSE a success. However, special thanks must go to the ROSE project team, led by our Director of Strategy and Development Andrew Hughes, Ben Boyd and Dave Hewitt; and our dedicated team of Super Users who have been out and about making sure the transition to Lorenzo has gone as smoothly as possible.

ROSE is an integral part of our ambition to become a 'digital by choice' organisation with a national reputation as a leader in the use of digital technology. It will enable us to deliver excellent care services, support people to recover, aid colleagues across the Trust to work effectively and lead to innovation in our healthcare services.

3. DISCOVER YOUR FUTURE RECRUITMENT CAMPAIGN

Our summer-long series of one-stop recruitment events has got underway at Harplands as part of our Discover Your Future campaign. We have been advertising for registered nurses mental health (RNMHs), registered nurses learning disability (RNLDs) and registered nurses adults (RNAs) to join Combined, with those applying having the opportunity to apply for available posts on the day, be interviewed by a panel and potentially leave with a job offer. We look forward to welcoming new members of staff to join the Trust over the summer and for more information about our upcoming events visit www.discoveryourfuture.co.uk.

4. CAROL SYLVESTER APPOINTED INTERIM CLINICAL DIRECTOR FOR ADULT MENTAL HEALTH INPATIENT SERVICES

Congratulations to Carol Sylvester, who has been appointed as the Clinical Director of our Adult Mental Health Inpatient services on an interim basis for six months. I am delighted for Carol, who is one of the most respected and well liked members of staff in the organisation. She has been serving as Deputy Director of Nursing and Quality since 2015 and has a wealth of knowledge and experience of collaborative working with clinical directorates and external stakeholders to support the delivery of high standards of clinical care. I'm sure you will join me in wishing Carol all the best in her new role.

5. CELEBRATING AND NURTURING NURSING EXCELLENCE CONFERENCE

We marked International Nurses Day on Friday 12 May in style with our Celebrating and Nurturing Nursing Excellence conference, held at Port Vale FC. It was a hugely successful event, led by our Director of Nursing & Quality Maria Nelligan and Julie-Anne Murray, our Head of Nursing & Professional Practice and featured a number of talks and presentations celebrating our nursing staff and the huge contribution they make to improving the lives of our service users.

I was unfortunately unable to attend the event, but I recorded a video talking about my journey from being a registered nurse to CEO. I am told the talk given by dementia care campaigner Tommy Whitelaw about his mother was extremely touching and left many of our nurses very emotional. During Tommy's talk he spoke about What Matters to You Day on 6 June, which aims to encourage and support more meaningful conversations between those who provide and receive care. We encouraged our staff to get involved and I am pleased a good number did.

We were also lucky to have a talk from award-winning mental health nurse Julie Sheen, who spoke eloquently about her journey from service user to mental health nurse. Both Tommy and Julie helped us to launch our Pledge Tree posters, which staff have been completing by writing individual pledges of care.

The afternoon was given over to a 'supercharge safari' in which staff were able to discover more about a series of themes exploring how we can further nurture nursing excellence, while the event concluded with our Mentor of the Year Award being presented to Mel Hope and Preceptor of the Year Award presented to Deb Scragg.

The event also saw the launch of a competition for staff to design a new Combined Healthcare Nursing Badge. Maria and Julie-Anne will be judging the entries and the badges will be given to all of our registered nurses in recognition of their having completed their nurse training.

Well done to everyone for making the event such a success.

6. TRUST HOLDS FIRST LGBT FOCUS GROUP

We held our first lesbian, gay, bisexual and trans (LGBT) Focus Group yesterday (Wednesday 7 June) at Harplands Hospital. The purpose of the session was to review the experience that we offer to LGBT service users and staff, identify where improvements could be made and highlight good practice. Thank you to everyone who attended the session, which was facilitated by Abby Crawford from LGBT charity and action group Stonewall.

We will be running a Black and Minority Ethnic (BME) Focus Group on Wednesday 2 August. All are welcome and more information will be shared in due course. To get involved please email Lesley Faux, our Diversity and Inclusion Lead, at Diversity@northstaffs.nhs.uk.

7. DEAF AWARENESS TEAM WINS RECOGNITION AWARD

Well done also to our Deaf Awareness team, who have won a Special Recognition Award from the charity DEAFvibe in recognition of the hard work that has gone in to improving mental health services for the local deaf community. The nomination from DEAFvibe said: "The Trust has a strong team whose staff are committed to making a difference to the lives of deaf people with mental health issues and this is demonstrated in the fact the Trust signed up to the Deaf Charter this year." This is fantastic news and is testament to the hard work of the team in raising awareness and making a difference to the lives of the local deaf community.

8. NEW ADMIRAL NURSE PARTNERSHIP PROVIDING SPECIALISED SUPPORT TO PEOPLE WITH DEMENTIA AND THEIR FAMILIES

We are proud to have worked in partnership with the Douglas Macmillan Hospice and Dementia UK to launch the first Admiral Nurse service in Staffordshire. Wendy Mountford has recently joined the Dougie Mac from our Memory Services and, as a newly appointed Admiral Nurse will provide specialist one-to-one support and guidance to people living with dementia and their families and carers.

I am delighted for Wendy, who has joined the hospice on a two-year secondment. This is an exciting partnership that will make a big difference to the lives of people living with dementia as well as their families and carers. Following the 'Outstanding' rating recently awarded by the Care Quality Commission for our Older Persons Community Teams, Wendy's appointment forms part of the work we are undertaking to further enhance the dementia and old age psychiatric care we provide.

9. OPEN DAY FOR PSYCHOLOGICAL SERVICES

As a reminder, we will be holding a second Open Day for Psychological Services on Friday 9 June from 9am-5pm at North Staffs Medical Institute, in Hartshill, Stoke-on-Trent, ST4 7NY. Everyone is welcome and there will be talks throughout the day from psychologists and therapists about the services we offer throughout the Trust to support people with their psychological care. As this is a drop-in event, no booking is required. Refreshments will be provided and for more information and the event programme, contact Jane Callear at jane.callear2@northstaffs.nhs.uk or Christina Twomlow at Christina.twomlow@northstaffs.nhs.uk.

10. HSJ VALUE IN HEATHCARE AWARDS SHORTLISTINGS

We were delighted that we had two teams invited to the national HSJ Value in Healthcare Awards on 25th May. Our learning disabilities services were finalists in the Community Healthcare Service Redesign Award and the Healthy Minds IAPT Team were shortlisted in the Improving the value of Primary Care Service Award. Although neither won the main award, their inclusion on the shortlist is further example of our growing reputation nationally for innovation, quality and value for money.

11. HPMA AWARDS PRESENTATIONS ON COMPASSION SCHEME AND FEEL GOOD FRIDAY

The work we have led across the health economy on compassion funded by Health Education England has been recognised nationally. Rob Cragg, our Deputy Director of People and Strategy, and Dr Sarah Leamann, Assistant Director of Human Resources at University Hospitals of North Midlands NHS Trust (UHNM), travelled to London on our behalf during May to give a presentation on the work we have done on compassion as a finalist in the national Healthcare People Management Awards (HPMA). This is something that is very close to my heart as I started off the Leading with Compassion scheme. I really felt there was much we could do after the legacy of Mid Staffs to shine a light on the importance of compassion and celebrate just what fantastic compassionate staff we have. We now have 475 staff who have been nominated for their compassion by service users and carers, staff themselves or partners – which is an achievement to be proud of.

Patrick Ross-Osborne, Senior HR Advisor, and Steve Jones, UNISON representative, also travelled to London to give a presentation about our Feel Good Friday initiative in support of our other HPMA nomination. Taking place on the first Friday of each month at Harplands Hospital, Feel Good Friday was set up as part of our ongoing health and wellbeing strategy and includes a range of stalls providing helpful information on health and wellbeing.

The winners of the HPMA Awards will be announced on 22nd June.

NATIONAL UPDATE

12. GENERAL ELECTION AND PURDAH

The ongoing General Election campaign and associated rules of 'purdah' has meant that NHS England, the Department of Health and other NHS bodies have refrained from issuing any material or undertaking public activities that might influence public opinion or be drawn into political debate. As a Trust, we have observed identical disciplines.

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REPORT TO: TRUST BOARD

Enclosure No:5

Date of Meeting:	8 June 2017		
Title of Report:	April 2017 Monthly Safe Staffing Report		
Presented by:	Maria Nelligan, Executive Director of Nursing & Quality		
Author:	Julie Anne Murray, Head of Nursing & Professional Practice		
Executive Lead Name:	Maria Nelligan	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 April 2017 in line with the national Quality Board requirements. The performance relating to fill rate (actual numbers of staff deployed vs numbers planned) during April 2017 was 83% for registered staff and 101% for care staff on day shifts and 83% and 109% respectively o night shifts. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover and Ward Manager supporting clinical duties. The data reflects that Ward Managers are staffing their wards to meet increasing patient needs as necessary.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☒ Date: 16th MAY 2017	Document Version No.	
Committee Approval / Review	• Quality Committee X☐ • 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 April 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 also 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 month review covering the period July 2016 - December 2016 is currently being finalised and will be reported to SLT in May 2017 and then to Board of Directors.

3 Trust Performance

During April 2017 the Trust achieved staffing levels of 83% for registered staff and 101% for care staff on day shifts and 83% and 109% respectively on night shifts. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by nurses working additional unplanned hours, cross cover, Ward Managers and the multi-disciplinary team supporting clinical duties and the prioritising of direct and non-direct care activities. A summary from Ward Mangers of issues established, planned (clinically required) and actual hours alongside details of vacancies, and actions taken to maintain safer staffing are in Appendix 2.

4 Issues impacting on fill rates

Ward Managers report the impact of unfilled shifts on a shift by shift basis. Themes and mitigating actions are summarised in Appendix 2.

4.1 Impact on Patient Safety

There were 7 incident forms completed by in-patient wards during April 2017 relating to nurse staffing issues. **No harm arose from these incidents.** Breakdown by ward is summarised as follows:

Ward	Incident
A&T	One occasion where staffing levels were reduced due to late notice agency cancellation leading to reprioritisation of workload for the shift.
Ward 2	One occasion where staffing levels were reduced by one, then a further reduction due to escorting a service user to UHNM.

Ward	Incident
Ward 5	Five incident forms were received. On two occasions ward was short by two members of staff and on further two occasions the ward was short of one member of staff for the shift. On these shifts it was challenging for remaining staff to safely care for service users. There was one incident form relating to medical staffing cover. **No harm to patients was reported.**
Ward 7	A further 4 incident forms were received from the Access Team who had to be based on Ward 7. This was due to there being no RN on Florence House and the agency RN being moved from Ward 7 to cover Florence.

4.2 Impact on Patient Experience

Staff prioritise patient experience and direct patient care. During April 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 safe staffing the following actions were taken by the Ward Manager during April 2017:

- 52 staff breaks were cancelled (equivalent to approximately 1% of breaks).
- 0 staff breaks were shortened.
- 150 hours 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 163 RN shifts were covered by HCSW where RN temporary staffing was unavailable. A total of 18 HCSW shifts were covered by RN staff where HCSW temporary staffing was unavailable. Additionally, as outlined in section 4.3, staff breaks have been shortened (time is given in lieu) or not taken and wards have cross covered to support safe staffing levels.

5 Summary

Safe staffing levels reported indicated challenges in staffing wards during April 2017. Vacancies across Acute Adult Mental Health wards in particular and the opening of Ward 4 have contributed to this. The allocation of RNs from Wards 5, 6 and 7 to Ward 4 has reduced RN staffing on those wards. Additionally the use of temporary staffing to support Ward 4 has reduced the availability of temporary staff to backfill other wards. Recruitment to RN vacancies has had limited success therefore alternative strategies are being investigated with the support of the HR and Communication teams.

APPENDIX 1 - April 2017 Safer Staffing

Apr-17	DAY						NIGHT						DAY		NIGHT						
	Registered nurses			Care staff			Registered nurses			Care staff											
Ward name	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	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Safe staffing was maintained by:	Vacancies	Bed occupancy	Movement	Provisional sickness data
Ward 1	1440	1440	953	1350	1350	1807	322	643	364	965	965	1231	66%	134%	57%	128%	Nurses working additional hours and altering skill mix. Cross cover was also provided to other wards.	2 B5 3 B3	97%	↑	3.40%
Ward 2	1455	1455	1191	1350	1350	1598	643	643	429	643	643	997	82%	118%	67%	155%	Altering skill mix. Cross cover was also provided to other wards.	4 B5 1 B3 1B2	92%	↓	6.77%
Ward 3	1515	1515	1157	1350	1350	1677	643	643	364	643	643	922	76%	124%	57%	143%	Altering skill mix. Cross cover was also provided to other wards.	3.8 B5 1.6 B2	86%	↓	2.18%
Ward 5	1050	1500	993	900	1770	1495	281	281	290	843	843	836	66%	84%	103%	99%	Nurses working additional hours and altering skill mix. Cross cover was also provided to other wards.	2 B5	91%	↓	0.00%
Ward 6	1050	1163	987	1800	1875	1770	281	281	291	835	957	910	85%	94%	103%	95%	Altering skill mix. Cross cover was also provided to other wards.	1 B5	92%	↑	3.14%
Ward 7	1035	1020	984	1350	1350	1319	281	281	281	563	563	571	96%	98%	100%	102%	Support from Access Team to cover RN on nights	1 B5	95%	↑	0.00%
A&T	1500	1305	1146	1350	2010	1886	323	323	333	968	1935	1871	88%	94%	103%	97%	Altering skill mix.	3 B5	100%	↑	3.38%
Edward Myers	1020	1020	976	900	900	850	281	281	283	553	563	545	96%	94%	101%	97%	Nurses working additional unplanned hours. Cross cover was also provided to other wards.	0.6 B3	94%	↓	11.39%
Darwin Centre	1093	1093	1018	1208	1208	1200	323	323	323	645	645	645	93%	99%	100%	100%	*	2.4 B5 0.2 B3	94%	↓	0.00%
Summers View	900	731	725	900	900	816	322	322	322	643	622	622	99%	91%	100%	100%	Support from the MDT.	0.8 B5 1 B3	96%	↓	9.85%
Florence House	450	450	426	900	825	619	322	322	322	321	322	322	95%	75%	100%	100%	Support from the MDT.	0.8 B5 0.5 B3	93%	↓	5.49%
Trust total	**12508**	**12691**	**10554**	**13358**	**14888**	**15036**	**4021**	**4343**	**3602**	**7622**	**8700**	**9471**	**83%**	**101%**	**83%**	**109%**	**Overall fillrate**	**95%**			

APPENDIX 2

Staffing Issues - April 2017

- Ward 4 opening temporarily in November 2016, to support the local health economy, has impacted on staffing levels since then. There are two reasons for this; firstly, the use of temporary staffing to staff the majority of Ward 4 shifts has resulted in other wards having difficulty in sourcing temporary staff when needed. Secondly, Wards 5, 6 and 7 released one WTE RN each to provide Ward 4 with stable RN leadership, additionally the Acting Ward 4 Manager was seconded from Ward 7. This has led to the temporary depletion of RNs on existing wards. Ward 4 was initially commissioned until the end of April 2017 but has recently been commissioned to open permanently as a shared care ward, therefore there will be a transition period whilst staffing, equipment, processes and procedures etc are put in place to safely open the ward as shared care. Across the wards there has also been staff turnover and further vacancies have arisen since October 2016. These have been difficult to fill and despite several adverts there are currently 20.8 WTE RN vacancies reported across in-patient wards. This is an increase from last month and is in line with the national picture where nursing shortages are being experienced across sectors. To pro-actively attract new Nurses to the Trust, twenty two Student Nurses, due to qualify in Oct 2017, have been offered posts. Sixteen have accepted offers of employment. Those who have not accepted an offer have indicated that they are moving away from the area following graduation. Monthly one-stop shops are also planned alongside a rolling recruitment campaign.

- The highest RN vacancies are across the Acute Adult Mental Health wards with Wards 1, 2 and 3 currently having B5 vacancies of 2, 4 and 3.8 WTE respectively; these posts have been advertised externally with limited success. Further recruitment events are being planned from May 2017 onwards with a rolling advert for Band 5 RNs.

- There is a further potential staffing issue due to Ward 4 opening permanently as a shared care ward. There will need to be a mixture of Mental Health and Adult RNs to support the ward and recruiting nurses for a whole ward will be challenging in the current climate. Furthermore the Acting Ward Manager and two substantive Staff Nurses currently allocated to Ward 4 have secured other posts within the Trust. Whilst there is some degree of flexibility with start dates due to posts being internal, these cannot be held indefinitely.

- Ward 5 RN fill rate on days was 66% during April 2017. The previous two six monthly safe staffing reviews have recommended that Ward 5 require an additional 4.26 RNs, additionally Ward 5 have one RN seconded to Ward 4 and one RN seconded to RAID. These factors are impacting on the RN fill rate. In terms of day shifts the ward is attempting to staff to the uplift in staffing recommended in the safer staffing, that is three RNs on the early shift and three on the late shift. Currently the ward establishment will only allow for staffing of two RNs on the early and late shifts, therefore as a maximum they can only achieve 72% fill rate within their current establishment. The impact of the Ward 4 secondment, recent RN vacancies and the difficulty of sourcing temporary staff due to the needs of Ward 4 have resulted in even the 72% fill rate not being achieved.

This situation has been raised with the Modern Matron and Head of Directorate who are reviewing this operationally and agency RN cover has been agreed to backfill the RN seconded to Ward 4.

- Ward 1 RN fill rate on days was 66% during April. During April 2017 the ward has two RNs on long term sick, two RN vacancies and one RN was seconded. Skill mix was altered to increase HCSW numbers during April bringing the overall day shift fill rate to 99%. The Modern Matron continues to oversee roster practices to ensure that resources are used effectively.

- Ward teams are supported by Modern Matrons, OTs 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.

- In June 2016 the planned RN night shift cover was increased from one to two RNs on the Acute Wards, 1, 2 and 3; this has led to a temporary decreased RN nightshift fill rate on these wards. It was expected that once the October 2016 newly qualified nurses had completed preceptorship, the Ward Managers have been directed to prioritise two RNs being rostered on nights. The number of vacancies have made this target challenging, however given that more Registered Nurse support is available on the day through Ward Managers, Modern Matrons and Nurse Practitioners, night shifts are the time when RN support needs to be strengthened. Therefore the Ward Managers have been directed to ensure that two RNs are rostered onto nights.

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

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO: TRUST BOARD

Enclosure No:6

Date of Meeting:	8 June 2017		
Title of Report:	Six monthly Safer Staffing report July - December 2016		
Presented by:	Maria Nelligan, Executive Director of Nursing & Quality		
Author:	Julie Anne Murray, Head of Nursing & Professional Practice		
Executive Lead Name:	Maria Nelligan	Approved by Exec	☒

Executive Summary:	Purpose of report	
This report details the findings of the January 2017 six monthly review of ward nurse staffing establishment, covering July-December 2016, in line with NHS England and National Quality Board (NQB) requirements.	Approval	☒
	Information	☐
	Discussion	☐
	Assurance	☐

Seen at:	SLT ☐ Execs X☐ Date: 16 May 2017	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.X☐ 6. Attract and inspire the best people to work here.X☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref			
Resource Implications: Funding Source:			
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	None		
Recommendations:	To receive the report for approval		

1 Executive Summary

The same methodology has been applied to this 6 monthly review. The Deputy Director of Nursing & Quality and the Head of Nursing & Professional Practice met with Ward Managers, Modern Matrons and members of the Multi-Disciplinary Team (MDT) to undertake the review. Due to the increasing acuity and dependency within the Acute Adult Mental Health wards the DoN has asked that a specific focus is taken with regards to these wards therefore the Quality Assurance and Improvement Manager also attended the AMH review meetings.

The review included a range of factors impacting on nursing and the potential to deliver high quality care. During the review meetings the quantitative data gathered, including areas of practice, staffing and leadership, was explored with the ward representatives to inform the conclusions and recommendations of the review.

The current and recommended staffing levels are detailed in Appendix 1, these remain consistent with the previous two six monthly reviews in January and July 2016.

A number of areas to be strengthened on the wards including an update on progress against the last six month safer staffing review. The Safe Staffing Group will implement the recommendations within the report and SLT will monitor progress.

2 Introduction

This report details the findings of the six monthly review of ward nursing staffing establishment completed in January 2017 in line with NHS England and National Quality Board (NQB) requirements. The NQB have produced further guidance in July 2016 that requires trusts to complete an annual strategic staffing review in future, followed by a comprehensive staffing report to board six months later to ensure that workforce plans are still appropriate.

3 Background

The first comprehensive review of nurse staffing was presented to the Board of North Staffordshire Combined Healthcare NHS Trust (the Trust) in June 2014. This resulted in investment in ward staffing for the 3 adult acute in-patient wards to uplift nurse staffing in response to increased occupancy. Two follow up reviews were held in January and June 2015, however in January 2016, following the appointment of the current Executive Director of Nursing & Quality (DoN), a further in-depth review was undertaken. The January 2016 review and the subsequent July 2016 review identified shortfalls in nurse staffing establishment within the three NOAP wards and one of the rehabilitation wards.

The original review in 2014 used the Hurst Tool methodology. From January 2016 onwards the Telford Model methodology, which is a recognised consultative approach based on professional judgement, has been used. When compared both tools provided the same outcome. In terms of the staffing establishment the reviews included both qualitative and quantitative data. To ensure the robustness of this approach and to prevent bias quantitative data from a number of sources was used to aid triangulation. The data examined for each ward review included:

- Current ward nursing and MDT establishment
- Rosters
- Skill mix ratios
- Temporary staffing arrangements
- Sickness
- Incidents
- Vacancies

4 National Guidance

As detailed in the previous six-monthly staffing review the revised NQB guidance (2016), included the need for greater triangulation of metrics including patient outcomes, productivity, financial sustainability, incident reporting/response and patient, staff and carer feedback. The procurement of the SafeCare module with the new e-rostering system will help to contribute to better triangulation of data. The NQB expect Trusts to develop a local Quality Dashboard for safe sustainable staffing therefore a recommendation in respect of this is included within this report.

The 2016 NQB guidance indicates that in the future, Trusts will be reporting on establishment, clinically required and actual hours. This is due to organisations interpreting 'planned' staffing in different ways which has hindered benchmarking. As yet there is no firm date set for when this will commence however the Trust has actioned this with effect from July 2016 and has reported to Board on this basis since.

Furthermore, Acute Trusts have had to report on Care Hours per Patient Day (CHPPD) since May 2016 and it is expected that all Trusts will be required to do the same in the near future. This process will be relatively straightforward, requiring the patient headcount at 23:59 each day, therefore the Trust will be able to respond to such a request promptly when received. At this time it is not clear when this will apply to Mental Health Trusts.

Finally, the new NQB requirements indicate that triangulation between local reviews, the use of professional judgement models (such as the Telford model) and the use of validated evidence based tools (such as the Hurst tool) are key to bringing together the outcomes from evidence-based tools alongside comparisons with peers in a meaningful way. The Trust initially utilised the Hurst tool, the subsequent use of the Telford model concluded the same nurse staffing requirement. Regionally there is work being undertaken to develop safe staffing tools in relation to both Mental Health and Learning Disabilities, this work is feeding into the national safe staffing agenda led by NHS Improvement. The Trust continues to be involved with these initiatives.

In the past six months the Trust has contributed to two consultations in relation to the draft National Guidance regarding Learning Disability staffing and Mental Health staffing. This guidance aims to support Trusts in ensuring robust processes are in place for safer staffing reviews and thus ensure that safe and sustainable staffing is achieved.

5 Standards relating to Mental Health Services

As part of this review the standards for in-patient care (NICE, 2011) and for therapy (NICE, 2009) were considered and discussed with clinical teams. These standards, set out below, were used to benchmark NSCHT wards.

5.1 Standards for In-patient Care (NICE, 2011)

- People using mental health services, and their families or carers, feel they are treated with empathy, dignity and respect.

- People using mental health services, and their families or carers, feel optimistic that care will be effective.

- People using mental health services understand the assessment process, their diagnosis and treatment options, and receive emotional support for any sensitive issues.

- People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy with an agreed date to review it.

- People in hospital for mental health care, including service users formally detained under the Mental Health Act, are routinely involved in shared decision-making

- People in hospital for mental health care have daily one-to-one contact with mental healthcare professionals known to the service user and regularly see other members of the multidisciplinary mental healthcare team

- Evidence of local arrangements to ensure that service users in hospital can see a mental healthcare professional known to the service user on a one-to-one basis every day for at least 1 hour

- Evidence of local arrangements to ensure that service users in hospital can see their Consultant on a one-to-one basis at least once a week for at least 20 minutes

- Evidence of local arrangements to ensure that service users in hospital are given an opportunity to meet a specialist mental health pharmacist

- People in hospital for mental health care are confident that control and restraint, and compulsory treatment including rapid tranquillisation, will be used competently, safely and only as a last resort with minimum force

- People in hospital for mental health care can access meaningful and culturally appropriate activities

- Evidence of local arrangements to ensure that service users in hospital have access to meaningful and culturally appropriate activities 7 days a week, not restricted to 9am to 5pm

5.2 Standards regarding Therapy (NICE, 2009)

Patients with a diagnosis of Mental Health whilst being an in-patient should have access to therapy including CBT, Family Therapy and Art Therapy.

NICE (2009) recommends Cognitive Behavioural Therapy (CBT) - to include

- Up to 8 sessions for anxiety and depression
- 16 sessions for psychosis
- 1:1 sessions up to 1 hour and include:
- Comprehensive assessment and engagement for people with a diagnosis of schizophrenia
- Provide manual based cognitive behavioural therapy

Family Therapy should be offered to all patients with a diagnosis of psychosis -

- Include the service user if practical
- Include at least 10 planned sessions over a period of 3 months to 1 year, 1:1 or group with choice
- Includes education on the illness, problem solving and communication modules

Art therapy should help people to:

- Experience themselves differently and develop new ways of relating to others
- Express themselves and organise their experiences into a satisfying aesthetic form
- Accept and understand feelings that may have emerged during the creative process at their own pace
- Be provided by a Health Professions Council registered arts therapist with experience of working with people with schizophrenia

- Have a group focus

6 Initiatives and Good Practice

There were a number of new initiatives and areas of good practice demonstrated during the review examples of which are detailed below:

- Summers View and Florence House, the rehabilitation units, have two weekly community meetings. These are chaired by service users thus enhancing partnership working and encouraging skills development during service users' rehabilitation.

- In line with National Guidance PBS is strongly embedded within Learning Disabilities services. To celebrate this and share best practice, the Modern Matron and Clinical Psychologist from the Learning Disabilities Directorate have submitted a poster demonstrating best practice to Positive Behavioural Support (PBS) National Conference.

- There are a number of supportive initiatives in place across the NOAP and AMH wards including reflective practice groups, a rolling CPD program and post incident debriefs. These are well embedded and as well as supporting staff, they encourage shared learning to enhance patient care.

- The Edward Myers team have been recognised as 'research ready' team and are currently involved in research relating to genetics and addiction. This will help build on the evidence base within their speciality.

- To support families during their child's hospital admission, staff at the Darwin Unit facilitate a weekly Parents Support Group. Additionally this helps to build relationships with parents, encouraging involvement and partnership in caring for their relative.

6.1 Progress on recommendations from July 2016 Review

Set out below is the progress in taking forward the previous six month safer staffing recommendations:

6.2 Local Quality Dashboard for Safe, Sustainable Staffing to be developed

The NQB requires Trusts to develop a local Quality Dashboard for safe, sustainable staffing. The Head of Nursing & Professional Practice will link with the Performance Team in order to identify a way forward with this. Once this is developed it will provide a method of measuring against triangulated data and actions can then be agreed to continually improve on identified areas.

Progress: There is currently no deadline set by NQB for the dashboard development however there is a Regional Group taking this forward that the Trust is participating with.

Additionally the procurement of SafeCare module to link with Healthroster will provide greater triangulation of data relating to staffing, bed occupancy, acuity and dependency in real-time. The newly appointed Associate Director of Performance and the Head of Nursing & Professional Practice will progress this in April/May 2017, with a view to having a dashboard operational by July 2017.

6.3 Implementation of Preceptorship Programme

The Clinical Placement Facilitator (CPF) developed a robust Preceptorship programme with the Modern Matrons in order to ensure that newly qualified nurses are supported through their first 12 months. Staff new to the organisation are also able to access the programme to assist their integration into the organisation and support their induction.
Due to the high numbers of newly qualified nurses recruited, senior nurses from operational and corporate services have been identified as buddies to support preceptors and preceptees.

Progress: The core Preceptorship Programme was delivered during October and November 2016 and was well evaluated by preceptees. The Clinical Education Team are supplementing the core programme by facilitating Action Learning Sets and workshops on relevant topics such as 'Are you ready to take charge?' The Preceptorship programme has been refined following evaluation by preceptees and the revised programme will commence in October 2017 to coincide with the recruitment of new qualified Registered Nurses.

6.4 Staffing for the Place of Safety S136 Suite

In order to ensure that there is staffing available for the S136 suite it is recommended that, as a minimum, an additional member of staff is rostered onto each night shift on Ward 1 specifically to cover the S136 suite. The current budgeted establishment for Ward 1 is 2 RN and 2 HCSW. This should be increased to 2 RN and 3 HCSW due to the frequency of use of the Suite and the difficulty in sourcing staff at short notice during the night. If the Suite is unoccupied the additional member of staff can be utilised across the Harpland's site to support areas with higher acuity, backfill shortfalls or facilitate staff breaks.

Progress: Ward 1 planned staffing is in line with this recommendation however the additional staffing is not within the budgeted establishment. In light of the S136 Suite moving from ward one this recommendation has been superseded. Safe staffing requirements are being considered in the options/proposals for an alternative, 1/2 bed, Place of Safety.

6.5 NOAP Safe Staffing Shortfalls

The uplift to baseline staffing for Ward 5 and the headroom of Ward 6 and Ward 7, recommended in the January 2016 six monthly review, continues to be required to meet clinical need. Therefore the recommended uplifts should be assigned to the relevant ward budgeted establishments.

Progress: Wards 5, 6 and 7 are staffing to safe staffing requirements however the additional staffing is not within the wards' budgeted establishment and therefore this continues to be a budget pressure. Further work is required to fully understand the impact of variable patient acuity on budgeted establishment.

6.6 LD Assessment and Treatment (A&T) Findings

6.5.1 Due to the high staff to patient ratio and robust MDT a contingency plan should be developed developed to identify how the staff will be utilised when beds are not fully occupied. The Head of Directorate will lead on this.

Progress: A protocol has been developed and implemented (Appendix 2) to ensure that A&T staff support other areas if and when beds are not fully occupied.

6.5.2 Consideration should be given to spreading the senior nursing (Band 6) cover over the 24 hour care period.

Progress: The Directorate have considered the need for senior nursing presence overnight and following a review of incident data established that there are very few clinical incidents at night. The majority of incidents are during day shifts and therefore senior nursing leadership presence is most needed during these shifts. Additionally, the service is moving imminently to a short shift system. This will result in a Band 6 presence being in place until later in the evening.

This has been discussed and agreed with the Head of Nursing and the situation will be kept under review. At present the Band 6 nurses do not routinely cover nights.

6.6 Summers View and Florence House - Clinical Leadership and HCSW Staffing

6.6.1 In order to strengthen clinical leadership, and in recognition of the responsibilities of the WM role, a further 1 WTE B7 RN should be employed across the 2 units. This would enhance the recovery model in place by having a combination of RN and OT leadership. The second Band 7 is currently available within the existing establishment.

Progress: This recommendation was considered by the Directorate and following discussions with the DoN the second Band 7 post was reconfigured to develop a third Band 6 RN position. This post works across the 2 units giving additional clinical leadership presence, supporting the WM with audits, quality assurance and quality improvement.

6.6.2 An uplift of 3.3 WTE HCSWs is required in order to meet the staffing requirements of Summers View. This is due to the staffing levels needed to support the client group and the fact that this is an isolated unit in relation to the main hospital site.

Progress: The reconfiguration of the second Band 7 allowed for a 1 WTE Band 2 post to be created. Summers View is staffing to safe staffing recommendations, however of the remaining 2.3 WTE HCSW posts all but 1.63 WTE have been established. The reconfiguration of the Band 7 post and the creation of a Band 6 and Band 2 post have been transacted within the budgeted establishment in April 2017.

6.7 RN Night Cover

6.7.1 Once the current cohort of RN recruits are in place there should be a timeline identified for achieving 2 RNs on night duty for Wards 1, 2 and 3. This will be dependent on experienced new starters being fully inducted onto wards and newly qualified nurses completing their preceptorship. The ability to achieve this will be built up over the next 6 months as new starters increase in competence and confidence and are able to support the night rota.

Progress: This continues to be worked towards and on occasions 2 RNs are being rostered on nights. However the current vacancy rate coupled with preceptorships is hindering full implementation of this requirement. As preceptees become competent in taking charge of shifts over the coming months and when vacancies are filled, the target of 2 RNs on nights will be more consistently met. The Head of Directorate has reinforced with the MM, the need for rostering 2 RNs on nights to be given high priority when completing rosters.

6.7.2 The Darwin Centre is a standalone unit and has one RN on duty at night. In order to strengthen support at night it is recommended that once the Harplands night staffing is strengthened, through the current recruitment programme, the DSN should make nightly supportive visits to the Darwin Centre.

Progress: As detailed in the previous point, RN night staffing has not progressed to the point where the night DSN could leave the site. Further barriers include the Fire Officer role held by the DSN and the fact that the DSN nights are generally filled by a Band 6 nurse.

To progress this further the Fire Officer role will be disseminated to other staff. MMs and the HoN are progressing this action as part of the Safer Staffing Group.

6.8 Senior Nursing Cover Out of Hours

In order to support staff nurses across 7 days it is recommended that the lead Duty Senior Nurses (DSNs), WMs, MMs and Nurse Practitioners provide cover over weekends and evenings. This would support our RNs and also increase visibility of senior clinical leadership across the 7 day week.

This recommendation has been implemented in August 2016 and will be reviewed in 3 months after our new RNs have commenced and increased in confidence within their new roles.

Progress: The senior nurse out of hours cover has supported junior staff during induction and preceptorship. It has also been valued by more experienced staff due to the increased clinical nursing leadership presence in evenings and weekends. The cover has also highlighted the need to ensure that Lead DSNs and WM's DSN shifts are spread across the 7 day week including late shifts. To address this, standards in relation to Band 7 cover of the DSN roster have been developed (Appendix 3); these have been agreed with the Heads of Directorate and will be implemented in April/May 2017.

6.9 Safe Staffing Group Progress

The Safer Staffing Group, led by the DoN, will be strengthened to include the Director of Finance. The function of the group will be to take forward the clinical and financial recommendations for safe staffing highlighted within this report.

Progress: The Director of Finance has joined the Safe Staffing Group. The following actions have been undertaken by the group in relation to progressing the recommendations of the 6 monthly staffing reviews.

Action	Outcome
Modelling of long day shift pattern and impact on quality and finance	Moving to long days still leaves a significant short-fall in required safe staffing funding and the impact on quality (in terms of supervision, training etc) mean this is not a viable option at this time.
Modelling of safe staffing recommendations with 19% margin headroom.	19% margin headroom equates to 23.5% mark-up headroom so no significant saving there as current headroom is 24% mark-up.
Examined in-patient budgets in relation to actual v established v safe staffing recommendations	Safe staffing recommendations indicate the need for a circa £600k uplift to established budgets, ytd spend indicates overspend of £990k relating to this staff group. Acuity, dependency and over occupancy all contribute to the need for additional staffing on an ad-hoc basis which contributes to this spend. Additionally the cost of backfilling vacancies and sickness will account for some of this overspend. It must also be recognised that there were still gaps in the required staffing levels throughout this time as evidenced in the monthly safe staffing reports however there is clinical support on the wards from other professional groups.

Action	Outcome
	Given the variables and the nature of staffing requirements, funding establishments to above levels would not be appropriate.
Commissioned an Acute Care Pathway T&F Group to embed the pathway within AMH services	Terms of Reference will be agreed to take this forward in March 2017 and will be led by the Consultant Psychiatrist Ward3 and the AMH Head of Directorate.
Acute AMH wards contract review	The service specification for the acute AMH wards has been reviewed and updated to capture the acuity and dependency levels currently being experienced. It has been acknowledged that the level of acuity/dependency should not be to the expected on a PICU or high dependency unit.
Commissioned review of Ward 5	Due to Ward 5 not being a core MH service and therefore not being reviewed by CQC during the comprehensive inspection, the ward will undergo a CQC style review. The review will consider CQC standards and compliance in order to identify areas of good practice and any areas for improvement. This is being led by the Consultant Nurse Physical Health & Infection Prevention Control.

7 Findings from current 6 monthly review July - December 2016

7.1 RN Vacancies

Several recruitment 'one stop shops' and the early offer of posts to newly qualified Keele University students during 2016 resulted in the majority of RN vacancies being filled by October 2016.

This resulted in a high level of preceptorships being required to support newly qualified nurses; this limits flexibility whilst preceptees work towards being able to take charge of shifts. A robust preceptorship programme has been facilitated for the preceptees and is continuing over their first 12 months in post.

Further vacancies that have arisen since October 2016 have been difficult to fill and despite several adverts there are currently 14 WTE RN vacancies across in-patient wards. One stop shop events in March 2017 have not been successful in attracting further candidates. This is in line with the national picture where nursing shortages are being experienced across sectors. To pro-actively attract new nurses to the Trust, 22 student nurses due to qualify in Oct 2017 have been offered posts. The permanent opening of Ward 4 and a PICU can be expected to further challenge RN recruitment. Targeted recruitment campaigns in addition to 10 'one stop shops' are planned between now to September with the aim of attracting RNs from mental health, learning disability and adult fields to the Trust.

Flexible retirement options are being highlighted and incentives to attract people to the Trust are being considered.

7.2 Medical Staffing

A number of issues regarding medical staffing was raised during the review. These have been picked up by the Medical Director who is commissioning a review of the distribution and effectiveness of resources across in-patient wards.

7.2.1 NOAP

During the review discussion took place regarding the role an Advanced Practitioner Physical Health could have in supporting Junior Doctors, this will be considered following the review of medical staffing commissioned by the Medical Director.

7.3 Acute AMH Occupational Therapy

Over the past 12 months the OT provision within Acute AMH wards has been strengthened; there is now 1 Band 5 OT on each of the wards overseen by a Band 6 OT lead.

This has raised the profile of OT within the AMH wards, with MDT members becoming more aware of the range of OT knowledge and skills that can be used to widen the support offered to service users.

OT is now well established within the MDT team and there has been support from the Directorate to develop what can be offered. Assessments, group work and 1:1 sessions are all facilitated. The OTs have also contributed to the improvement of therapeutic element of clinical observations through jointly educating and training non-registered nurses.

It was noted that there is a lack of 'off the ward' space available for OT, the provision of this would strengthen the value of OT sessions for service users.

7.4 CAMHS Multi-disciplinary Team

Over the past 12 months the Multi-disciplinary Team (MDT) has been strengthened with the addition of OT, Psychology, systemic Family Worker, Social Worker, Activity Worker and Housekeeper to the ward team. The MDT are now well established and the value of having this skill mix was reported by the ward team during the safe staffing review.

A change in service specification means that the unit will be accepting 24 hour emergency admissions. This may result in the need for an extra RN at night to be addressed. This will be monitored and discussed with Commissioners should the need arise.

7.5 Access to Meaningful Activities

NICE standards for in patient care (2011) require there to be evidence of local arrangements to ensure that service users in hospital have access to meaningful and culturally appropriate activities 7 days a week, not restricted to 9am to 5pm. All wards have an Activity Worker and several of the Activity Workers work over the 7 day week and into the evening on occasions. However there is no capacity for Activity Worker backfill cover for sickness or maternity leave. ll wards also have OTs, OTs currently work Mon-Fri in normal working hours and a part of their role includes meaningful activities.

Furthermore 'off the ward' space for activities is limited the range of meaningful activities and groups that can be offered as well as OT assessment. Therefore it is recommended that an area is identified within the Harplands site to facilitate such activities.

7.6 Acute AMH Bed Occupancy

Occupancy across the 3 Acute AMH wards is above the 85% threshold recommended by the Royal College of Psychiatrists (2011) who state:

"Very high bed occupancy militates against quality and safety of in-patient care. Bed utilisation is at its most efficient when bed occupancy is at 85%.

This means that patients can be admitted in a timely fashion to a local bed, retain the connections with their social support network and take leave without the risk that they cannot return to their ward should they need a longer period of in-patient care.

It allows functioning space to accommodate those newly admitted and to provide proper treatments to current patients. Delays in admission to hospital can result in patients becoming more distressed and unwell, and likely to need more long-term care."

With the additional funding agreed for acute wards in 2014, there was an agreement that occupancy of 90% was acceptable. The occupancy from April 2016 to date indicates that the occupancy for Wards 1, 2 and 3 has been 103%, 99% and 100% respectively.

This has been highlighted at the Trust`s Senior Leadership Team (SLT) and raised with Commissioners through CQRM.

Following a review of the AMH service specification with the NHS Standard, the content has been strengthened to clearly outline the acuity, occupancy and observation levels that the Trust is routinely commissioned to provide. Any variation to this will need to be raised with Commissioners.

7.7 Acuity within NOAP and AMH Wards

There is increased acuity and dependency locally; this is in line with the national picture and means that increased observation levels are regularly required. This has an impact on safe staffing levels given that fluctuating acuity and dependency levels lead to planned safe staffing figures to also vary. The recommendations made by this and previous safe staffing reports are in relation to the baseline staffing numbers and these equate to the budgeted establishment on wards (except where shortfalls have been identified). The Trust is then required to report to the Board and UNIFY on planned versus actual staffing numbers. Planned staffing numbers are the number of nursing staff (registered and non-registered) clinically required, on shift, to meet the needs of service users at that particular time. Actual staffing relates to the nursing team on duty on that shift.

A core function of Mental Health Nursing is the responsibility to keep patients safe. Failure to do so can lead to varying levels of harm to patients or staff, including death.

To meet this core function within mental health in-patient settings, one of the most common interventions is to allocate the care and supervision of a patient to an individual nurse (Bowers, Gourney & Duffy, 2000). When caring for acutely ill patients, presenting with disturbed and threatening behaviour, this allocation is facilitated by the use of increased clinical observations. Nationally, NHS Trusts have policies and procedures to support this intervention and these policies follow the Department of Health (1999) practice guidelines which identified 3 levels of enhanced observation. In line with these guidelines NSCHT's Policy and Procedure for the Safe and Supportive Observation and Engagement of Patients at Risk (Policy 1.35) identifies four levels of nursing observations:

General Observation (Level 1): This is the minimum acceptable level of observation. Under this level of observation, nursing staff make regular checks on the whereabouts and well-being of all patients. In practice this is implemented by a minimum of hourly contact with all patients on the ward. This is in line with statutory Health & Safety regulations.

Close Intermittent Observation (Level 2): This level of observation is appropriate when patients are potentially, but not immediately, at risk.
A designated nurse is assigned to monitor the patient's whereabouts and circumstances at regular, intermittent periods (generally 10 – 15 minute intervals). In practice this level supports the management of risks associated with harm to self and others, or poor physical health.

Constant Visual Observation (Level 3): Continuous visual observation is required when the patient demonstrates vulnerability but without clear intent or plan and is assessed as being at risk of serious harm to themselves or others at any time.

In practice this level supports the management of risks associated with serious harm to self and others or significantly poor physical health that requires constant nursing attention.

Special Observation (Level 4): Special observations are applied when a patient demonstrates immediate/imminent risk of suicide or seriously harming themselves or others. This results in the need for the patient to be nursed in close proximity and requires nurses to give due regard to safety, privacy, dignity, gender and environmental dangers.

A designated nurse is physically present by the patient's side 24 hours per day and never leaves the patient for any reason unless relieved by another designated nurse. There may be occasions when more than one nurse is required to support this level of observation due to the level of risk presented by the patient.

The impact of all levels of increased observations on patients can be distressing due to their restrictive nature. Similarly nurses are affected by undertaking increased clinical observations which require extended periods of intense concentration and engagement with patients presenting with the highest levels of need. These interventions require highly skilled interactions to support therapeutic engagement with patients during increased observations. The ability to engage therapeutically during enhanced observations can improve the experience for patients however this can be emotionally and mentally exhausting for nurses who are responsible for delivering these interventions 24 hours a day. Furthermore, dependent on the number of patients being supported on increased observations, nurses may have to undertake enhanced observations for extended periods of time. This may impact on their ability to take breaks and rest periods in line with NSCHT policy and the European Working Time Directive.

Wards can absorb a certain level of increased observations within their current staffing establishment and the Adult Mental Health and NOAP wards have indicated that these are in the table below and would be on the basis of Level 2 OR Level 3 OR Level 2&3:

Obs Level	Level 2	Level 3	Mixture of Level 2&3
Ward 1	2	1	1 Level 2 & 1 Level 3
Ward 2	2	1	1 Level 2 & 1 Level 3
Ward 3	2	1	1 Level 2 & 1 Level 3
Ward 5	1	1	1 Level 2 or 1 Level 3
Ward 6	2	2	1 Level 2 & 1 Level 3
Ward 7	2	1	2 Level 2

*NB Level 4 not included as this is rarely used

Examination of observation levels between September and November 2016 (Appendix 4) evidenced frequent use of level 2 and 3 observations. Level 4 observations were rarely used.

The use of observations during that time period indicated that, on average, an additional 10 members of nursing staff per shift were required to support increased observations across these six wards.

Within NSCHT the agreed RN to non-registered nurse (HCSW) staffing ratio is 50:50. Based on this ratio an additional 29.75 RN and 29.75 HCSW Whole Time Equivalents are required to support these additional increased observations if this was a permanent requirement.

It is not always possible to backfill the staffing required for increased observations however a significant proportion are backfilled and these increased staffing levels are currently being absorbed within the Trust`s current financial envelope; this is unsustainable in the long term.

The thresholds for acute AMH beds have been included in this year's service specification with the CCG and reconfirmed the role of Wards 1, 2 and 3 as acute mental health and not high dependency/PICU. As a result the HoD and CD are amending and reinforcing the admission criteria.

The financial status of the AMH In-patient Directorate corroborates the cost of this additional staffing, contributing to the overspend within the Directorate. The NOAP Directorate financial status does not indicate an overspend and therefore the cost of the additional staffing within NOAP is currently being absorbed within the Directorate. The Finance Department has investigated how this is being funded to understand whether a realignment of funding is possible. However the outcome of this investigation identified that a number of vacancies within the Directorate have off-set the over spend on the NOAP wards. These posts are needed within NOAP community services and have been recruited to therefore realignment of funding would not be appropriate. A skill mix review should still be undertaken to ensure quality, safety and affordability are aligned.

7.8 Impact of the re-opening Ward 4

In November 2016, in response to demands within the Local Health Economy, the Trust agreed to open Ward 4 as a nursing assessment unit. At that point, nurse staffing across the wards, was coming to a point where the overall majority of vacancies were filled and there was capacity within temporary staffing to meet any shortfalls. However, the requirement for the 3 NOAP wards to second a total of 4 RNs to ward 4 has had an impact on their ability to meet safe staffing requirements in relation to registered nurses. Additionally, the use of temporary staffing to meet the rest of Ward 4's staffing establishment has left the temporary staffing depleted thus impacting on staffing across all in-patient wards.

The forthcoming plan for Ward 4 to be commissioned permanently as a shared care (physical health and mental health) facility will require substantive staffing to be in place prior to opening. This will be challenging within the current recruitment climate and a targeted recruitment campaign is being launched to market these employment opportunities. This will ensure that recruitment is high profile in order to attempt to attract registered and non-registered nurses. There will be a balance of mental health and adult nurses and therefore there is an opportunity to seek candidates from out with the Trust's usual recruitment pool.

7.9 Impact of ROSE

In May 2017, through the ROSE project, the Trust will launch a new Electronic Patient Record system. The new system will result in a greater proportion of patient records being electronic than with the current CHIPS system.

Some organisations have found that whilst EPR has many associated benefits they may also result in higher administrative burden on nurses and the need for higher nurse staffing levels (Furukawa, Raghu & Shao, 2010). The impact of ROSE on nursing workload will be monitored in relation to safe staffing levels.

7.10 In-patient Crisis Response

Within the Harplands site there is a PIT (Passive Infrared Transmitter) alarm system in use to alert staff (across wards) of the need to assist colleagues in the management of a medical or psychiatric emergency. Currently there is no rota in place to identify which members of staff are expected to respond to the alarm and therefore there is the potential for too few or too many staff to respond. This has patient and staff safety implications alongside efficiency considerations. Furthermore the way the PIT system is currently set up the alarm sounds on the majority of wards impacting on patients across the hospital.

It is proposed that a Crisis Response rota is devised across the site indicating which members of staff are expected to attend incidents. Those staff on the Crisis Response rota will be alerted of the need to attend an incident by a bleep system.

This will enable the current system, of alarms sounding across all wards, to be removed. The WM T&F group is currently undertaking this piece of work.

7.11 Clinical Supervision in Nursing

Currently Ward Managers provide caseload management supervision to nurses with nurses accessing clinical supervision from another practitioner, generally of their choice. Ward Managers from the acute in-patient wards have clinical supervision from the wards' Clinical Psychologists. From a professional perspective there is value in accessing clinical supervision external to the practitioner's profession; this should be in relation to a specific area of practice and based on the supervisor's ability to support the supervisee's development due to their expertise and experience in that area of practice.

Further clinical supervision activities such as reflective practice groups and risk review forums are also in place across wards. There is also an embedded culture of post incident debriefs which provides further support.

The WMs T&F group have clinical supervision on their work plan for this year and are reviewing clinical supervision within nursing and the implementation of a values based clinical supervision toolkit for their wards.

7.12 Nursing Red Flags

NICE guidance for 'Safe Staffing for Nursing in Adult In-patient Wards in Acute Hospitals' (2014) introduced nursing 'red flags' which warn when nurses in charge of shifts must act immediately to ensure they have enough staff to meet the needs of patients on that ward. Whilst these red flags relate to Acute hospitals a number of indicators are relevant to mental health and learning disability in-patient areas including incidents of there being less than 2 RN's on duty. The DoN has requested that wards complete an incident form to highlight any such incidents and RNs are expected to address and escalate if necessary.

This is a particular issue on nights shifts where only the acute AMH wards are established for 2 RNs on duty. A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift.

Another pertinent red flag is the need to highlight when there is a shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift.

This will be considered when setting the thresholds for the SafeCare module within the e-rostering project whereby this can be calculated automatically in real-time and escalated.

7.13 HCSW Skill Mix

A number of wards now have Band 2 HCSW's in post and this is being considered further in terms of developing staff through the Apprenticeship Levy.

Although non-registered nursing recruitment is not as challenging as RN recruitment the challenges of caring for our service users and our aim to attract the best quality candidates are factors that need to be considered when altering skill mix.

Furthermore the overlap of Band 2 and 3 pay scales and the fact that unsocial hours payments for Band 2's are higher than Band 3's means that there is only a small difference in salary as detailed in the table below:

24/7 shift pattern	Cost	Cost	Difference between B3 and B2
Top point of scale	£30,438	£28,841	1,597
Mid-point of scale	£28,112	£26,265	1,848
Bottom point of scale	£26,017	£24,466	1,551

Due to this minimal difference and given the complexity of the care needed to support our service users, it is recommended that Band 2 posts are limited to apprenticeships with an uplift to Band 3 on successful completion of the apprenticeship is considered.

7.14 Assistant Practitioners

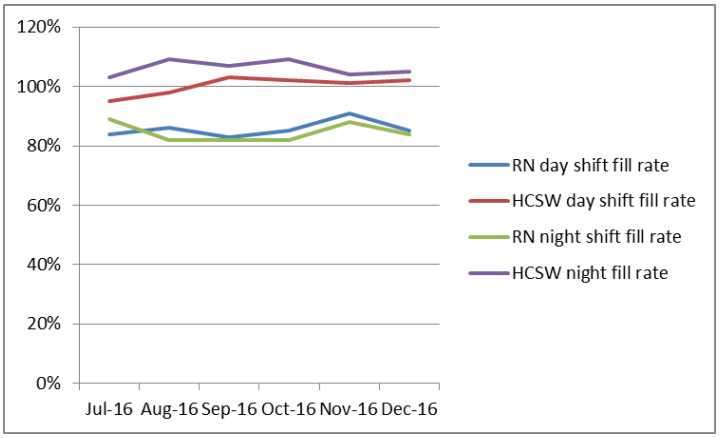
There are six Trainee Assistant Practitioners (TAPs) within the AMH and NOAP wards due to qualify this year. The TAPs have been seconded to complete their Foundation Degree training funded by Health Education West Midlands (HEWM). The Assistant Practitioner model allows employers to tailor the role to the needs of the service. Within the AMH and NOAP wards the role has been designed to facilitate discharge and has released registered nurses time in relation to this activity. When seconding a member of staff to complete the TAP training there is an expectation from HEWM that an Assistant Practitioner role will be available on completion of training.

The AP role developed by the Directorates has clarity around purpose and differentiation from the HCSW role. It utilises the knowledge and skills attained by the TAPs during their Foundation Degree and it is important that this is recognised by ensuring that there are Band 4 AP roles available on completion.

Additionally, in some cases APs can complete their registered nurse training in a shortened timescale. With the development of pre-registration nurse apprenticeships this could be an opportunity to grow our own RNs in a shorter timescale.

8 Safer Staffing Performance July - December 2016

Safe staffing levels are reported monthly to UNIFY and Board. The table below demonstrates the safe staffing levels over the past 6 months:



This indicates that RN cover has ranged between 84% and 91% on days and 82% and 89% on nights. The nights shift cover on Wards 1, 2 and 3 is challenging due to preceptorships and vacancies. There is always an RN on duty but the 2nd RN, as recommended by safe staffing reviews, is not consistently being achieved.

Following on from several recruitment drives it is likely that vacancies will not be substantively filled until the newly qualified nurses graduate in October 2017.

8.1 Staffing fill rate and the impact on Patient Safety, Patient Experience and Staff Experience

Each month the Board receives a safer staffing report highlighting the impact of staffing shortfalls and the mitigations implemented to ensure that safety is maintained. During July - December 2016 there were 47 incident forms completed relating to staffing issues. **No harm arose from these incidents.** Ward Managers take a number of actions to ensure that wards are safely staffed, prioritising direct patient care. These include the following:-

- 106 patient activities were shortened or cancelled
- 239 staff breaks were cancelled (time in lieu given)
- 70 staff breaks were shortened
- 51 mandatory training and supervision sessions were cancelled and rescheduled
- 1270 hours of cross cover was provided between wards
- 796 vacant RN shifts were backfilled by an HCSW
- 180 vacant HCSW shifts were backfilled by an RN

Additionally the Multi-Disciplinary Team and Ward Managers support nursing staff when staffing levels are reduced. There are also Senior Nurses, MMs, Nurse Practitioners and DSNs, who provide additional support to clinical teams. The Head of Nursing is working with the Modern Matrons and Ward Managers to address staff taking breaks in a timely manner and develop time in lieu standards which will support staff well-being and the implementation of the E-roster.

As indicated above HCSW cover is routinely over 100% as the skill mix is altered to provide cover in the absence of available RNs.

Given the ability to source non-registered staffing and the difficulty in recruiting to RN positions the Trust should consider apprenticeships in pre-registration nursing and nursing associates to strengthen a 'grow your own' model of workforce planning.

8.2 Rostering and Temporary Staffing

The Trust has procured the e-rostering system (Healthroster) and a 12 month implementation programme has commenced with the first ward going live on 01 May 2017.

E-rostering will allow for greater transparency in relation to rosters and also for Key Performance Indicators (KPIs) to be set and monitored. Rosters will also be created further in advance, this has been found to reduce temporary staffing use across Trusts using Healthroster.

To prepare for the 2017-18 annual leave year, all rostered areas have been issued with weekly annual leave targets of a minimum of 11% and maximum of 17%, this will ensure that all rostered areas are managing annual leave effectively and are prepared for the transition to e-rostering from the beginning of the annual leave year. Wards have also been encouraged to reduce time-owing balances to zero to enable a smooth transition.

Alongside Healthroster, a temporary staffing software solution, BankStaff, is being implemented. Going live on 03 April 2017, the BankStaff system will improve financial and clinical governance in relation to temporary staffing. This will address the issues previously highlighted on the risk register.

There is a further module, SafeCare, which will be rolled out to work alongside Healthroster and BankStaff.

SafeCare gives real-time visibility of staffing levels across wards in relation to patient numbers and acuity, it responds in real time to roster changes and gives visibility of staffing changes and the impact on patient safety, on redeployments and on usage of temporary staff. This helps avoid over or under-staffing and makes optimum use of substantive staff. SafeCare will go live toward the ends of the year, after the majority of wards are live on Healthroster.

8.3 Sickness

The table below identified sickness levels across wards over the six month period July - December 2016 in comparison the 2 previous six-monthly staffing reviews.

Average sickness	July-Dec 2015	Jan-Jun 2016	Jul-Dec 2016
Ward 1	8.2%	2.1%	11.4%
Ward 2	11.6%	10.6%	7.6%
Ward 3	9.1%	4.6%	3.2%
Ward 5	8.2%	6.3%	6.6%
Ward 6	9.5%	6.5%	6.9%
Ward 7	3.2%	1.8%	6%
Florence House	5.1%	10.2%	3.3%
Summers View	10.9%	13.8%	8.4%
Darwin Centre	2.1%	3.2%	4.7%
Assessment and Treatment (A&T)	4.4%	12.1%	5.5%
Edward Myers	2.0%	7.6%	4.6%

Human Resources information supplied by the Human Resources Department.

Whereas the other 6 wards have shown a reduction in sickness levels compared with the previous 6 months, 3 of these wards (Ward 2, Summers View and A&T) had sickness levels above the 5% Trust target. Five wards (Wards 1, 5, 6, 7 and Darwin) had an increase in sickness and the Darwin Centre stayed below the 5% sickness target. Wards 5, 6 and 7 are NOAP wards and in addition to increased sickness levels have shortfalls identified in budgeted establishment. These are the wards where experienced staff have been seconded to Ward 4 from.

Whilst there are a range of factors that impact on sickness levels, recurrent short staffing has been found to result in staff stress and reduced staff well-being, leading to higher sickness absence (RCN, 2010) therefore the sickness levels on Wards 5, 6 and 7 will continue to be closely monitored by the Directorate to identify and address any underlying trends.

9 Recommendations

The staffing review recommends the same baseline nurse staffing levels as the previous 2 six monthly staffing reviews. The recommendations carried over from the previous staffing reviews (Jan 2015 and July 2016) are detailed below alongside additional recommendations that have arisen during this review.

9.1 Care Contact Time

Care hours per patient day will be captured and analysed within the new Healthroster and SafeCare software. This will enable benchmarking across organisations to provide further assurance relating to safe staffing levels.

9.2 Dashboard Development

The development of a safe staffing dashboard triangulated with other quality indicators is a requirement of the NQB guidance (July 2016). This will be progressed by the Head of Nursing and the Associate Director of Performance. Once this is developed it will provide a method of measuring against triangulated data and actions can then be agreed to continually improve on identified areas.

9.3 Staffing for the Place of Safety S136 Suite

The current place of safety (PoS) has one bed and is situated on Ward 1. There are no substantive staff attached to the Suite, there is funding of circa £26k per annum within the ward budget. Ward 1 source staff from their establishment or Bank when a person is admitted to the PoS. The PoS Suite will move from Ward 1 in the near future with a proposal to increase to 2 beds to meet with current national guidance in relation to reducing the number of incidents where police custody suites are utilised for this purpose. The staffing of the Suite will be dependent on where the Suite is situated and the number of beds. Additionally benchmarking with other Mental Health Trusts will inform the final recommendation and the use of substantive staffing within this model will be considered.

9.4 NOAP Safe Staffing Shortfalls

The uplift to baseline staffing for Ward 5 and the headroom of Wards 6 and 7 recommended in the January 2016 six monthly review, continues to be required to meet clinical need. Therefore the recommended uplifts should be assigned to the relevant ward budgeted establishments to address budget pressure.

9.5 Summers View HCSW Staffing

An uplift of 1.63 WTE HCSWs continues to be required in order to meet the safe staffing levels within Summers View. The gap has been closed following the previous review. This is due to the staffing levels needed to support the client group and the fact that this is an isolated unit. Therefore the recommended uplifts should be assigned to the relevant ward budgeted establishments to address budget pressure.

9.6 RN Night Cover

9.6.1 Acute AMH RN Night Cover

RN night cover should be prioritised within Wards 1, 2 and 3 where the budgeted establishment includes 2 RNs per night shift. Where there are insufficient RNs available to meet the RN safe staffing recommendations across the 24hr roster (for example due to vacancies and sickness) and backfill is unable to be sourced, then early shifts should reduce to 2 RN before nights reduce to 1 RN. The rationale being that there are more staff available during the day as WMs and MMs work day shifts predominantly.

9.6.2 CAMHS RN Night Cover

The Darwin Centre is a standalone unit and has one RN on duty at night. In order to strengthen support at night it is recommended that once the Harplands night staffing is strengthened through the current recruitment programme, the DSN should make nightly supportive visits to the Darwin Centre.

Furthermore a change in service specification means that the unit has been accepting 24 hour emergency admissions for the past 18 months. This was not identified in the previous six monthly reviews; currently this has not led to issues in relation to out of hours RN cover. This potential issue will continue to be monitored.

9.7 RN Recruitment Challenges

Due to the difficulty in recruiting to RN posts and the ability to source non-registered staffing locally, the Trust should consider apprenticeships in pre-registration nursing and Nursing Associates to strengthen a ‘grow your own’ model of workforce planning. Furthermore developing such opportunities will act as an attractive recruitment factor for non-registered posts.

9.8 Development of HCSWs

The difference in salary between Band 2 and Band 3 HCSWs working over a 24/7 shift pattern ranges from £1500-1800 per annum. Furthermore HCSWs spend the majority of their working day delivering direct patient care. Due to this minimal difference in salary and given the complexity of the care needed to support our service users, it is recommended that Band 2 posts are limited to apprenticeships and that an automatic uplift to Band 3 on completion of the apprenticeship is considered.

9.9 Medical Staffing

A review of the use of medical resource across in-patient wards has been commissioned by the Medical Director.

9.9.2 NOAP

Consideration will be given to the role of Advanced Practitioners of Physical Health following the review of medical staffing by the Medical Director.

9.9.3 Service Users Reviews

A weekly timetable of medical reviews will be available on all wards and developed by Consultants and Ward Managers.
This will also enable the NICE (2011) standards in relation to patients meeting with their Consultant Psychiatrist for at least 20 minutes per week to be fulfilled and time-tabled.

9.10 Monitor the impact of ROSE on Nursing Workload

Following the implementation of the Trust`s new electronic patient record through the ROSE Project, the impact of a higher proportion of documentation being electronic will be monitored.

9.11 Implementation of In-patient Crisis Response Rota

A crisis response rota is devised across the Harplands site indicating which members of staff are expected to attend incidents. This will strengthen the response to medical and psychiatric emergencies and will benefit both service users and staff. The WM T&F group are progressing this recommendation.

9.12 Assistant Practitioners

Assistant Practitioner posts should be available for the 6 TAPs due to qualify this year.
This is in recognition of the role they have developed over the past 2 years of training and the knowledge and skills they have gained within their Foundation degree to enable them to fulfil this role.

9.13 Safe Staffing Group

The Safe Staffing Group will meet bi-monthly to ensure that recommendations from this and previous reviews are progressed. The group will also monitor the progress of the implementation of Healthroster, BankStaff and SafeCare to ensure that KPI's and expected benefits are monitored and reviewed.

9.14 Frequency of Safe Staffing Reviews

In line with the latest NQB guidance (2016) strategic safe staffing reviews will be carried out annually moving forward. Monthly reporting will continue and should this identify areas of immediate concern these will be raised with the relevant directorate and escalated as required. A comprehensive 6 monthly report will then be provided to Board to ensure that workforce plans and recommendations continue to be contemporaneous.

10 Conclusion

Progress has been made against the recommendations of the previous review and these have been highlighted within the report.

The current six monthly safer staffing review has corroborated the baseline staffing levels identified in the previous two reviews which indicate that the 3 NOAP wards and 1 rehab ward require an uplift in staffing. Therefore there are continued budget pressures in terms of maintaining safe staffing. Additionally the fluctuating demands due to increasing acuity and dependency impact on safe staffing. These have been included in the contract with the CCG for the AMH wards and the AMH admission criteria is being reviewed by the HoD and CD to bring practice into line with the contract.

The inclusion of the staffing required to meet this fluctuating demand, on top of baseline staffing, is currently being met within the Trust`s financial envelope but is unsustainable and will be monitored by the Safe Staffing Group.

Recommendations carried over from the previous 6 monthly report and further recommendations arising from this review have been highlighted within Section 9 of this report. The Board is asked to approve this report.

11 References

Furukawa, M. F., Raghu, T. S., & Shao, B. B. M. (2010). Electronic Medical Records, Nurse Staffing, and Nurse-Sensitive Patient Outcomes: Evidence from California Hospitals, 1998–2007. *Health Services Research*, *45*(4), 941–962. http://doi.org/10.1111/j.1475-6773.2010.01110.x

NICE. (2011). Service user experience in adult mental health services. Retrieved from https://www.nice.org.uk/guidance/qs14

NQB Guidance. (July 2016). *'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time'.* https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf

12 Appendices

12.1 Appendix 1 Current and recommended staffing levels

Ward	Role	WTE inc headroom	Current establishment	Variance	Recommendations
Ward 1	B6	2.00	2.00	0.00	No change (shortfall in HCSW due to PoS N not in est)
	B5	13.37	13.27	0.10	
	HCSW	17.85	15.27	2.58	
Ward 2	B6	2.00	2.00	0.00	No change
	B5	13.37	13.27	0.10	
	HCSW	15.37	15.27	0.10	
Ward 3	B6	2.00	2.00	0.00	No change
	B5	13.37	13.27	0.10	
	HCSW	15.37	15.27	0.10	
Ward 5	B6	1.00	1.00	0.00	Uplift required
	B5	13.76	9.50	4.26	
	HCSW	14.76	12.20	2.56	
Ward 6	B6	1.00	1.00	0.00	Uplift required
	B5	13.76	11.90	1.86	
	HCSW	14.76	14.30	0.46	
Ward 7	B6	1.00	1.00	0.00	Uplift required
	B5	9.11	9.00	0.11	
	HCSW	14.76	10.80	3.96	
Summers View	B7	0.50	0.50	0.00	Improvement made small Uplift required
	B6	2.00	2.00	0.00	
	B5	7.20	7.93	0.73	
	HCSW	11.00	11.91	0.91	
Florence House	B7	0.50	0.50	0.00	No change
	B6	1.00	1.00	0.00	
	B5	5.60	5.43	0.17	
	HCSW	9.23	9.39	0.16	
Darwin	B6	2.00	2.00	0.00	No change
	B5	10.90	10.80	0.10	
	HCSW	15.39	12.64	2.75	
Telford	B6	5.60	5.60	0.00	No change
	B5	7.30	6.88	0.42	
	HCSW	17.88	16.72	1.16	
Edward Myers	B6	1.00	1.30	0.30	No change
	B5	8.42	8.26	0.16	
	HCSW	11.90	11.28	0.62	

NB the above exclude ward managers except Summers View and Florence House

12.2 Appendix 2 LD assessment and treatment (A&T) protocol

LD Admission and Discharge Protocol Fin

12.3 DSN roster standards

DSN roster standards.docx

12.4 Acute AMH and NOAP Sep-Nov 2016 observation levels

In terms of safe staffing baseline levels, across the 6 AMH and NOAP wards, the following increased observations can be supported:

11 Level 2 observations OR

7 Level 3 observations & no Level 2 observations OR

7 Level 2 observations & 4 Level 3 observations OR

6 Level 2 & 5 Level 3 observations

Where the number of patients requiring enhanced observation levels exceeds this capacity on a ward, additional staffing resource must be used to ensure wards are safely staffed. On each shift the remaining nursing staff are required to provide care for the rest of the patients on general observations. During September - November 2016 there were, on average, 23 Level 2 observations, 3.8 Level 3 observations and 0.1 Level 4 observations on every shift. The number of Level 2 observations did not fall below 14 on any shift, therefore any Level 2 observations above 11 and any level 3 or 4 observations required additional staffing.

Increased Observations	Level 2	Level 3	Level 4	Total
Total no. of increased observations per day from Sep - Nov 2016	2096	343	10	2449 increased observations
Average no. of increased observations per day	23	3.8	0.1	26.9 increased observations
Increased observations supported within existing safe staffing levels	11	0	0	11 Level 2 observations
Increased observations not supported within existing safe staffing levels	12	3.8	0.1	12 Level 2, 3.8 Level 3, 0.1 Level 4 observations
Additional nursing staff required per shift to support increased observations not absorbed within safe staffing numbers	6	3.8	0.2	10 nursing staff

The table above demonstrates that despite the capacity to absorb an element of increased observation levels within ward staffing establishment, this is regularly exceeded. The first 11 Level 2 observations would be absorbed within the safe staffing numbers meaning, 12 Level 2 observations, 3.8 Level 3 observations and 0.1 Level 4 observations would need to be supported with additional staffing. This would require 6 staff for the 12 Level 2 observations and 4 staff for the remaining Level 3/4 observations. Therefore, on average, an additional 10 members of nursing staff per shift were required to support increased observations during Sep - Nov 2016.

Within NSCHT the agreed RN to non-registered nurse (HCSW) staffing ratio is 50:50. Based on this ratio an additional 29.75 RN and 29.75 HCSW Whole Time Equivalents (Table 4) are required to support these additional increased observations.

It is not always possible to backfill support required for increased observations, however a significant proportion are backfilled and these increased staffing levels are currently being absorbed within the Trust`s current financial envelope; this is unsustainable in the long term.

Additional clinical hours required each day	WTE excl headroom	WTE inc headroom	50:50 ratio
10 x(7.5+7.5+10.7) = 257	(257x7)/37.5 = 48WTE	59.5 WTE	29.75 RN and 29.75 HCSW

Table 4 NB Headroom calculated as 24% mark-up (equivalent to 19% margin headroom)

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO Trust Board (Meeting)

ENC No. 7

Date of Meeting:	8 June 2017		
Title of Report:	2017/18 M1 Performance Report		
Presented by:	Director of Finance and Performance		
Author:	Performance Team		
Executive Lead Name: **[Approved by Exec Lead]**	Suzanne Robinson	Approved	☐

Executive Summary:	Purpose of report	
This report provides the Board with a summary of performance to the end of Month 1 (April 2017). Performance against NHSI metrics and key national targets is included within the report. At Month 1 there are 4 metrics rated as Red and 2 metrics rated as Amber	Approval	☐
	Information	☐
	Discussion	☐
	Assurance	☐

Seen at:	SLT ☐ Exec ☐ 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 (time limited) ☐		
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. ☐ Comments:		
Risk / legal implications: (Risk Register Ref [if applicable])	All areas of under performance are separately risk assessed and a rectification plan is prepared dependent upon the outcome of the risk assessment		
Resource Implications: Funding Source:			
Diversity & Inclusion Implications:	Not directly		
Recommendations:	The Board is asked to; - Note the performance reported - Review areas of under performance as summarised in this report and identify further action required		

PERFORMANCE MANAGEMENT REPORT TO TRUST BOARD

Date of meeting:	8 June 2017
Report title:	**Performance & Quality Management Framework Performance Report – Month 1 2017/18**
Executive Lead:	Director of Finance & Performance
Prepared by:	Performance & Information Team
Presented by:	Director of Finance & Performance

1 Introduction to Performance Management Report

The report provides an overview of performance for April 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.

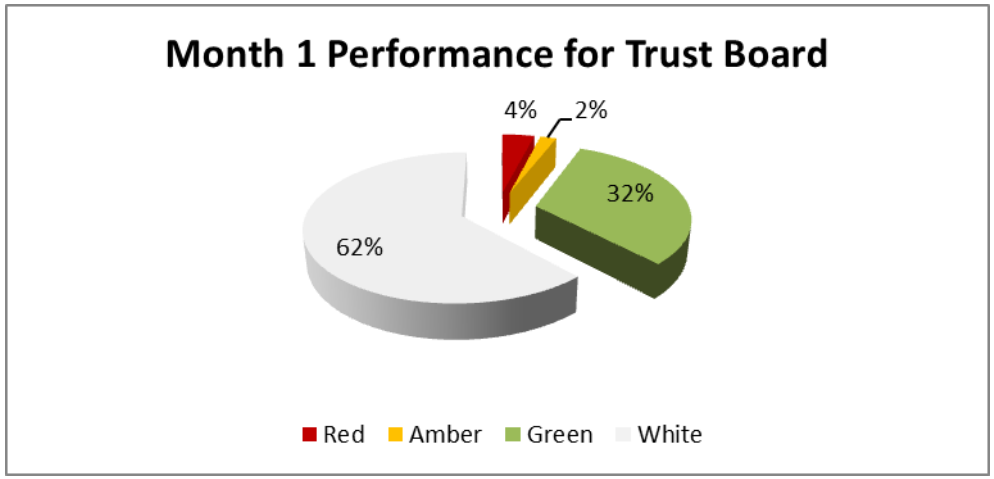
2 Executive Summary – Exception Reporting

The following performance highlights should be noted;

- 100% of IAPT patients were treated within 6 weeks of referral
- 93.5% of patients (excluding ASD) have been referred for treatment or intervention within 18 weeks
- 99.4% of all service users to the IAPT service have been contacted within 3 working days of referral

In Month 1 there are 4 related metrics rated as Red and 2 as Amber; all other indicators are within expected tolerances. White KPIs are those where targets are yet to be agreed or where the requirement is to report absolute numbers rather than % performance.

Contracted (National/Local CCG) & NHSI KPIs					
Metric	Red	Amber	Green	White	TOTAL
Exceptions – Month 11	2	1	44	67	114
Exceptions – Month 12	2	1	39	67	109
Exceptions – Month 1	4	2	32	62	100

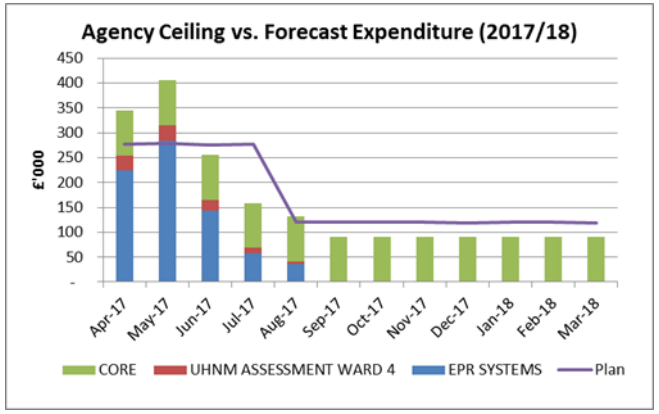


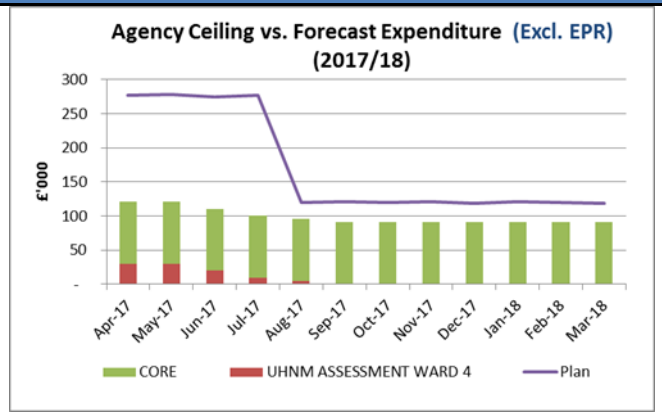
3 Rectification Plans

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.

4 Exceptions - Month 1

KPI Classification	Metric	Exec/Op Lead	Target	M12	M1	Trend	Commentary
NHSI	Delayed Transfers of Care	Dir of Ops	4.7%	RED 12.9%	RED 14.8%	↗	14.8% at M1 from 12.9% at M12 The delays relate to delays in accessing access to health and social care funding and placements and patient choice. The Trust continues to pilot the RED and GREEN approach developed by the Emergency Care Programme (ECIP). A deep dive of all DTOCs in 2016/17 is being undertaken to identify themes and trends. This will result in an action plan to reduce delays across the health and social care system. Confirm and challenge sessions are held with ward managers to ensure that delays are escalated to CCGs and Local Authorities for speedy resolution. AMH IP – 7.4% at M1 from 8.6% at M12 NOAP – 23.2% at M1 from 31.3% at M12 Rectification Plan: Will be produced for Finance & Performance Committee.
NHSI	Agency Spend: Core Agency Spend	Dir of Workforce	2.7%	RED 6.2% 2.9%	RED 6.6% 1.9%	↗ ↘	6.6% at M1 from 6.2% at M12. Core Agency – 1.9% at M1 from 2.9% at M12 Forecast Performance 2017/18

KPI Classification	Metric	Exec/Op Lead	Target	M12	M1	Trend	Commentary
							The plan submitted for 2017/18 remains at £2.068m. The graph below summarises the Agency position for 2017/18. • EPR and Ward 4 Agency is anticipated to cease by September 2017 • The use of resources framework is anticipated to be October 2017 • Trust and national initiatives are likely to reduce core agency spend further than levels modelled 

KPI Classification	Metric	Exec/Op Lead	Target	M12	M1	Trend	Commentary
							
	ROSE Agency Spend			2.3%	4.0%	↗	ROSE – 4.0% at M1 from 2.3% at M12
	Ward 4 (EMI) Nurse Agency Spend			0.7%	0.5%	↘	0.5% at M1 from 0.7% at M12 Agency spend on Ward 4 (EMI) was approximately £30k at M1 the same as at M12. A detailed agency plan has previously been submitted to the Trust Board. Rectification Plan: Received at all sub-committees
NHSI	CPA: The proportion of those on Care Programme Approach (CPA) for at least 12 months having a formal review within 12 months	Dir of Ops	95%	GREEN 96.2%	RED 94.3%	↘	94.3% at M1 from 96.2% at M12 AMH Community = 94.4% at M1 from 96.4% at M12 NOAP = 72.7% at M1 from 66.7% at M12 CYP = 0.0 at M1 from 50.0% at M12 Rectification Plans will be required for NOAP and CYP directorates

KPI Classification	Metric	Exec/Op Lead	Target	M12	M1	Trend	Commentary
Local Quality	Readmissions: Percentage of patients readmitted within 28 days of discharge	Dir of Ops	7.5%	RED 8.8%	RED 15.0%	↗	15.0% at M1 from 8.8% at M12 Adult IP = 33.3% at M1 from 12.1% at M12 Older Adult Inpatient = 6.3% at M1 from 0.0% at M12 A deep dive is being undertaken analysing the emergency readmissions for Adult Inpatient services over the last 6 months. This has provided a detailed analysis of the circumstance of each emergency readmission and this will be followed up through a quality audit to understand where improvement may be required. Rectification Plan: Will be produced for Finance & Performance Committee
Local Quality	RAID: RAID response to A&E referrals within 1 hour	Dir of Ops	95%	GREEN 95.0%	AMBER 94.0%	↘	94.0% at M1 from 95.0% at M12
Local Quality	CPA: All Service Users to have a care plan in line with their needs. % on CPA with a Care Plan (North Staffordshire)	Dir of Ops	95%	GREEN 96.6%	AMBER 93.4%	↘	93.4% at M1 from 96.6% at M12 AMH Community = 93.9% at M1 from 97.0% at M12 NOAP = 83.3% at M1 from 78.4% at M12 CYP = 66.7% at M1 the same as at M12 Rectification Plans will be required for NOAP and CYP

5 Recommendations

The Trust Board is asked to note the contents of this report.

Trust Dashboard
Month: **April**

1
Key:-

National Operational	NHS Standard Contract Schedule 4 Quality Requirements : Operational Standards
National Quality	NHS Standard Contract Schedule 4 Quality Requirements : National Quality Requirements
Local Quality	NHS Standard Contract Schedule 4 Quality Requirements : Local Quality Requirements (CCG Commissioners)
National Reporting	NHS Standard Contract Schedule 6 Reporting & Information Requirements : National Requirements
Local Reporting	NHS Standard Contract Schedule 6 Reporting & Information Requirements : Local Commissioner Requirements
NHSI	NHS Improvement metric
Trust Measure	Locally monitored metric

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

North Staffordshire Combined Healthcare NHS Trust

					2017-18													
	Metric	**Frequency**	**Target (2016/17)**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD**	**Trend Rate**
NHSI Domain - Responsive																		
National Quality	Early Intervention in Psychosis programmes: % of service users experiencing a first episode of psychosis who commenced a NICE concordant package of care within 2 weeks	Monthly	50%	84.6%	83.3%													↔
National Quality	IAPT % of service users referred treated within 6 weeks of referral	Monthly	75%	100.0%	100.0%												100.0%	↔
National Quality	IAPT % of service users referred treated within 18 weeks of referral	Monthly	95%	100.0%	99.7%												99.7%	↔
National Quality	Zero tolerance RTT waits over 52 weeks for incomplete pathways	Monthly	0	0.0	0.0												0	↔
Local Quality	Compliance with 18 week waits (Referral to Treatment or Intervention) (Excluding ASD)	Monthly	92%	94.3%	93.5%												93.5%	↔
Local Quality	AMH IP	Monthly	92%	100.0%	100.0%												100.0%	↔
Local Quality	AMH Community	Monthly	92%	90.6%	89.0%												89.0%	↔
Local Quality	Substance Misuse	Monthly	92%	100.0%	100.0%												100.0%	↔
Local Quality	LD	Monthly	92%	100.0%	100.0%												100.0%	↔
Local Quality	NOAP	Monthly	92%	98.5%	97.4%												97.4%	↔
Local Quality	C&YP	Monthly	92%	99.5%	100.0%												100.0%	↔
Local Quality	Patients will be assessed within 12 weeks of referral to the Memory Assessment service	Monthly	95%	100.0%	100.0%												100.0%	↔
Local Quality	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%	97.0%	95.3%												95.3%	↔
Local Quality	RAID response to A&E referrals within 1 hour	Monthly	95%	95.0%	94.0%												94.0%	↔
Local Quality	RAID: Referrals in FEAU, other portals and urgent wards seen within 4 hours	Monthly	90%	100.0%	100.0%												100.0%	↔
Local Quality	RAID : All other referrals seen on same day or within 24 hours	Monthly	90%	98.0%	99.0%												99.0%	↔
Local Quality	Percentage of inpatient admissions that have been gatekept by crisis resolution/ home treatment team	Monthly	95%	100.0%	100.0%												100.0%	↔
Local Quality	Patients seen within 7 days of discharge from hospital (CPA)	Monthly	95%	91.0%	95.7%												95.7%	↔
Local Quality	IAPT : All Service Users contacted within 3 working days of referral	Monthly	95%	112.5%	99.4%												99.4%	↔
Local Quality	IAPT : Service Users are assessed within 14 days of referral	Monthly	95%	98.8%	99.3%												99.3%	↔
Local Quality	IAPT : The number of active referrals who have waited more than 28 days from referral to first treatment/first therapeutic session	Monthly	5%	0.6%	0.9%												0.9%	↔
Local Reporting	S136 (Place of Safety) Assessments	Monthly	No Target	25.0	23												23	↔
Local Reporting	- Formal Admissions	Monthly	No Target	1.0	4.0												4	↔
Local Reporting	- Informal Admissions	Monthly	No Target	7.0	4.0												4	↔
Local Reporting	- Under 18 Yrs Old	Monthly	No Target	0.0	0.0												0	↔
NHSI	The proportion of those on Care Programme Approach (CPA) for at least 12mths having a (HONOS) assessment within the last 12mths	Monthly	90%	93.8%	91.4%												91.4%	↔
NHSI	AMH Community	Monthly	90%	93.9%	91.5%												91.5%	↔
NHSI	NOAP	Monthly	90%	71.4%	66.7%												66.7%	↔
NHSI	The proportion of those on Care Programme Approach (CPA) for at least 12mnths having formal review within 12mnths *NHSI*	Monthly	95%	96.2%	94.3%												94.3%	↔
NHSI	AMH Community	Monthly	95%	96.4%	94.4%												94.4%	↔
NHSI	LD	Monthly	95%	100.0%	100.0%												100.0%	↔
NHSI	NOAP	Monthly	95%	66.7%	72.7%												72.7%	↔
NHSI	C&YP	Monthly	95%	50.0%	0.0%												0.0%	↔
NHSI	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%)	Monthly	4.7%	12.9%	14.8%												14.8%	↔
NHSI	AMH IP	Monthly	4.7%	8.6%	7.4%												7.4%	↔
NHSI	LD	Monthly	4.7%	1.1%	0.0%												0.0%	↔
NHSI	NOAP	Monthly	4.7%	31.3%	23.2%												23.2%	↔
Local Quality	Patients seen within the access service (Stoke): Emergency 1 hour	Monthly	No Target	N/A	New													
Local Quality	Patients seen within the access service (Stoke): Emergency 1 hour	Monthly	No Target	N/A	New													

	Metric	Frequency	Target (2016/17)	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend Rate
Local Quality	Patients seen within the access service (Stoke): Emergency 1 hour	Monthly	No Target	N/A	New													
Local Quality	Patients seen within the access service (County): Emergency 1 hour	Monthly	No Target	N/A	New													
Local Quality	Patients seen within the access service (County): Emergency 1 hour	Monthly	No Target	N/A	New													
Local Quality	Patients seen within the access service (County): Emergency 1 hour	Monthly	No Target	N/A	New													
National Operational	The proportion of those on Care Programme Approach(CPA) receiving follow-up contact within 7 days of discharge	Monthly	95%	91.0%	95.7%												95.7%	⇔
Local Quality	Readmission rate (28 days). Percentage of patients readmitted within 28 days of discharge.	Monthly	7.5%	8.8%	15.0%												15.0%	⇔
Local Quality	Adult IP	Monthly	7.5%	12.1%	18.4%												18.4%	⇔
Local Quality	OA IP	Monthly	7.5%	0.0%	0.0%												0.0%	⇔
Local Quality	Neuro Rehab	Monthly	7.5%	0.0%	2.3%												2.3%	⇔
Local Quality	LD	Monthly	7.5%	0.0%	0.0%												0.0%	⇔
Local Quality	MH Rehab	Monthly	7.5%	0.0%	0.0%												0.0%	⇔
Local Quality	All Service Users to have a care plan in line with their needs (North Staffordshire CCG) % on CPA with a Care Plan	Monthly	95%	96.6%	93.4%												93.4%	⇔
Local Quality	AMH Community	Monthly	95%	97.0%	93.9%												93.9%	⇔
Local Quality	LD	Monthly	95%	100.0%	100.0%												100.0%	⇔
Local Quality	NOAP	Monthly	95%	78.4%	83.3%												83.3%	⇔
Local Quality	C&YP	Monthly	95%	66.7%	66.7%												66.7%	⇔
Local Quality	All Service Users to have a care plan in line with their needs (Stoke-on-Trent CCG) % on CPA with a Care Plan	Monthly	95%	N/A	96.1%												96.1%	⇔
Local Quality	AMH Community	Monthly	95%	N/A	96.3%												96.3%	⇔
Local Quality	LD	Monthly	95%	N/A	100.0%												100.0%	⇔
Local Quality	NOAP	Monthly	95%	N/A	85.7%												85.7%	⇔
Local Quality	C&YP	Monthly	95%	N/A	66.7%												66.7%	⇔
Local Quality	IAPT: Service User Satisfaction Local. To include questions on: • Access/referral arrangements • Treatment Options • Communication / Contact • Overall service provided (From a minimum sample of 30% of Service Users less than 15%	Monthly (questionnaire to be agreed with commissioners)	15%	0.0%	N/A													⇔
Local Quality	IAPT: Referrer Satisfaction Local. To include questions on: • Response to referrals • Contact / Communication • Treatment Outcomes • Overall Service provision (<15% expressing dissatisfaction)	Methodology to be agreed by September 2014. Application of methodology Q3.	15%	N/A	N/A													⇔
Local Quality	IAPT : Local. Service Users who are referred to employment support services (90% of suitable referrals)	Quarterly	90%	100.0%	N/A													⇔
Local Quality	IAPT : Local. Routine: Service User records and associated letters/reports completed and sent to GP within 5 working days of assessment/outcome measures undertaken as part of treatment/discharge (Qtr2 & Qtr 4 90% (sample of minimum 150 patients)	Half-yearly	90%	76.5%	N/A													⇔
Local Quality	IAPT: Local. The number of staff who have accessed clinical supervision Requirement is for minimum of 1 hour per week for all IAPT staff, - target % of staff in receipt of required level. (No threshold but there should be a framework in place that the Provider is working to ensure that all staff are approporaitely supervised)	Quarterly	No Target	100.0%	N/A													⇔
NHSI	% of clients in settled accommodation	Monthly	No Target	88.8%	88.5%												88.5%	⇔
NHSI Domain - Caring																		
National Operational	Mixed Sex Accommodation Breach	Monthly	0	0.0	0.0												0.0	⇔
NHSI	Staff FFT Percentage Recommended – Care	Quarterly	61.5%	N/A	N/A													
NHSI	Inpatient Scores from Friends and Family Test – % positive	Monthly	No Target	85.0%	89.0%												0.9	⇔
NHSI Domain - Safe																		
National Quality	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	⇔
Local Quality	People with LD/ Autistic Spectrum condition or long term mental illness should receive appropriate physical healthcare	Annual	95%	100.0%	N/A													
Local Quality	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%	100.0%	N/A													
Local Quality	Preventing Category 3 and 4 Avoidable Pressure Ulcer	Monthly	0	0.0	0.0												0.0	⇔
Local Quality	MRSA Screening (% of patients screened on admission)	Monthly	100%	100.0%														⇔
National Reporting	Cases of C Diff	Monthly	No Target	0.0														⇔
National Reporting	Cases of MRSA	Monthly	No Target	0.0														⇔

	Metric	Frequency	Target (2016/17)	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend Rate
National Reporting	Never Events	Monthly	0	0.0	0.0												0.0	⇔
National Reporting	Number of Reported Serious Incidents	Monthly	No Target	4.0	5.0												5.0	⇔
National Reporting	Total Incidents	Monthly	No Target	405.0	363.0												363.0	⇔
National Reporting	Incidents leading to Moderate/Severe harm/death	Monthly	No Target	24.0	18.0												18.0	⇔
Local Reporting	Cases of MSSA	Monthly	0	0.0														⇔
Local Reporting	Cases of E Coli	Monthly	0	0.0														⇔
Local Reporting	Medication Errors Total	Monthly	No Target	12.0	12.0												12.0	⇔
Local Reporting	Medication Errors leading to Moderate/Severe harm/death	Monthly	No Target	0.0	0.0												0.0	⇔
Local Reporting	Mental health Absconds/AWOL – rate	Monthly	No Target	2.0	12.0												12.0	⇔
Local Reporting	Safety Thermometer - Percentage Harm Free Care	Monthly	No Target	96.1%	100.0%												1.0	⇔
Local Reporting	Safety Thermometer - Percentage New Harm	Monthly	No Target	0.0%	0.0%												0.0	⇔
Local Reporting	Preventing Future Deaths Regulation 28	Monthly	No Target	0.0	0.0												0.0	⇔
Local Reporting	Proportion of patients who had recorded incidents of physical assault to them	Monthly	No Target	13.0	13.0												13.0	⇔
Local Reporting	Proportion of patients who had recorded incidents of physical assault to them leading to Moderate/Severe harm/death	Monthly	No Target	0.0	1.0												1.0	⇔
Local Reporting	Suspected Suicides	Monthly	No Target	3.0	2.0												2.0	⇔
Local Reporting	Inpatient	Monthly	No Target	0.0	0.0												0.0	⇔
Local Reporting	Inpatient on home leave	Monthly	No Target	0.0	0.0												0.0	⇔
Local Reporting	Community Patient (in receipt)	Monthly	No Target	0.0	2.0												2.0	⇔
Local Reporting	Community patient (in receipt) within 3 months of discharge from service	Monthly	No Target	0.0	0.0												0.0	⇔
Local Reporting	Community patient who had an inpatient stay in last 3 months prior to death	Monthly	No Target	0.0	0.0												0.0	⇔
Local Reporting	Unexpected Deaths	Monthly	No Target	3.0	0.0												0.0	⇔
Local Reporting	Inpatient	Monthly	No Target	0.0	0.0												0.0	⇔
Local Reporting	Inpatient on home leave	Monthly	No Target	0.0	0.0												0.0	⇔
Local Reporting	Community Patient (in receipt)	Monthly	No Target	3.0	0.0												0.0	⇔
Local Reporting	Inpatient on home leave	Monthly	No Target	3.0	0.0												0.0	⇔
Local Reporting	Community patient (in receipt) within 3 months of discharge from service	Monthly	No Target	0.0	0.0												0.0	⇔
Local Reporting	Community patient who had an inpatient stay in last 3 months prior to death	Monthly	No Target	0.0	0.0												0.0	⇔
Local Reporting	Use of Restraint: Number of patient restraints-prone	Monthly	No Target	3.0	1.0												1.0	⇔
Local Reporting	Slips Trips & Falls	Monthly	No Target	43.0	43.0												43.0	⇔
Local Reporting	Slips Trips & Falls leading to Moderate/Severe harm/death	Monthly	No Target	1.0	6.0												6.0	⇔
Local Reporting	Self Harm Events: Inpatient	Monthly	No Target	49.0	48.0												48.0	⇔
Local Reporting	Self Harm Events: Community	Monthly	No Target	27.0	35.0												35.0	⇔
Local Reporting	Self-Harm Events leading to Moderate/Severe harm/death:Inpatient	Monthly	No Target	5.0	1.0												1.0	⇔
Local Reporting	Self-Harm Events leading to Moderate/Severe harm/death: Community	Monthly	No Target	11.0	4.0												4.0	⇔
Local Reporting	DNA Rate Analysis by Directorate (split by CCG)	Monthly	No Target	6.0%	5.7%												0.1	⇔
Local Reporting	AMH IP	Monthly	No Target	5.9%	6.1%												0.1	⇔
Local Reporting	AMH Community	Monthly	No Target	6.7%	6.3%												0.1	⇔
Local Reporting	LD	Monthly	No Target	2.5%	2.9%												0.0	⇔
Local Reporting	NOAP	Monthly	No Target	4.9%	4.6%												0.0	⇔
Local Reporting	C&YP	Monthly	No Target	7.5%	7.4%												0.1	⇔
Local Reporting	Average Length of Stay: North Staffs CCG	Monthly	No Target	17.5	18.0												18.0	⇔
Local Reporting	Adult IP	Monthly	No Target	8.2	15.7												15.7	⇔
Local Reporting	CYP	Monthly	No Target	148.9	0.0												0.0	⇔
Local Reporting	NOAP	Monthly	No Target	57.9	117.3												117.3	⇔
Local Reporting	CYP	Monthly	No Target	13.4	10.5												10.5	⇔
Local Reporting	LD	Monthly	No Target	3.1	0.0												0.0	⇔
Local Reporting	Average Length of Stay: Stoke CCG	Monthly	No Target	29.2	23.6												23.6	⇔
Local Reporting	Adult IP	Monthly	No Target	32.7	25.6												25.6	⇔
Local Reporting	CYP	Monthly	No Target	108.9	88.2												88.2	⇔
Local Reporting	NOAP	Monthly	No Target	52.6	106.3												106.3	⇔
Local Reporting	Substance Misuse	Monthly	No Target	11.7	12.4												12.4	⇔
Local Reporting	LD	Monthly	No Target	2.4	0.0												0.0	⇔
NHSI	Never Events Incidence Rate	Monthly	0	0.0	0.0												0.0	⇔
NHSI	Proportion of reported patient safety incidents that are harmful	Monthly	2.97%	0.0%	2.0%												0.0	⇔
NHSI	CAS alerts outstanding	Monthly	0	0	0												0.0	⇔
NHSI	Safety Thermometer - Percentage of Harm Free Care	Monthly	95%	96.1%	100.0%												1.0	⇔
NHSI	Safety Thermometer - Percentage of new harms	Monthly	No Target	0.0%	0.0%												0.0	⇔

	Metric	Frequency	Target (2016/17)	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend Rate
NHSI	Admissions to adult facilities of patients who are under 16 years of age	Monthly	0	0.0	0.0												0.0	⇔
NHSI Domain - Well Led																		
National Quality	Completion of Mental Health Services Data Set ethnicity coding for all Service Users	Monthly	90%	100.0%	100.0%												100.0%	⇔
National Quality	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS	Monthly	99%	100.0%	99.8%												99.8%	⇔
National Quality	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users	Monthly	90%		Retrospective reporting													⇔
NHSI	Agency Spend (of total paybill) (M9-2.9%, M10-2.8%, M11-2.7%, M12-2.6%)	Monthly	2.7%	6.2%	6.6%												6.6%	⇔
NHSI	Sickness Absence Percentage: Days lost	Monthly	5.1%	3.7%	3.1%												3.1%	⇔
NHSI	Corporate	Monthly	5.1%	2.7%	1.8%												1.8%	⇔
NHSI	AMH Community	Monthly	5.1%	4.5%	3.8%												3.8%	⇔
NHSI	AMH IP	Monthly	5.1%	6.4%	4.4%												4.4%	⇔
NHSI	C&YP	Monthly	5.1%	1.8%	1.4%												1.4%	⇔
NHSI	LD	Monthly	5.1%	3.0%	0.9%												0.9%	⇔
NHSI	Neuro and Old Age Psychiatry	Monthly	5.1%	2.9%	3.8%												3.8%	⇔
NHSI	Substance Misuse	Monthly	5.1%	3.9%	6.4%												6.4%	⇔
NHSI	Staff Turnover (FTE)	Monthly	No Target	0.0	0.9												89.0%	⇔
NHSI	Corporate	Monthly	No Target	2.1	0.8												80.0%	⇔
NHSI	AMH Community	Monthly	No Target	2.1	0.7												69.0%	⇔
NHSI	AMH IP	Monthly	No Target	0.0	0.7												66.0%	⇔
NHSI	C&YP	Monthly	No Target	0.0	1.6												163.0%	⇔
NHSI	LD	Monthly	No Target	1.8	0.9												91.0%	⇔
NHSI	Neuro and Old Age Psychiatry	Monthly	No Target	0.0	0.8												78.0%	⇔
NHSI	Substance Misuse	Monthly	No Target	5.9	2.2												219.0%	⇔
NHSI	MH FFT response rate	Monthly	No Target	52.0	193.0												193	⇔
NHSI	Staff FFT response rate	Quarterly	No Target	N/A	N/A													
NHSI	Staff FFT Percentage Recommended – Work	Quarterly	No Target	N/A	N/A													
NHSI	Overall safe staffing fill rate	Monthly	No Target	105.9%														⇔
Local Reporting	Percentage compliance with data completeness identifiers for patients on CPA: In "employment" SHA measure >10% is performing	Monthly	10%	10.7%	10.5%												10.5%	⇔
Local Reporting	Percentage compliance with data completeness identifiers for patients on CPA; In "settled accommodation" - Monitor measure	Monthly	No Target	84.7%	83.9%												83.9%	⇔
Local Reporting	Percentage compliance with data completeness identifiers for patients on CPA; who have had a HONOS assessment in the last 12 months - Monitor measure	Monthly	No Target	93.6%	91.8%												91.8%	⇔
Local Reporting	Percentage compliance with data completeness identifiers for patients on CPA; Who have had a diagnosis assessment in the last 12 months	Monthly	No Target	98.1%	100.0%												100.0%	⇔
Other Indicators																		
Local Quality	IAPT : number people referred for psychological therapies (Target tbc)	Monthly	0	493.0	385.0												385	⇔
Local Quality	IAPT : Balance of Service Users mapped against the local population in terms of : Age	Monthly	95%	100.0%	100.0%												100.0%	⇔
Local Quality	IAPT : Balance of Service Users mapped against the local population in terms of : Ethnicity	Monthly	95%	100.0%	100.0%												100.0%	⇔
Local Quality	IAPT : Balance of Service Users mapped against the local population in terms of : Gender	Monthly	95%	100.0%	100.0%												100.0%	⇔
Local Quality	IAPT : Balance of Service Users from across the geographical Contract Area	Monthly	95%	100.0%	100.0%												100.0%	⇔
Local Quality	IAPT : The proportion of people who have depression and/or anxiety disorders who receive psychological therapies (Target 3.75% per quarter)	Monthly	3.75%	1.50%	1.05%												0.0	⇔
Local Quality	IAPT :The number of people who have entered (i.e. received) psychological therapies during the reporting quarter (Target 1,057 per quarter)	Monthly	1057	421.0	296.0												296	⇔
Local Quality	IAPT: The number of people who have completed treatment during the reporting quarter broken down by age	Monthly	No Target	227.0	160.0												160	⇔
Local Quality	IAPT: The number of people who have completed treatment during the reporting quarter broken down by sex	Monthly	No Target	227.0	160.0												160	⇔
Local Quality	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	145.0	102.0												102	⇔
Local Quality	IAPT : The number of people who have completed treatment not at clinical caseness at treatment commencement	Monthly	No Target	15.0	8.0												8	⇔
Local Quality	IAPT : The number of people moving off sick pay or ill-health related benefit	Monthly	No Target	21.0	17.0												17	⇔
Local Quality	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: !tr 1 to 3 - 447, Qtr 4 - 448)	Monthly	448	211.0	152.0												152	⇔
Local Quality	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%	68.7%	67.1%												67.1%	⇔

	Metric	Frequency	Target (2016/17)	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend Rate
Local Reporting	Bed Occupancy (Including Home Leave)	Monthly	No Target	94.0%	97.0%												97.0%	⇔
Local Reporting	AMH IP	Monthly	No Target	91.1%	94.0%												94.0%	⇔
Local Reporting	Substance Misuse	Monthly	No Target	93.5%	94.4%												94.4%	⇔
Local Reporting	LD	Monthly	No Target	96.2%	100.0%												100.0%	⇔
Local Reporting	Neuro	Monthly	No Target	100.0%	90.6%												90.6%	⇔
Local Reporting	Old Age Psychiatry	Monthly	No Target	89.9%	95.0%												95.0%	⇔
Local Reporting	C&YP	Monthly	No Target	96.2%	94.2%												94.2%	⇔
Local Reporting	Bed Occupancy (Excluding Home Leave)	Monthly	No Target	89.7%	89.2%												89.2%	⇔
Local Reporting	AMH IP	Monthly	No Target	88.3%	91.0%												91.0%	⇔
Local Reporting	Substance Misuse	Monthly	No Target	87.9%	86.1%												86.1%	⇔
Local Reporting	LD	Monthly	No Target	96.2%	100.0%												100.0%	⇔
Local Reporting	Neuro	Monthly	No Target	96.8%	78.0%												78.0%	⇔
Local Reporting	Old Age Psychiatry	Monthly	No Target	89.2%	94.0%												94.0%	⇔
Local Reporting	C&YP	Monthly	No Target	76.9%	75.7%												75.7%	⇔

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REPORT TO TRUST BOARD

Enclosure No:8

Date of Meeting:	8TH June 2017		
Title of Report:	UK Threat Level Critical		
Presented by:	Dr Nasreen Fazal-Short – Acting Director of Operations		
Author:	Mrs Karen Day – Emergency Planning Officer		
Executive Lead Name:	Nasreen Fazal-Short - Interim Director of Operations	Approved by Exec	☐

Executive Summary:	Purpose of report	
For acknowledgement of approach taken and for approval and support on the actions taken.	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	EPRR Risks on Risk Register	
Resource Implications: Funding Source:	None identified at this stage	
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	None identified at this stage	
Recommendations:	For acknowledgement of approach taken and for approval and support on the actions taken.	

To: **Trust Board**

Date: **31 May 2017**

SUBJECT: **UK Threat Level Critical.**

NHS England Gateway Reference 06835 letter, dated 24 May 2017 was issued based on the UK Threat Level changing from Severe to Critical (See Appendix 1) and the Trust requirement to provide the relevant assurance of preparedness.

NSCHT response was provided (See Appendix 2) and highlighted below are the key actions taken:-

The 2 specific actions for us as Mental Health provider are:

1. Review staffing availability for crisis intervention teams
2. Prepare to support any accelerated discharges from acute care settings.

Actions have been taken in line with the North Staffordshire System Escalation plan. The escalation action cards associated with the plan are being reviewed in the coming weeks with Avril Miller (Regional Capacity Manager).

This dove tails with the requirements in the letter from NHS England and for Directorates the following actions have been taken:

- The Change in alert level has been cascaded to staff.
- Staff have been referred to the refreshed Business Continuity plans and are clear around on call and escalation arrangements.
- Staff are clear around expectations that may be cascaded down from conference calls such as requests for mutual aid and staffing enhancements.
- Staff will work in line with the action cards detailed within the attached escalation plan for NSCHT. This will include the need to flex criteria and create capacity to support flow across the system.
- Daily capacity monitoring and rapid escalation pathways.
- Additional beds can be brought in if necessary and capacity enabled through early supported discharge.

NHS England Gateway Reference 06838 letter (Appendix 3), dated 31 May 2017, advising the threat level as of the 27 May 2017 had reduced to Severe and recognised this was an opportunity to take stock of our Emergency Preparedness Resilience and Response plans.

Recommendations

The Trust Board is asked to **acknowledge** our **approach** and to **approve and support** the actions taken.

NHS Provider Organisations CEO
NHS Clinical Commissioning Groups Chief Accountable Officers
Commissioning Support Units

Dr Anne Rainsberry
National EPRR Unit
NHS England
Skipton House
80 London Road
London
SE1 6LH

Publications Gateway Reference 06835

24 May 2017

Dear colleagues,

The Joint Terrorism Analysis Centre (JTAC) has advised that the UK Threat Level should be changed from **SEVERE** (an attack is highly likely) to **CRITICAL** (an attack is expected imminently). Further information regarding this change is available at https://www.mi5.gov.uk/threat-levels.

The consequence of this is that longstanding NHS Emergency Preparedness Resilience and Response (EPRR) protocol means all NHS organisations are now required please to:

- Immediately cascade the change in alert level to your staff
- Review relevant staffing levels and security arrangements across your health facilities, taking account of any additional advice from your local security experts in conjunction with the local police
- Ensure all staff are aware of your organisation's Incident Response Plans, business continuity arrangements and on call notification processes
- Ensure appropriate senior representation is available to join any NHS England Regional or Directorate of Commissioning Operations team teleconferences that may be called to brief on the situation
- Notify your local NHS England EPRR Liaison of any current or scheduled works or operational changes currently affecting service delivery within your organisation
- Review the Home Office advice issued in relation to this threat, and risk assess this against your own organisation, taking steps where possible to mitigate identified risks

- Review mutual aid agreements with other health services including specialist and private providers

Acute care providers are required to:

- Review Emergency Care, Theatre and Support Services, paying particular attention to staff availability, stocks and current blood stock levels
- Clearly identify and review patients who could be discharged safely to create capacity if your organisation is responding to an incident
- Review availability of your Patient Transport Service (PTS) particularly in the event of the local NHS Ambulance Trust requesting mutual aid from your PTS provider

Community and Mental Health providers are required to:

- Review staffing availability for crisis intervention teams
- Prepare to support any accelerated discharge from acute care settings

Clinical Commissioning Groups and Commissioning Support Units are required to:

- Act in support of accelerated discharge and where necessary support Trusts in maintaining their contracted services

NHS England will continue to work with you, the Department of Health, NHS Improvement and other government departments and agencies, and issue further advice as required.

Thank you for your leadership at this time.

Kind regards

Dr Anne Rainsberry
National Incident Director

Copy:
Tom Easterling, Director of Chair and Chief Executive Office, NHS England
Ed Rose, Chief Executive Office, NHS England
Matthew Swindells, National Director, Operations and Information, NHS England
Nicky Murphy, Head of Office, National Director Operations and Information, NHS England
Prof. Sir Bruce Keogh, Medical Director, NHS England
Prof. Jane Cummings, Chief Nurse, NHS England
Karen Wheeler, National Director Transformation and Corporate Operations, NHS England
Prof. Keith Willett, Director for Acute Care, NHS England
Dr Bob Winter, National Clinical Director EPRR, NHS England
Simon Weldon, Director of NHS Operations and Delivery, NHS England
Regional Directors, NHS England
Regional Directors of Operations and Delivery, NHS England
Simon Enright, Director of Communications, NHS England
Stephen Groves, National Head of EPRR, NHS England
National On Call Duty Officers, NHS England
National Second On Call Officers, NHS England
National Media On Call, NHS England
Ash Canavan, National EPRR Communications Lead, NHS England
Regional Heads of EPRR, NHS England
Business Continuity Team, NHS England
Jim Mackey, Chief Executive, NHS Improvement
Kathy McLean, Medical Director, NHS Improvement
Regional Managing Directors, NHS Improvement
Clair Baynton, Deputy Director of EPRR, Department of Health
Department of Health Duty Officer, Department of Health
Public Health England Duty Officer, Public Health England

Appendix 2

North Staffordshire Combined Healthcare NHS Trust

Document Title:	UK threat level
Directors	Nasreen Fazal-Short, Director of Operations -Security Management Director (SMD)
Authors:	Mick Daniels Trust Local Security Management Specialists (LSMS) For Attention: Dean Burgess LSMS
Date:	24th May 2017

1 Introduction

This paper highlights the current position in regard to the UK Threat Level.

Following the recent incident in Manchester - The Joint Terrorism Analysis Centre (JTAC) has increased the UK Threat Level to the highest level – change from **SEVERE** (an attack is highly likely) to **CRITICAL** (an attack is expected imminently).

2 Communications

.

- Publications Gateway Reference 06835 dated 24th May 2017 (attached) - has been received by the Director of Operations and communicated to Clinical Directors, Heads of Departments and senior Leadership team for cascading to all staff
- The trust Local Security Management Specialist (LSMS) has requested the Trust Communications department to promulgate to all staff a reminder around high standards of security both across Trust premises and in the community – vigilance, observant and to report anything that may look or sound suspicious. Information links to Staffordshire Police website were provided.

3 Security arrangements

There is no direct threat to the NHS or the Trust and security arrangements which are in place across the organisation and Trust sites should be maintained to a high standard. There is no requirement to increase or provide any additional security measures. This should be reviewed based on any future intelligence or information.

4 Conclusion

Staff awareness and vigilance; maintain security, business as usual.

The Staffordshire regional security network will be meeting on the 6th June at St Georges Stafford so this will be discussed. Both Trust Local Security Management Specialists (LSMS) will be attending

NHS Provider Organisation CEOs
NHS Clinical Commissioning Groups Chief Accountable Officers
Commissioning Support Units

Dr Anne Rainsberry
National EPRR Unit
NHS England
Skipton House
80 London Road
London
SE1 6LH

Publications Gateway Reference 06838

31 May 2017

Dear colleagues,

On Saturday 27 May 2017 the Joint Terrorism Analysis Centre (JTAC) advised that the UK Threat Level should be reduced to **SEVERE** (an attack is highly likely) from CRITICAL (an attack is expected imminently). Further information regarding this change is available at https://www.mi5.gov.uk/threat-levels.

Thank you for the actions taken in response to the earlier change in threat level to critical (as requested in NHS England's letter of the 24 May, Gateway Ref 06835). Although the immediate threat of attack has diminished, the current **SEVERE** threat level means we are still all being advised that an attack is considered "highly likely" such that we should continue to remain vigilant.

Please therefore use this opportunity to take stock of your plans and their concordance with the NHS England Core Standards for Emergency Preparedness Resilience and Response, and incorporate any lessons identified from the recent raised threat level.

We will be doing the same nationally, in conjunction with the Department of Health, NHS Improvement and other government departments.

Kind regards,

Dr Anne Rainsberry

Copy:
Tom Easterling, Director of Chair and Chief Executive Office, NHS England
Ed Rose, Chief Executive Office, NHS England
Matthew Swindells, National Director, Operations and Information, NHS England
Nicky Murphy, Head of Office, National Director Operations and Information, NHS England
Prof Sir Bruce Keogh, Medical Director, NHS England
Prof Jane Cummings, Chief Nurse, NHS England
Karen Wheeler, National Director Transformation and Corporate Operations, NHS England
Prof Keith Willett, Director for Acute Care, NHS England
Dr Bob Winter, National Clinical Director EPRR, NHS England
Simon Weldon, Director of NHS Operations and Delivery, NHS England
Regional Directors, NHS England
Regional Directors of Operations and Delivery, NHS England
Simon Enright, Director of Communications, NHS England
Stephen Groves, National Head of EPRR, NHS England
National On Call Duty Officers, NHS England
National Second On Call Officers, NHS England
National Media On Call, NHS England
Ash Canavan, National EPRR Communications Lead, NHS England
Regional Heads of EPRR, NHS England
Business Continuity Team, NHS England
Jim Mackey, Chief Executive, NHS Improvement
Kathy McLean, Medical Director, NHS Improvement
Regional Managing Directors, NHS Improvement
Clair Baynton, Deputy Director of EPRR, Department of Health
Department of Health Duty Officer, Department of Health
Public Health England Duty Officer, Public Health England

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REPORT TO: TRUST BOARD

Enclosure No:9

Date of Meeting:	8 June 2017		
Title of Report:	Service User & Carer Council Report		
Presented by:	Wendy Dutton, Vice Chair, Service User & Carer Council		
Author:	Wendy Dutton, Vice Chair, Service User & Carer Council		
Executive Lead Name:	Maria Nelligan	Approved by Exec	☐

Executive Summary:	Purpose of report	
This report has been prepared to provide an update of the Service User & Carer Council since the last meeting held on 31 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.X☐ 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.☐ 6. Attract and inspire the best people to work here.X☐ 7. Continually improve our partnership working. X☐		
Risk / legal implications: Risk Register Ref	None identified		
Resource Implications: Funding Source:	None identified		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	None		
Recommendations:	The Trust Board receives the update for information and assurance		

North Staffordshire Combined Healthcare NHS Trust

SERVICE USER & CARER COUNCIL UPDATE TO TRUST BOARD ON THURSDAY 8 JUNE 2017

1 INTRODUCTION

Chair`s report of Service User & Carer Council for Trust Board following the meeting held Wednesday 31 May 2017. Below are the key points from this meeting.

2 RESHAPING THE SERVICE USER & CARER COUNCIL

Review of Terms of Reference (ToR) and Role Description

Increasing membership from 2 to 3 from Service User & Carer Council, each Directorate to both increase the pool of experiences and opinions available and ensure better resilience in the event of absence/sickness and departure of members - modifications approved**.**

Reformat of Meetings

Alternate Formal/Business meeting with less formal Educational/Workshop meeting to deep dive into specific areas e.g. Care Plans which were highlighted as a need from 'Open Space Event'.
Agreed, trial of new format from June meeting - Care Planning focus on quality

3 ELECTION OF NEW CHAIR

Process clarified.
Nomination forms circulated to those eligible to vote.
Closing date for return of nomination forms is 5 June 2017 and voting will take place at the June meeting.

4 SERVICE USER & CARER STRATEGY 2016

Copy available at meeting on 31 May 2017 - to be reviewed at the workshop in July 2017.

5 CITIZENS JURY

Discussion took place on the above CCG led project. Mental Health access information and positive changes suggested were discussed. The full report when available will be an agenda item for the Service User & Carer Council meeting in October 2017.

6 DATE AND TIME OF NEXT MEETING

The first Educational/Workshop of the Service User & Carer Council will take place on Wednesday 28 June 2017 at 1430 in the Boardroom, Lawton House, Trentham and the subject matter will be Lorenzo Care Planning focus on quality with Ben Boyd.

The next Service User & Carer Council Business meeting will take place on Monday 24 July 2017 at 1430, in the Boardroom, Lawton House, Trentham

Wendy Dutton
Vice Chair - Service User & Carer Council
1 June 2017

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REPORT TO: TRUST BOARD

Enclosure No:10

Date of Meeting:	8 June 2017		
Title of Report:	Feedback from the Service User and Carer Council Open Space Event Quality Priorities		
Presented by:	Maria Nelligan, Executive Director of Nursing & Quality		
Author:	Zoe Grant, Quality Assurance & Improvement Manager		
Executive Lead Name:	Maria Nelligan	Approved by Exec	☐

Executive Summary:	Purpose of report	
Following the Open Space event held on 29th March 2017 the Service User and Carer Council completed a workshop to highlight the quality improvement issues it wished to prioritise with the Trust. A summary of these were presented to the Board as part of the Service User and Carer Council report in May 2017. It was agreed to draft a briefing in response to the priorities agreed by the Service User and Carer Council and highlight where these would be addressed within the Trust`s Improvement Programme.	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	None		
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		
Recommendations:	The Board is asked to note the content of the report		

North Staffordshire Combined Healthcare NHS Trust

Feedback from the Service User and Carer Council Open Space Event Quality Priorities

Briefing for Trust Board on 8 June 2017

1 Introduction

Following the Open Space event on 29th March 2017 the service user and carer council completed a workshop to highlight the quality improvement issues it wished to prioritise with the Trust.

A summary of these were presented to the Board as part of the Service User and Carer Council report in May 2017.

The Executive Director of Nursing and Quality agreed to draft a briefing in response to the priorities agreed by the Service User and Carer Council and highlight where these would be addressed within the Trust`s Improvement Programme.

2 Themes

The issues that were raised and subsequent agreed priorities have been broken down into six key themes:

- Care Planning
- Provision of medication
- Care co-ordination
- Recovery focused Care
- Communication
- Service User and Carer Council

3 Trust Improvement programme

The following tables highlight where and how each of the key priorities will be addressed, it also demonstrates where action has already been taken.

4 Recommendations

The Board is asked to note the content of this report.

1 Care Planning

Area of Concern	Trust Quality Standard	Action	Progress
Ensure Care Plans are provided during the transition from in-patient to community services.	Admissions, discharge and transfer policy: Page 14, Section 5.3, para 1. ***'The patient must be supported to understand and sign the care plan before discharge and given a copy to refer to. Where appropriate the carer should also have access to this information'.***	**Inpatient Safety Matrix Audit in place:** Patients receiving care plans on discharge is routinely monitored.	Monthly audit.
Need to avoid anagrams and jargon.	Effective Care planning Policy: Page 5, Section 1.3, bullet 2& 3. A care plan should: • ***reflect the person's own assessment of their situation and priorities*** • ***be written in simple personally meaningful language***	**Inpatient Safety matrix;** 'Is there evidence that patient has been involved in their care plan with clear evidence that their views and opinions are recorded' **Community care plan audit:** **'**Are the Service Users views and/or carer opinions clearly identified?'	Monthly audit.
To set timescales for when care plan should be written.	The quality standard for timescales will form part of the Trust`s Care Management Policy.	Care management Policy update required.	Care Management Policy is currently under review.

2 Provision of Medicines

Area of Concern	Trust Quality Standard	Action	Progress
Provision of a sufficient supply of medicines.	Medicines Management Policy: Page 10, section 5.1.8, para 3. ***'Prescriptions are valid for up to 26 weeks (specify the time period when prescribing) and can be repeated within that time period. The original prescription should include details for length of repeat and monitored dosage if necessary. A copy of this prescription should be kept in the patient's notes for review. The prescription should be reviewed prior to rewriting towards the end of the 26 weeks. Prescriptions issued in resource centres should be dispensed via community pharmacy (FP10)'***	Medicines management audit to incorporate monitoring of this standard.	Community Safety matrix currently in draft.

3 Care Co-ordination

Area of Concern	Trust Quality Standard	Action	Progress
Ensure care co-ordinator cover is consistently available.	The Trust has an operational protocol in place which outlines clear standards for ensuring that care co-ordination responsibilities are covered during periods of sickness or absence.	The community in-patient safety audit will monitor compliance against the protocol.	Community Safety matrix currently in draft.

4. Recovery Focused Care

Area of Concern	Trust Quality Standard	Action	Progress
Increased recovery focused care.	This is currently a BAF requirement and a key objective for the Director of Nursing and Quality.	To have a dedicated Recovery/ Wellbeing College or programme for service users.	Training requirements currently under review. Design and implementation being reviewed with ongoing engagement from service users.

Area of Concern	Trust Quality Standard	Action	Progress
Ensuring value is placed on the role of carers in the person`s care.	Effective Care Planning Policy: Page 10, section 8, para 3. ***'NSCHT recognises that Carers often make a major and valued contribution to the support received by many people who may come into contact with our services. The Trust has a Carers Charter in place (Appendix 4)'.***	In-patient safety Matrix in place and monitors carer involvement in the care plan process. Community care plan audit in place and monitors carer involvement in the care planning process. To fully implement the Triangle of Care.	Monthly audit. Monthly audit. Self-assessment complete proposal to SLT in June 2017.

5 Communication Systems

Area of Concern	Trust Quality Standard	Action	Progress
Provision of resource packs for service users.	The Trust`s Care planning CQUIN programme identified this as an ongoing quality priority; With the suggestion of providing:- Care Plan templates Information leaflets Patient passports Getting to know me packs Self-help material	Patient related information will be made available via the Trust`s Intranet and website with input from the Service User & Carer Council.	The Head of Comms is re-designing the Trust`s Intranet and website and a dedicated patient resource page will be available.
Ensure GP aware of mental health and substance misuse issues.	There is an acceptance that is a requirement for our service users.	To take back to the MCP programme for consideration.	
To improve communication between teams and ensure that timely feedback to service users.	The Trust have now implemented ROSE with staff being able to access patient related information as it is entered into the Lorenzo system.	Benefits monitoring of ROSE via regular feedback from service users.	ROSE is now ‘live’.

Area of Concern	Trust Quality Standard	Action	Progress
Clinical notes are read prior to service users attending appointments to avoid having to repeat.	The Trust have now implemented ROSE with staff being able to access patient related information as it is entered into the Lorenzo system.	Benefits monitoring of ROSE via regular feedback from service users.	Rose is now 'live'.
Telephone calls from service users not being returned.	This is considered an 'Always' event.	Deputy Director of Nursing is taking this forward as an 'Always' event with a group of service users and staff.	Workshop planned for July 2017.

6. Service User and Carer Council

Area of Concern	Trust Quality Standard	Action	Progress
Inviting carers as part of the interview process.	The Trust expects full service user and carer participation throughout all recruitment processes.	To monitor current service user and carer representation and involvement in the recruitment process.	The Service User and Carer Council are currently reviewing this.
Ensuring consistency in service user involvement in projects, for instance Lorenzo.	The Trust expects full service user and carer participation throughout service developments and improvements.	To monitor current service user and carer representation and involvement in the recruitment process.	The Service User and Carer Council are currently reviewing this.

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REPORT TO TRUST BOARD

Enclosure No:11

Date of Meeting:	8th June 2017		
Title of Report:	ROSE Update		
Presented by:	Mr Gwyn Thomas		
Author:	Mr Ben Boyd		
Executive Lead Name:	Miss Suzanne Robinson	Approved by Exec	☒

Executive Summary:	Purpose of report	
Lorenzo Go Live rescheduled from 13th May to 20th May due too cyberattack. Downtime preparations for Go Live actually helped deal with cyberattack, no negative impact on patient care. Feedback from NHS Digital and DXC that transition from old system to new was excellent. All services live on system by 22nd May2017. Some teething issues as staff becoming more familiar with system. System update on the 24th May lead to performance issues but quickly resolved. Priority plan for development over next 3 months and measures of success presented	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	Corporate risk 747		
Resource Implications: Funding Source:	NHS Digital Funding		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	None		
Recommendations:	For Assurance		

North Staffordshire Combined Healthcare NHS
NHS Trust

ROSE Project
Go-Live Update

DIGITAL BY CHOICE ROSE

safe • personalised • accessible • recovery focused

spar

Headlines

- Go-Live Rescheduled
- Go-Live 20th May
- Upgrade to Hot Fix 2
- Floorwalking
- Issues
- Ongoing Support
- 3 Month Plan

Go-Live

- CHiPS taken down at 8pm
- Some sites were on downtime from 5-6 pm
- Ran to schedule, DM was early
- Validation and Testing started earlier
- From 10 am onwards
- Inpatient Wards, Access Team, IST

Hot Fix 2 Upgrade

- Testing from Wednesday 17th
- Switched to Other Tower, new servers (slower)
- Issues reported re Clinical Notes
- Performance Issues
- Highlighted issues with some updates pushed out by HIS

Floorwalking

- 10 Extra Floorwalkers drafted in
- Cover arranged for Main sites based on Teams and Devices
- Continued through weekend and first week until Midnight
- Scaled back over 2nd weekend to 10pm

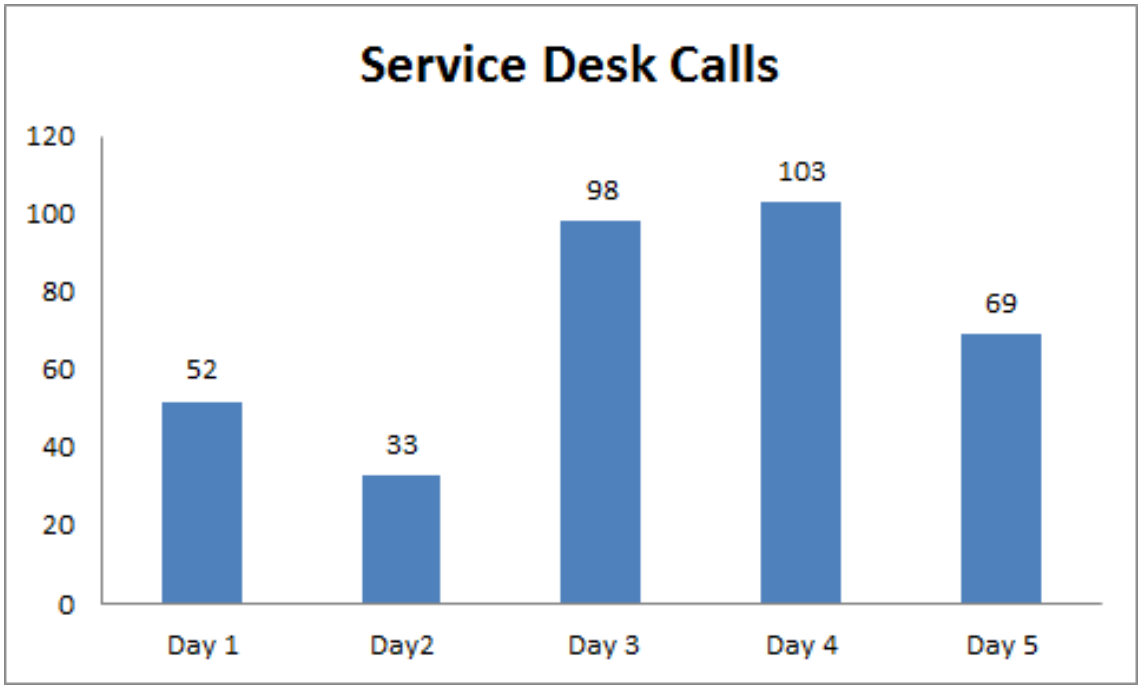
Early Life Support

- Floorwalkers supporting all areas
- Super Users (Sporadic)
- Ext 2050 for system issues for 1st week
- Ext 4804 for failures , floorwalker support
- Ext 2050 dropped on Friday, went back to online logging of issues.

Issues

- Ext 2050 to log calls
- Tree affecting signal at A&T- now improved
- Some Performance issues following upgrade
- Letters
- Process issues

Area	Open Calls
SmartCards	4
Caseloads	15
Clinical Notes	12
Patient Dempgraphics	11
Clinics	56
CHiPS	14
Access	24
Performance	3
Letters	9
Referrals	10
Scanning	3
Printing	4
Others	46
	211



Ongoing Support

- Ext 2050 number used for first week only
- Calls now using online as before
- Ext 4804 number continues to coordinate floorwalkers
- Floor walker support until Friday 2nd June??
- Training sessions started today at Edward Myers
- QRGs – good feedback from services
- Business Processes reviews ?

Performance

- DXC are providing a Performance Dashboard
- Too early for any real analysis but we have this in week 1 whereas Norfolk only got this MONTH 18
- Important to differentiate between Lorenzo, PC,

Performance issue	Business description	Functional area	QC	Target	Current Mean Exec Time (MS	Current Exec Count (day hour)	New Mean Exec Time (MS)
dbo.PGETVMR_REQBASE_210000000	Request	R&R	200493	2.11 HF1	24.56	0	2.22
dbo.PGETVMR_PATBASE_210000000	View my requests and results Search	R&R	N/A	2.11 HF1	24.56	4	0.31
dbo.PGETRMTABVIEW_210000001	Results Requests EPR tab	R&R	N/A	2.11 HF1	0.19	7	0.17

Performance issue	Business description	Functional area	QC	Target	Current Mean Exec Time (MS	Current Exec Count (day hour)	New Mean Exec Time (MS)
dbo.PGETLIFEVIEW_210000001	LifeView faux tab	User Services	200485	2.12	2.24	0	2.36
dbo.pGetECHistoryView_210000001	Emergency Care - History View	Emergency care	200496	Analysis	0.25	0	0.36

Performance issue	Business description	Functional area	QC	Target	Current Mean Exec Time (MS	Current Exec Count (day hour)	New Mean Exec Time (MS)
dbo.pGetDoseUOMDefaults_P2_210010000	OP Prescribe	IPPMA	200486	2.11 HF2	0.61	0	0.51
dbo.PIPPGETPRESVW_P2_210010000	Prescription List View	IPPMA	200488	2.11 HF2	3.08	0	1.73
dbo.PREQEMERGDET_210010000	Current view	R&R	N/A	Analysis	0.77	5,251	0.44
dbo.pgetPlndTrsforWard_210000000	Floor Plan View	Inpatient	N/A	2.12	5.82	170	0.43

Areas to Address

- Further Floorwalker Support pared back
- Letters review
- Training – Training sessions to be covered as BAU
- Business Process- Team away days and workshops
- Care Plan Pathway communications
- Further Updates pushed out by HIS
- 3 month plan
- 282 of 1200 staff not logged in yet (List available)

3 Month Plan – Priority

- Pathology Messaging
- Emergency Care – Configuration
- Electronic and Prescribing and Meds Administration
- Clinical Data Capture Forms- Development
- Service Management
- Benefits Realisation

Measures of Success

- 100% Data Migration
- 99.7% Staff Trained
- 1321 Staff Engaged during the project
- 100% of services live
- Recovered well from Cyber attack one week before go-live
- Downtime Packs used well during Cyber attack and go-live
- Quick Reference Guides were well received

ROSE Project in Numbers

Users Not Logged In @30th May 2017

Users Not Logged Into Lorenzo	
bm_subdivision(Directorate)	CountOfUser
232 AMH Community Directorate	139
232 AMH In Patient Directorate	52
232 Bank	17
232 Business Development and Strategy	2
232 Chief Executives Office	1
232 Children and Young People Directorate	26
232 Directorate of Medicine and Clinical Effectiveness	8
232 Directorate of Nursing and Quality	5
232 Finance and Performance Management Directorate	8
232 Learning Disabilities Directorate	37
232 Neuropsychiatry and Old age Psychiatry Directorate	59
232 Operations (Corporate Services)	4
232 Substance Misuse Directorate	32
232 Workforce and Leadership Directorate	13
External	1

92 Staff do not have a SmartCard


Q
&
A


Questions

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO Trust Board

Enclosure No:12

Date of Meeting:	08/06/2017		
Title of Report:	Finance Report		
Presented by:	Suzanne Robinson		
Author:	Lisa Dodds		
Executive Lead Name:	Suzanne Robinson	Approved by Exec	☒

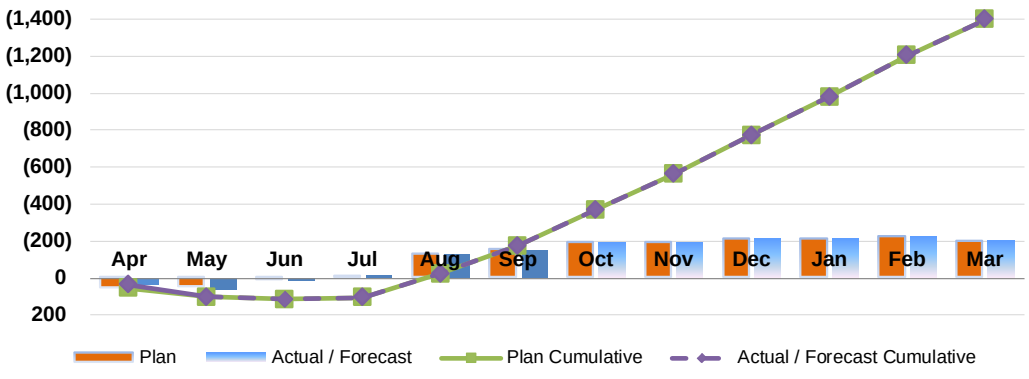
Executive Summary:		Purpose of report	
The report summarises the finance position at month 1		Approval	☐
		Information	☐
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee X • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☐ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently. X 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref			
Resource Implications: Funding Source:	N/A		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	N/A		
Recommendations:	Note the year to date performance of finance performance against the plan as at month 1		

Financial Overview as at 30th April 2017

Income & Expenditure - Control Total (Surplus) / Deficit

£000	Plan	Actual	Var	%	RAG
YTD	56	37	(19)	35	G
FOT	(1,400)	(1,400)	0	0	G

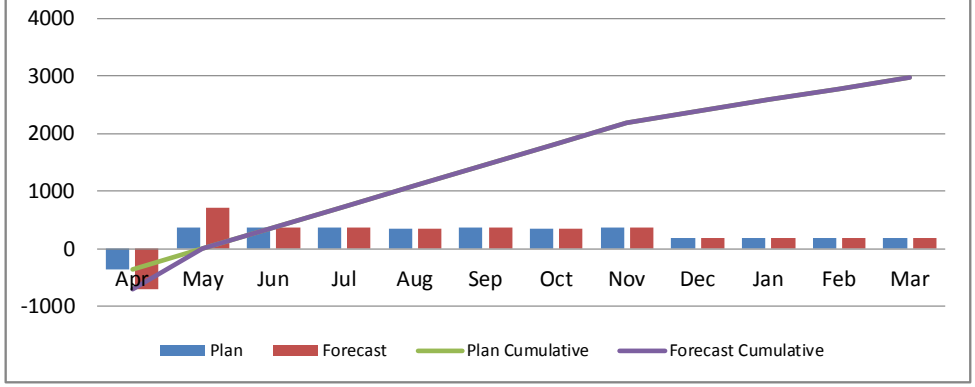
Retained (Surplus) / Deficit Run Rate 2017/18



Net Capital Expenditure

£000	Plan	Actual	Var	%	RAG
YTD	(349)	(693)	(344)	99	G
FOT	2,979	2,979	0	0	G

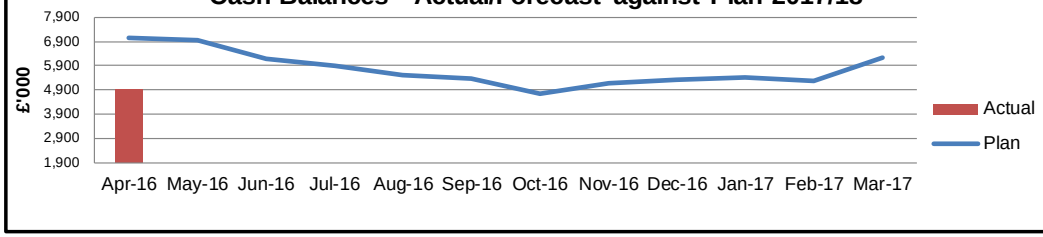
Net Capital Expenditure - Plan / Forecast 2017/18



Cash Balances

£000	Plan	Actual	Var	%	RAG
YTD	6,964	4,945	(2,019)	(41)	R

Cash Balances - Actual/Forecast against Plan 2017/18



Cost Improvement

£000	Plan	Actual	Var	%	Rec Var	RAG
Clinical	109	2	(107.0)	(98)	23.0	R
Corporate	28	0	(28.0)	(100)	0.0	R
Total	137	2	(135)	(99)	23	R

Use of Resource

Overall Risk Rating	3
Liquidity Ratio	1
Capital Servicing Capacity	4
I& E Margin	4
I&E Margin Variance to Plan	1
Agency Spend	2

Introduction:

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

1. Income & Expenditure (I&E) Performance

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

- The trust has a trading position of £62k deficit against a plan of £81k deficit; **a favourable variance to plan of £19k**;
- The trust has a Control Total deficit £37k against a plan of £56k; **a favourable variance to plan of £19k**.

£'000	Annual Budget	In Month Budget	In Month Actuals	In Month Variance	YTD Budget	YTD Actual	YTD Variance
Income	(78,545)	(6,821)	(6,653)	168	(6,821)	(6,653)	168
Pay	60,738	5,316	5,058	(259)	5,316	5,058	(259)
Non-Pay	14,176	1,358	1,440	82	1,358	1,440	82
EBITDA	**(3,631)**	**(147)**	**(156)**	**(9)**	**(147)**	**(156)**	**(9)**
Other Non-Op Costs	2,731	228	217	(10)	228	217	(10)
Trading Surplus	**(900)**	**81**	**62**	**(19)**	**81**	**62**	**(19)**
Sustainability & Transformational Funding	(500)	(25)	(25)	0	(25)	(25)	0
Control Total	**(1,400)**	**56**	**37**	**(19)**	**56**	**37**	**(19)**

2. 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 to an invoice disputed for 2016/17;

- Under recovery of £17k on Associates Contracts is due to a reduction in contract values and £13k under recovery on OATS due to activity levels;

		Month 1			Year-to-Date		
Table 2: Income	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
NHS Stoke-on-Trent CCG	(34,579)	(2,957)	(2,915)	42	(2,957)	(2,915)	42
NHS North Staffordshire CCG	(23,782)	(2,023)	(2,023)	(0)	(2,023)	(2,023)	(0)
Specialised Services	(3,097)	(258)	(258)		(258)	(258)	
Stoke-on-Trent CC s75	(3,659)	(305)	(305)	0	(305)	(305)	0
Staffordshire CC s75	(1,054)	(88)	(88)	0	(88)	(88)	0
Stoke-on-Trent Public Health	(344)	(29)	(23)	6	(29)	(23)	6
Staffordshire Public Health	(613)	(51)	(51)	0	(51)	(51)	0
ADS/One Recovery	(1,391)	(116)	(116)	0	(116)	(116)	0
Associates	(916)	(76)	(59)	17	(76)	(59)	17
OATS	(600)	(50)	(37)	13	(50)	(37)	13
Total Clinical Income	**(70,036)**	**(5,952)**	**(5,875)**	**77**	**(5,952)**	**(5,875)**	**77**
Other Income	(8,510)	(869)	(778)	91	(869)	(778)	91
Total Income	**(78,545)**	**(6,821)**	**(6,653)**	**168**	**(6,821)**	**(6,653)**	**168**
Sustainability Transformation Funding	(500)	(25)	(25)	0	(25)	(25)	0
Total Income Incl. STF	**(79,045)**	**(6,846)**	**(6,678)**	**168**	**(6,846)**	**(6,678)**	**168**

3. Expenditure

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

		Month 1			Year-to-Date		
Table 3: Expenditure	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
Medical	7,584	633	547	(86)	633	547	(86)
Nursing	26,527	2,303	2,278	(25)	2,303	2,278	(25)
Other Clinical	15,146	1,270	1,087	(183)	1,270	1,087	(183)
Non-Clinical	10,471	891	813	(78)	891	813	(78)
Non-NHS	1,010	219	333	113	219	333	113
Total Pay	**60,738**	**5,316**	**5,058**	**(259)**	**5,316**	**5,058**	**(259)**
Drugs & Clinical Supplies	2,161	183	171	(12)	183	171	(12)
Establishment Costs	1,712	142	111	(31)	142	111	(31)
Information Technology	456	38	49	11	38	49	11
Premises Costs	2,025	170	148	(23)	170	148	(23)
Private Finance Initiative	4,087	341	359	19	341	359	19
Services Received	3,078	272	261	(11)	272	261	(11)
Residential Payments	1,420	118	168	50	118	168	50
Consultancy & Prof Fees	379	32	63	31	32	63	31
Unidentified CIP	(3,174)	(135)	0	135	(135)	0	135
Other	2,031	198	111	(87)	198	111	(87)
Total Non-Pay	**14,176**	**1,358**	**1,440**	**82**	**1,358**	**1,440**	**82**
Finance Costs	1,293	108	108	0	108	108	0
Local Government Pension Scheme	0	0	0	0	0	0	0
Unwinding of Discounts	0	0	0	0	0	0	0
Dividends Payable on PDC	561	47	47	0	47	47	0
Investment Revenue	(14)	(1)	(1)	1	(1)	(1)	1
Fixed Asset Impairment	0	0	0	0	0	0	0
Depreciation (excludes IFRIC 12)	891	74	63	(11)	74	63	(11)
Total Non-op. Costs	**2,731**	**228**	**217**	**(10)**	**228**	**217**	**(10)**
Total Expenditure	**77,645**	**6,902**	**6,715**	**(187)**	**6,902**	**6,715**	**(187)**

Pay

- There is a net underspend on pay of £259k year to date due to vacancies across the trust, particularly Other Clinical (£183k) and Medical (£86k) being backfilled with agency and bank.

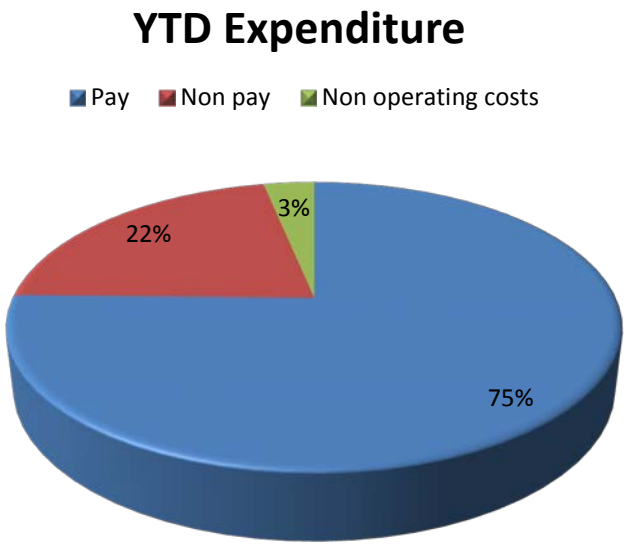
- Agency expenditure is £333k in month 1, with £205k being attributable to implementation of ROSE.
  - M1 Agency is £35k above the agency ceiling for M1.
  - This is mainly driven by Agency expenditure for the implementation of ROSE, which is £51k above the planned spend.

Non Pay

- Residential payments are overspent by £50k in M1. NSCHT and City Council are jointly reviewing to establish further assurance around the accuracy of the charges.

- Consultancy and Professional Fees are overspent by £31k on Trust Board and PMO.

- Unidentified CIP is £135k. Directorates are working on plans to close this gap, with worked up schemes expected to be transacted in month 2.



4. Directorate Summary

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

	Year to Date											
	Pay			Non Pay			Income			Total		
Table 4: 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	1,495	1,336	(158)	316	381	65	(177)	(125)	52	1,634	1,593	(41)
AMH Inpatients	529	547	18	18	26	8	0	(0)	(0)	546	573	26
Children's Services	547	502	(45)	45	57	12	(56)	(62)	(6)	535	497	(38)
Substance Misuse	188	205	17	53	40	(13)	(39)	(31)	8	202	214	12
Learning Disabilities	446	400	(46)	21	17	(4)	(5)	(3)	2	462	415	(48)
Neuro & Old Age Psychiatry	910	885	(25)	40	48	8	(76)	(75)	1	873	858	(16)
Corporate	1,203	1,183	(20)	1,093	1,087	(6)	(6,493)	(6,383)	111	(4,198)	(4,112)	85
Total	**5,316**	**5,058**	**(259)**	**1,586**	**1,657**	**71**	**(6,846)**	**(6,678)**	**168**	**56**	**37**	**(19)**

- AMH Community is underspent on pay due to a vacancies not fully covered by Agency and Bank. The adverse variance on Non Pay results from under delivery of CIP against the target and overspends against residential payments.

- AMH Inpatient is overspent on pay mainly due to vacancies on medics being covered by Agency at a premium cost. Overspends on Non Pay are driven by under achievement of CIP against the plan.

- Learning Disabilities, Children's Services and NOAP underspent due to vacant posts not fully covered by Agency and Bank. Vacant posts are currently being reviewed by Directorates as part of CIP plans and may be recognised as CIP following a full Quality Impact Assessment.

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 month 1. The Trust wide CIP achievement is 1% at M1 compared to plan.

		YTD @ M1				Forecast					
CIP Delivery	Annual CIP Target 2017/18	Plan	Actuals	(Under)/Over Achievement	RAG	Plan	Actuals	(Under)/Over Achievement	RAG	Recurrent Transacted	Recurrent Forecast
	£'000	£'000	£'000	£'000		£'000	£'000	£'000		£'000	£'000
Clinical											
AMH Community	1,084	46	0	(46)	0%	1,084	498	(586)	46%	0	741
AMH Inpatients	379	16	0	(16)	0%	379	44	(336)	11%	0	119
Children's Services	333	14	0	(14)	0%	333	271	(62)	81%	0	319
Learning Disabilities	256	11	2	(9)	18%	256	256	0	100%	23	222
NOAP	495	21	0	(21)	0%	495	449	(46)	91%	0	503
Total Clinical	**2,547**	**109**	**2**	**(107)**	2%	**2,547**	**1,518**	**(1,030)**	60%	**23**	**1,904**
Corporate											
CEO	49	2	0	(2)	0%	49	0	(49)	0%	0	0
Finance & Planning	56	2	0	(2)	0%	56	69	13	123%	0	71
MACE	62	3	0	(3)	0%	62	15	(47)	24%	0	15
Operations	29	1	0	(1)	0%	29	33	4	114%	0	35
Quality & Nursing	13	1	0	(1)	0%	13	8	(5)	62%	0	10
Strategy	15	1	0	(1)	0%	15	16	1	107%	0	20
Trustwide	365	16	0	(16)	0%	365	54	(311)	15%	0	130
Workforce & OD	61	3	0	(3)	0%	61	76	15	125%	0	80
Total Corporate	**650**	**28**	**0**	**(28)**	0%	**650**	**271**	**(379)**	42%	**0**	**361**
Total	**3,197**	**137**	**2**	**(135)**	1%	**3,197**	**1,789**	**(1,409)**	56%	**23**	**2,265**

Below 75%	
Below 90%	

Below 75%	
Below 90%	

Target	**3,197**
Variance	**(932)**

- The year to date CIP achieved stands at £2k (1%)
- The recurrent value of schemes transacted is £23k against £3.2m target. The recurrent forecast as at M1 is £2.265m; **this represents a recurrent shortfall against the target of £932k.**

6. Statement of Financial Position

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

Table 6: SOFP	31/03/2017 £'000	30/04/2017 £'000
Non-Current Assets		
Property, Plant and Equipment	28,037	27,983
Intangible Assets	222	232
NCA Trade and Other Receivables	1,426	1,426
Other Financial Assets	897	897
Total Non-Current Assets	**30,581**	**30,538**
Current Assets		
Inventories	88	84
Trade and Other Receivables	5,146	5,857
Cash and Cash Equivalents	6,964	4,945
Non-Current Assets Held For Sale	0	0
Total Current Assets	**12,198**	**10,886**
Total Assets	**42,780**	**41,424**
Current Liabilities		
Trade and Other Payables	(7,472)	(6,195)
Provisions	(333)	(328)
Borrowings	(457)	(633)
Total Current Liabilities	**(8,262)**	**(7,156)**
Net Current Assets / (Liabilities)	**3,937**	**3,731**
Total Assets less Current Liabilities	**34,518**	**34,268**
Non Current Liabilities		
Provisions	(474)	(474)
Borrowings	(12,189)	(11,975)
Total Non-Current Liabilities	**(12,663)**	**(12,449)**
Total Assets Employed	**21,855**	**21,819**
Financed by Taxpayers' Equity		
Public Dividend Capital	7,648	7,648
Retained Earnings reserve	3,987	3,951
Revaluation Reserve	9,323	9,323
Other Reserves	897	897
Total Taxpayers' Equity	**21,855**	**21,819**

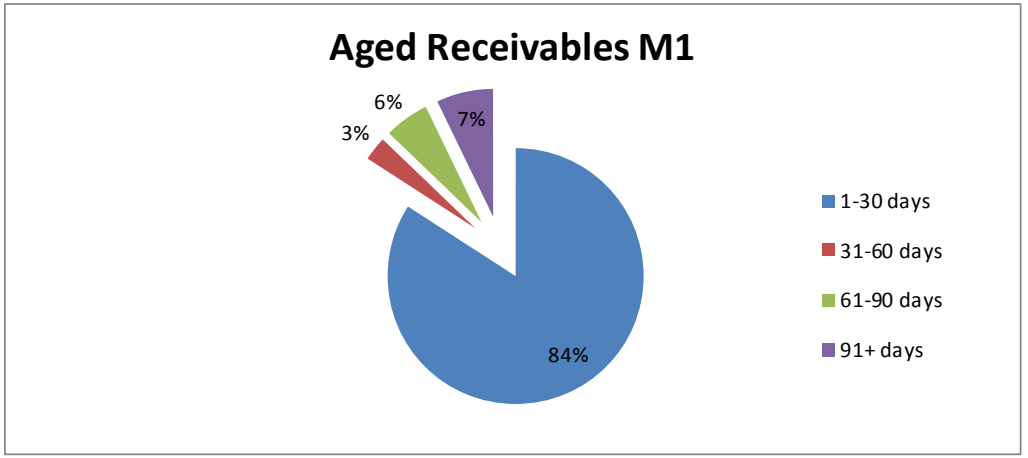
Current receivables are £5,857k

- £3,327k is based on accruals (not yet invoiced) and relates in the main to STF and prepayments.
- £2,530k in awaiting payment on invoice. (£104k within terms)

£385k 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;
- £361k 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	828	11	0	37	876
Receivables NHS	1,213	63	137	137	1,550
Payables Non NHS	603	29	1	113	746
Payables NHS	273	7	0	0	280



7. Cash Flow Statement

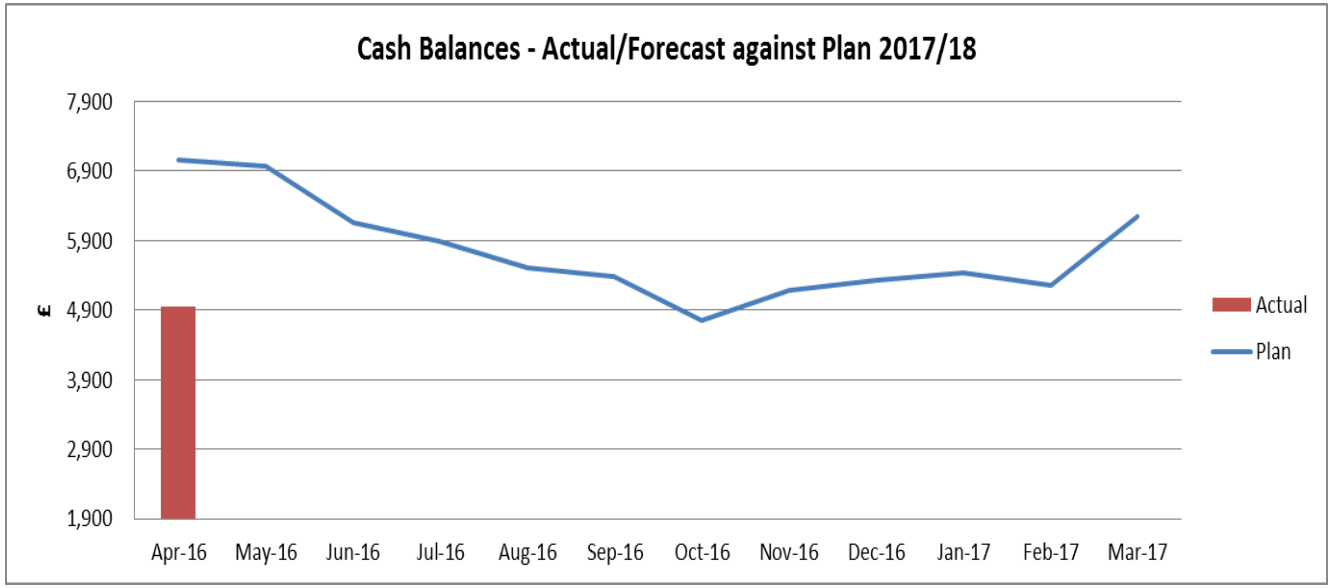
The Trust's cash position was £6.964m at 31st March 2017. The cash balance at 30th April 2017 has decreased to **£4.945m** due to an increase in the value of receivables and a reduction in the payables. The Trust cash position at 30th April 2017 is **£2,119k lower than planned.**

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

Table 7: Statement of Cash Flows	Apr-16 £'000
Net Inflows/(Outflow) from Operating Activities	(1,961)
Net Inflows/(Outflow) from Investing Activities	(21)
Net Inflows/(Outflow) from Financing Activities	(38)
Net Increase/(Decrease)	**(2,019)**

Opening Cash & Cash Equivalents	**6,964**
Closing Cash & Cash Equivalents	**4,945**

Plan	7,064
Variance	**2,119**



Summary of Outstanding Income		
Receivables	**£'000**	**RAG**
NHS Digital	359	
North Staffs and Stoke CCGs	352	
ADS	632	
NHSE	221	
STF	604	
TOTAL	**2,168**	

Capital Expenditure

The Trust's permitted capital expenditure agreed within the 2017/18 plan is £2.973m. Table 8 below shows the planned capital expenditure for 2017/18 as submitted to NHSI.

		Year to Date			Forecast		
Table 8: Capital Expenditure	**Annual Plan £'000**	**Plan £'000**	**Actual £'000**	**Variance £'000**	**Plan £'000**	**Actual £'000**	**Variance £'000**
Place of Safety	600	37	0	37	600	600	0
Psychiatric Intensive Care Unit	2,253	265	(10)	275	2,253	2,253	0
E-rostering	102	11	11	0	102	102	0
Information Technology	250	4	2	2	250	250	0
Environmental Improvements (backlog)	120	10	17	(7)	120	120	0
Reduced Ligature Risks	217	25	0	25	217	217	0
Equipment	50	4	0	4	50	50	0
Contingency	100	8	0	8	100	100	0
Total Gross Capital Expenditure	**3,692**	**364**	**20**	**344**	**3,692**	**3,692**	**0**
Bucknall Hospital (Part)	(713)	(713)	(713)	0	(713)	(713)	0
Total Capital Receipts	**(713)**	**(713)**	**(713)**	**0**	**(713)**	**(713)**	**0**
Total Charge Against CRL	**2,979**	**(349)**	**(693)**	**344**	**2,979**	**2,979**	**0**

- £713k was received in month 1 for the sale of Bucknall. This was included in the cash plan for 2017/18.

8. 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	3,815	
Annual Operating Expenses	6,498	
Liquidity Ratio days	18	
Liquidity Ratio Metric	**1**	
Capital Servicing Capacity (times)		
Revenue Available for Debt Service	180	
Annual Debt Service	193	
Capital Servicing Capacity (times)	0.9	
Capital Servicing Capacity Metric	**4**	
I&E Margin		
Normalised Surplus/(Deficit)	(37)	
Total Income	6,653	
I&E Margin	(0.01)	
I&E Margin Rating	**4**	
I&E Margin Variance from Plan		
I&E Margin Variance	0.00	
I&E Margin Variance From Plan	**1**	
Agency Spend		
Providers Cap	277	
Agency Spend	333	
Agency %	20	
Agency Spend Metric	**2**	
Use of Resource	**3**	

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	0.01	0.00	(0.01)	<=(0.01)
Agency Spend	0	25	50	>50

The Capital Servicing Capacity and I&E margin risk ratings are both level 4 due to the YTD planned deficit.

In later months where there is a planned surplus, due to delivery of CIP's, both ratings will improve.

9. Better Payment Practice Code

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

At month 1, the Trust has under-performed against this target for the number of invoices, having paid 84% of the total number of invoices (98% for 2016/17), and paid 83% based on the value of invoices (95% for 2016/17).

In order to meet its statutory obligation, to operate within its External Financing Limit (EFL), the trust reduced payment runs in M12, maintaining cash balances. Performance in Month 1 is reflective of a number of breaches, triggered upon payment of an invoice which exceeds the 30 day target.

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

	2016/17			2017/18 YTD		
Table 10: Better Payment Practice Code	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**
Number of Invoices						
Total Paid	508	13,183	13,691	109	1,442	1,551
Total Paid within Target	459	11,610	12,069	98	1,203	1,301
% Number of Invoices Paid	90%	88%	88%	90%	83%	84%
% Target	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**-4.6%**	**-6.9%**	**-6.8%**	**-5.1%**	**-11.6%**	**-11.1%**
Value of Invoices						
Total Value Paid (£000s)	6,860	29,380	36,240	1,264	1,579	2,843
Total Value Paid within Target (£000s)	6,385	27,914	34,299	1,194	1,154	2,348
% Value of Invoices Paid	93%	95%	95%	94%	73%	83%
% Target	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**-1.9%**	**0.0%**	**-0.4%**	**-0.5%**	**-21.9%**	**-12.4%**

10. Recommendations

The Trust Board are asked to:

Note:

- The reported deficit of **£37k against a planned deficit of £56k**. This is a favourable variance to plan of £19k.
- The M1 CIP achievement:
    - In month achievement of £2k (1%); **an adverse variance of £135k**;
    - 2017/18 forecast CIP delivery of £1,798k (56%) based on schemes identified so far; an adverse variance of £1,409k to plan;
    - The recurrent forecast delivery at month 1 of £2.265m representing a **recurrent variance to plan of £932k**.
- The cash position of the Trust as at 30th April 2017 with a **balance of £4,945k**; £2,119k worse than plan.
- Capital expenditure for 2017/18 is £20k compared to a plan of £364k;
- Use of resource rating of **3**.

Approve

- The month 1 position reported to NHSI

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REPORT TO TRUST BOARD

Enclosure No:13

Date of Meeting:	8TH June 2017		
Title of Report:	Summary of the Finance and Performance Committee held on 1st June 2017		
Presented by:	Mr Tony Gadsby, Chair / Non Executive		
Author:	Finance Department		
Executive Lead Name:	Miss Suzanne Robinson	Approved by Exec	☐

Executive Summary:		Purpose of report	
This report provides a summary of the key headlines from the Finance and Performance Committee held on the 1st June 2017. The full papers are available as required to members.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☒ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☒ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☒ 4. Encourage, inspire and implement research & innovation at all levels.☒ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☒ 7. Continually improve our partnership working. ☒		
Risk / legal implications: Risk Register Ref	To ensure that the committee meets its terms of reference by receiving reports of the work of its sub groups		
Resource Implications: Funding Source:	n/a n/a		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	n/a		
Recommendations:	Receive for assurance purposes		

Assurance Report to the Trust Board – Thursday, 8th June 2017

Finance and Performance (F&P) Committee Report to the Trust Board – 8th June 2017

This paper details the issues discussed at the Finance and Performance Committee meeting on the 1st June. The meeting was quorate with minutes approved from the previous meeting on the 4th May. Progress was reviewed and actions confirmed taken from previous meetings.

The committee has requested a review of the Shared Services for Estates.

Director of Finance Update

The following updates were given by the Director of Finance;

Local updates;

- The Finance Strategy for 2017/18 and 5 year Finance strategy was presented, which builds on the strategy from last year and details the overall objectives of delivering financial control and achieving CIP recurrently. Sustainability objectives, challenges and opportunities have been updated to reflect the current financial challenges the trust faces. .

- NHS Improvement has launched a number of expert groups which focus on 'what good looks like' for benchmarking of back office functions. The Trust has put forward Senior Trust representatives to sit on the expert groups.

- NHS Improvement is undertaking a national exercise which investigates the terms and conditions within different PFI contracts to draw out some learning and recommendations to share. The first stage will be an initial survey which NSCHT will take part in.

- There are no further updates around the Capped Expenditure Process (CEP) process at this stage.

Finance

The committee reviewed the Month 1 Finance position which is £37k deficit against a plan deficit of £56k; a favourable variance to plan.

The capital spend was £344k behind planned spend.

The committee were assured around the financial position.

Cost Improvement Programme (CIP)

The committee received an update on the process around transacting of CIP which introduced improved rigour and process. The Directorates are already identifying schemes for 2018/19.

The committee were concerned that the total CIP identified was significantly short of the target

at M1, with £2,265k forecast to be recurrently delivered at M12 against the £3,197k target. It was noted that schemes should be identified which exceed the target, well in advance of the start of the financial year.

The committee also noted the emphasis on transactional rather than transformational schemes, which does not enable the trust to deliver a long term and sustainable financial position.

The committee were unable to give assurance around the ability to deliver the full CIP target for 2017/18 and have requested an in depth analysis of CIP has been requested after Q1.

Cash

Cash balances were under plan in Month 1. The committee noted that the timing difference between cash spent on EPR and funding received from NHS Digital was a significant factor, which would be resolved on conclusion of the project.

Agency

It was noted that there are still challenges in the recruitment of Medical Locums, which was causing Agency expenditure to be incurred. The Trust has been to retain the same Locums ensuring consistency of service.

The committee discussed whether there was an alternative way of using vacancies which challenged traditional structures and ways of working.

It was noted that CAMHs is currently undertaking transformational work and looking at ways of doing things differently, by using for example Nurse Prescribers and Nurse consultant roles.

Other Reports and Updates

The Committee received additional assurance reports as follows:

- Capital Report

Performance

- **Performance Report (PQMF)**

This report provides the committee with a summary of performance to the end of Month 1 (April 2017). It was noted that performance picture for M1 is very similar to the performance M12 2016/17.

Recruitment continues to be a challenge but the committee acknowledged that there is an ongoing recruitment drive which had demonstrated success around Ward 4 recruitment. The committee noted that the trust turnover rate is a more effective method of monitoring staffing.

CPA compliance remains an issue in respect of care plan compliance and 12 month reviews undertaken. In respect of CPA 7 day follow up, NHSE have indicated the standard could be increased to allow for 48 hour follow up and the committee have asked for shadow monitoring of this ahead of mandatory reporting.

- **CYP Waiting Times (PQMF)**

The committee discussed the CAMHS waiting times for CYP and ASD.

The ASD target was reported as being on track and the committee can be assured that the planned trajectory will be achieved.

After concerns in M12 that performance for CYP waiting list targets had plateaued. April showed a worsening of performance, with the Directorate to meet the two contacts in 18 week target and one contact in 4 week target. It was agreed that the Head of Directorate would be invited to the next committee to explain the deviation in performance. The committee cannot provide assurance that this target will be achieved at this stage.

- **Deep Dive Analysis into Readmissions and DTOCs**

A verbal update was given on Readmissions following a deep dive of all emergency readmissions undertaken in Quarter 3 & 4, noting that Directorates would undertake quantitative analysis and work up recommendations to improve.

Delayed Transfers of Care (DTOCs) – concerns had been raised about the delayed discharges, as in previous months, which triggered a deep dive. Verbal update was given around the progress of the report, which is deemed to be a valuable exercise. The report detailing the outcome is expected at the next committee including themes and trends by Directorate is to be reported the next F&P.

Capital and Estates

A Capital Projects Report was presented detailing expenditure to date on the PICU project, as well as forecast expenditure against plan against key expense categories. The project currently forecasts £176k underspend, including £87k unused contingency.

The committee felt it could give further assurance around Capital with the detail presented in the report, however a request was also made for a phasing profile to be included.

No Estates compliance reports were received at the Committee. This is currently being reviewed by the new Director of Operations and an update will be given at the next Committee.

Other

- **Financial Risk Register**

The paper describes the risks contained within the Trust risk register which falls under the portfolio of the Finance and Performance Committee. The committee was comfortable that all relevant risks were being captured, but advised that the residual risks should be reviewed for deliverability.

- **Meridian Phase 1 Return on Investment**

An evaluation of the Meridian Phase 1, demonstrated that Meridian delivered an actual return on investment of 274% against a proposal of 479%. The committee noted that although the investment did not achieve its proposed ROI, the savings realised were

significant and a key aspect of the 2016/17 CIP delivered.

- **Activity Report**

The report detailed M1 activity against plan using traditional reporting methods and clustering. The committee is not able to give assurance around activity reported due to issues around quality of recording by operational staff. An action plan has been requested to map out the steps required to improve.

- **Developing Business Intelligence through Lorenzo Reporting**

The report detailed the work the performance team is doing post Lorenzo migration, to move towards a business intelligence function, as well as the benefits this will have to the trust and directorates.

- **For Information**
  - Agency Rectification plan
  - Finance and Performance Monitoring Schedule
  - Cycle of Business

.

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

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REPORT TO TRUST BOARD

Enclosure No:14

Date of Meeting:	8TH June 2017		
Title of Report:	Summary of the Audit Committee held on 31st May 2017		
Presented by:	Mrs Bridgett Johnson, Chair / Non Executive		
Author:	Zoe Grant, Quality Assurance and Improvement Manager		
Executive Lead Name:	Miss Suzanne Robinson	Approved by Exec	☐

Executive Summary:		Purpose of report	
This report provides a summary of the key headlines from the Audit Committee held on the 31st May 2017. The full papers are available as required to members.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☒ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☒ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☒ 4. Encourage, inspire and implement research & innovation at all levels.☒ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☒ 7. Continually improve our partnership working. ☒		
Risk / legal implications: Risk Register Ref	To ensure that the committee meets its terms of reference by receiving reports of the work of its sub groups		
Resource Implications: Funding Source:	n/a n/a		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	n/a		
Recommendations:	Receive for assurance purposes		

North Staffordshire Combined Healthcare NHS Trust

Summary Report of the Audit Committee
31st May 2017

Annual Report

This is in a larger format this year to create a greater visual impact. The committee were informed that the Annual Report serves as the 'sister' document to the Trust's Quality Account and the Trust are able to provide translated versions into the 4 other most frequently used languages in the area. It will also be available through social media and on the Trusts website.

The committee were advised that the 'in-house' production of this document has incurred a saving of around £2000.

The only final changes to make is to the back cover which will contain the Trusts recruitment poster and demonstrate ethnicity and diversity inclusion and pictures of service users will also be added to the document.

On this understanding committee gave its approval to the Annual Report.

Quality Account

The committee received a draft version of the document for assurance. The final version will go to the Quality Committee for their approval on 30th June 2017.

ISA Audit

The Trusts external auditors, Ernest Young, presented their findings to the Committee. They were pleased to report unqualified opinion of the 2016/17 accounts.

The audit also looked at the design of the Trust controls and found no weaknesses to report. Previous recommendations have been addressed and no further recommendations made.

Value for Money conclusion was positive.

It was recognised that the STP is financially challenged and therefore stringent project management is essential going forward.

They thanked the Finance team for their support alongside a request to bring forward the future Annual report deadline.

2016/17Annual Accounts

These were reviewed and approved by members of the committee.

Audit Recommendations progress report:

The committee were appraised about the current progress:

- 17 actions are currently outstanding
- 12 actions are not yet due
- 5 have received a revised completion date with a valid reason for extension. This included the medical revalidation audit, this is now complete
- One action was recorded as complete, however this has been amended to partially complete. Action E10 will be addressed at the Service User Council and be reported via the Quality Committee.

The committee were assured by the progress made on actions identified by the Internal Auditors.

Quality Standard Assurance Reports

The committee received an overview of the Trusts unannounced assurance visits programme and the Joint quality visits conducted with CCG and Healthwatch colleagues. These results are presented to Quality Committee.

The visits programme support the ongoing monitoring of quality standards and are integral to trust systems and processes. The Committee raised concerns about the level of NED involvement in these visits and the number of visits over a year.

The Committee were only partially assured and requested that the visit schedule and executive and non-executive leads will be presented to the next Audit committee.

Business Conduct Policy

This was approved by the committee

RSM Annual report

The committee were informed that the Trust were in the second to top section of performance which is comparable with 95% of trusts.

The following key points were highlighted;

- There were 9 recommendations made for the medical staff revalidation report mainly in relation to policy updates and spreadsheet update and mechanisms all of these actions are in progress.
- Counters Fraud – the heat map suggests that some risks have moved, this is in line with a national picture. Compliance check lists have been issued and will inform this year's plan.
- There will be a focused assessment carried out by NHS Protect on 4th July.

Purchase order wavers process

The Committee were pleased with the new documentation but asked for some assurance on the levels of smaller wavers.

North Staffordshire Combined Healthcare NHS Trust

Losses and Compensations

The committee were provided with the latest update which was a £4000 settlement.

Cyber Attack

The committee received an update about the Trusts response to the cyber-attack on 12th May 2017 the following information was shared:

- The Trust was well prepared due to the 'go live' date for Lorenzo being scheduled – there were floor workers and paper backup systems already in place.
- The attack had no impact on patient care.

DATA protection regulations

The committee were informed that there are EU standards, an action plan has been devised and assurance will be received back to the audit committee in March 2018.

Information Governance

The committee were notified of a recent information governance breach.
The committee were informed that this was reported accordingly by the Trust and an investigation is underway.

The completed action plan will be presented to the Audit committee.

Committee Summary reports:

Received for information:

- Cycle of business

Summary prepared by Zoe Grant – Quality Assurance and Improvement Manager

On behalf of Bridget Johnson – Audit Committee Chair.

1st June 2017.

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REPORT TO Trust Board

Enclosure No:15

Date of Meeting:	8th June 2017		
Title of Report:	Self-Certification – Condition FT4		
Presented by:	Laurie Wrench		
Author:	Laurie Wrench		
Executive Lead Name:	Caroline Donovan	Approved by Exec	☒

Executive Summary:	Purpose of report	
This is the first year NHS trusts must self-certify. Although NHS trusts are exempt from needing the provider licence, directions from the Secretary of State require the NHS Trust Development Authority to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate. The Single Oversight Framework (SOF) bases its oversight on the NHS provider licence. NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions (including Condition G6 and Condition FT4) and must self-certify under these licence provisions. NHS trusts are required to self-certify that they can meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that they have complied with governance requirements. Trust Board must self-certify and confirm compliance against condition FT4 by 30th June 2017	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:	The Single Oversight Framework (SOF) bases its oversight on the NHS		

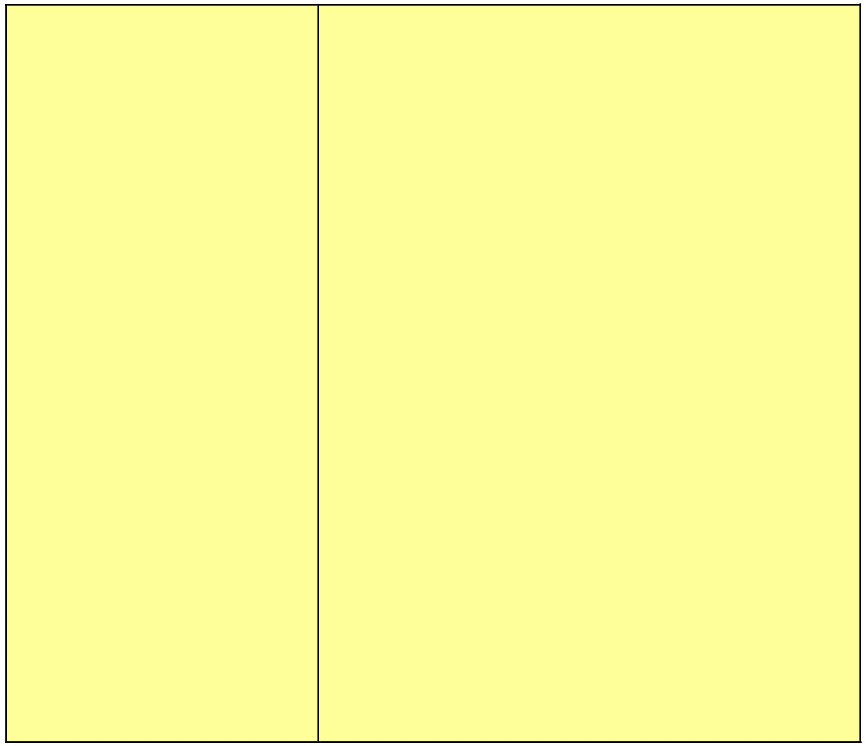
Risk Register Ref	provider licence. NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions (including Condition G6 and Condition FT4) and must self-certify under these licence provisions
Resource Implications: Funding Source:	N/A
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	N/A
Recommendations:	The Board approve the self-certification for condition FT4

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

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

3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	**Confirmed** Risk is mitigated through: • A review of Board and Committee effectiveness undertaken including Committee Terms of Reference, frequency of meetings, membership of sub committees, ongoing Board development, sub group reporting arrangements • Committee structure review including sub-committees
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on	**Confirmed** Risk is mitigated through: • Financial balance • Finance and Performance committee reporting to Board • CQC rating of 'good' • Robust Performance Management Framework and rectification plans • Purchase order processes • Investment policy • Delegated authority limits1, 2 and 5 year business plans • 2 year CIP plans

such plans and their delivery; and
(h) To ensure compliance with all applicable legal requirements.



5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	**Confirmed** Risk is mitigated through: • Executive Director leadership for quality by Director of Nursing and Quality and Medical Director • Board developments topics in quality • Board to team unannounced quality assurance visits • Announced quality assurance visits with CCG, service users / carers and Healthwatch • Involvement of service user and carer council • QIA on CIP • Quality Account • Quality Committee reports to Board • Scrutiny of the Performance Management Framework at committee and Board • Rectification plans for metrics where target not achieved, including actions and trajectory for improvement • Quality priorities – Safe, Personalise, Accessible and Recovery Focussed (SPAR) • Strategic objectives relate to quality measured through the BAF • CQC overall rating of good (September 2016)

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

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

Signature _____

Name David Rogers

Signature _____

Name Caroline Donovan