North Staffordshire Combined Healthcare NHS
NHS Trust

MEETING OF THE TRUST BOARD

TO BE HELD IN PUBLIC
ON THURSDAY, 9 MARCH 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 – 9 February 2017** *To APPROVE the minutes of the meeting held on 9 February 2017*	Approve Enclosure 2
5.	**ACTION MONITORING SCHEDULE & MATTERS ARISING FROM THE MINUTES** *To CONSIDER any matters arising from the minutes*	Note Enclosure 3
6.	**CHAIR'S REPORT** *To RECEIVE a verbal report from the Chair*	Note
7.	**CHIEF EXECUTIVE'S REPORT** *To RECEIVE a report from the Chief Executive*	Note Enclosure 4
	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*	Verbal
10.	**SPOTLIGHT ON EXCELLENCE INDIVIDUAL AND TEAMS** *To PRESENT the ;* • *Individual Spotlight Award – Dr J Sorensen, Consultant Clinical Psychologist* • *Spotlight on Excellence Team for North Staffordshire Children and Young People Improving Access to Psychological Therapies (IAPT) Youth Council*	Verbal Presentation

	To be introduced by the Chief Executive and presented by the Chair	
11.	**ASSURANCE REPORT FROM THE QUALITY COMMITTEE** *To RECEIVE the Quality Committee assurance report from the meeting held on 28 February 2017 from Mr T Gadsby, Vice Chair/Non-Executive Director*	Assurance Enclosure 5 ***To follow***
12.	**NURSE STAFFING MONTHLY REPORT - January 2017** *To RECEIVE the assurance report on the planned versus actual staff variances from Ms M Nelligan, Executive Director of Nursing & Quality*	Assurance Enclosure 6
13.	**DIRECTOR OF INFECTION PREVENTION AND CONTROL (DIPC) QUARTER 3 – 1 OCTOBER – 31 DECEMBER 2016** *To RECEIVE a report in respect of DIPC Q3 from Ms M Nelligan, Executive Director of Nursing and Quality*	Assurance Enclosure 7
14.	**BOARD ASSURANCE FRAMEWORK Q3 2016/17** *To RECEIVE the Board Assurance Framework Q3 update from Mrs L Wrench, Associate Director of Governance*	Assurance Enclosure 8
15.	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 10** *To RECEIVE the Month 10 Performance Report from Miss S Robinson, Director of Finance and Performance*	Assurance Enclosure 9
16.	**RAISING OUR SERVICE EXCELLENCE (ROSE) UPDATE** *To RECEIVE an update for Raising Our Service Excellence (ROSE) Update from Mr T Thornber, Director of Strategy and Development* *Mr G Thomas, Digital Strategic Lead to be in attendance for this item.*	Assurance Enclosure 10
	TO ENHANCE SERVICE USER AND CARER INVOLVMENT	
17.	**SERVICE USER AND CARER COUNCIL** *To RECEIVE an update from, Ms W Dutton, Vice Chair of the Service User and Carer Council*	Verbal
	CREATE A LEARNING CULTURE TO CONTINUALLY IMPROVE	
18.	**ASSURANCE REPORT FROM THE PEOPLE AND CULTURE DEVELOPMENT COMMITTEE** *To RECEIVE the People and Culture Development Committee Assurance Reports from the meetings held on 27 February 2017 from Mr P Sullivan, Chair/Non-Executive Director*	Assurance Enclosure 11
	ENCOURAGE, INSPIRE AND IMPLEMENT RESEARCH AND INNOVATION AT ALL LEVELS	

19.	*To RECEIVE a verbal update on progress from Dr B Adeyemo, Medical Director*	Verbal
	MAXIMISE AND USE OUR RESOURCES INTELLIGENTLY AND EFFICIENTLY	
20.	**FINANCE REPORT – MONTH 10 (2016/17)** *To RECEIVE for discussion the Month 10 financial position from Miss S Robinson, Director of Finance and Performance*	Assurance Enclosure 12
21.	**ASSURANCE REPORT FROM THE FINANCE & PERFORMANCE COMMITTEE** *To RECEIVE the Finance & Performance Committee Assurance report from the meeting held 2 March 2017from Mr T Gadsby, Chair/Non-Executive Director*	Assurance Enclosure 13
	ATTRACT AND INSPIRE THE BEST PEOPLE TO WORK HERE	
22	**VALUES AND BEHAVIOURS PRESENTATION** *To RECEIVE the Behaviour Framework Work Presentation from Mr R Cragg, Deputy Director of People and Strategy on behalf of Mr P Draycott, Executive Director of Leadership and Workforce*	Presentation
	CONTINUALLY IMPROVE OUR PARTNERSHIP WORKING	
23.	*To RECEIVE a verbal update on progress from Mr T Thornber, Director of Strategy and Development*	Verbal
	DATE AND TIME OF THE NEXT MEETING	
24.	*The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday, 6 April 2017 at 10:00am.*	
25.	**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	

Enclosure

North Staffordshire Combined Healthcare NHS Trust

TRUST BOARD

Minutes of the open section of the North Staffordshire Combined Healthcare NHS Trust Board meeting held on Thursday, 9 February 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 T Thornber
Director of Strategy and Development

Ms M Nelligan
Executive Director of Nursing and Quality

Ms W Dutton
Vice Chair – Service User and Carer Council

Ms Joan Walley
Non-Executive Director

Ms Lorien Barber
Non-Executive Director

Dr K Tattum
GP Associate Director

Ms Suzanne Robinson
Director of Finance and Performance

In attendance:

Mrs L Wrench
Associate Director of Governance

Mrs J Scotcher
Executive PA

Mr J McCrea
Associate Director of Communications

Members of the public:
Phil Leese, NSUG
Mrs H Johnson, NSUG
Irene Crellin, O2

Team Spotlight: - CQC
Laurie Wrench
Kate Walker
Zoe Grant

Team Spotlight – Flu Campaign Team
Dan Hooper
Alex Shaw
Sonia Goodwin
Andrew Wilshaw
Carol Sylvester
Sue Slater
Emily Allen
Jenny Cunningham
Andy Bough
Josie Sage

Individual spotlight
Mel Hope

Staff Retirements
Brian Shufflebotham

The meeting commenced at 10:00am.

569/2017	**Apologies for Absence** Apologies were received from Ms Harvey, UNISON. The Chair welcomed Ms Dutton, Vice Chair – Service User and Carer Council.	**Action**

570/2017	**Declaration of Interest relating to agenda items** There were no declarations of interest relating to agenda items.	
5712017	**Declarations of interest relating to any other business** There were no declarations of interest to Any Other Business.	
572/2017	**Minutes of the Open Agenda – 12 January 2017** The minutes of the open session of the meeting held on 12 January 2017 were approved, subject to the following: Dr Adeyemo requested that the following be removed on page 4 536/16; *'to rectify the outcomes and this will be ready for the next quarterly report'*. Ms Nelligan requested that on page 19 584/16; it should be noted that there is a review of the Terms of Reference for the Service User and Carer Council. There is also an Open Space event on 29 March 2017 for wider service users and carers which will be publicised through our Communications Team.	
573/2017	**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. ***The Trust is continuing to negotiate and gain support in respect of the 56% cuts in funding for Substance Misuse services across Staffordshire, however this is due to be implemented from 1 April 2017 and remains very concerning due to the impact on service users. Staff have been through a Management of Change process with every effort is being made for redeployment and to reduce redundancy implications. The Chairman has also written to our five CCG Boards. To date there have been several responses in support of the Trust position.*** ***There is an event scheduled next week with commissioners, council leaders and services to see if we can mitigate further.***	

	A recent meeting has taken place with the Police Commissioner. The meeting was positive and there may be some small scale proposals which could make a difference. ***A session has been scheduled with all Substance Misuse staff for February 2017 to provide further updates.*** ***The Chair noted that he had attended the last Board Meeting for both North Staffordshire and Stoke on Trent CCGs and their level of concern was high and commitment to find ways to mitigate and support the Trust.*** ***The Chair has accepted an invitation to be interviewed about this issue on the 'You and Yours' BBC radio programme.*** ***536/16 - Serious Incidents Q2*** - With regards to incidents, there has been an increase from the last quarter, however a downward trend continues. Themes and trends will be ready for the next quarterly report. ***On today's agenda – remove from schedule*** ***544/16 - Assurance Report from the Charitable Fund Committee -*** The total funds were noted at £434,290. The future of the management of the Charitable Funds was discussed and an option appraisal will be reviewed and will come back to the Trust Board ***Miss Robinson noted this is being addressed and will be discussed at a future meeting – remove from schedule*** ***584/17 Service User and Carer Council -*** The next Service User and Carer Council meeting will take place on 25 January 2017, however the Chair, Mr Cotterill has now stepped down. A formal note of thanks will be sent to Mr Cotterill. The meeting in January will review the election of a new Chair and the Terms of Reference. ***The Service User and Carer Council is continuing to be strengthened and the Board will be informed going forward – remove from schedule*** **598/17 – Register of Sign and Seals -1 Jan – 31 December 2016** Mr Gadsby requested that the register reflect the two sign and seal stages. 1)When the deal is agreed 2) When sale is complete	

	The Chair stated that the Trust procedures have been updated accordingly in order to capture all transactions – remove from schedule ***Mr Rogers stated that the purchase of A&T is still not complete, the funds were transferred to our solicitors 8 February 2017, although it is still not reflected on our books officially.***	
574/2017	**Chair's Report** The Chair made reference to the Staffordshire Transformation Plan and the recent stepdown of leadership. There is recruitment process ongoing and it is anticipated that new appointments will be made in due course. To give some background he noted that the NHS is having to make a cultural shift from one Trust competing with another to working in collaboration in order to provide better care and redesign our services. The Chair then gave an example of the pressures on Accident and Emergency and the impact of delayed discharges, for which the University Hospital of North Midlands cannot solve alone. The Trust continues to generate capacity and confidence and work closely with other health care and social care providers in the area. The Chair commented he had attended various Board meetings recently to gain an understanding from the perspective of other Trusts. ***Received***	
575/2017	**Chief Executive's Report** Mrs Donovan, Chief Executive, presented this report which provides an update on the activities undertaken since the last meeting in January 2017 and draws the Board's attention to any other issues of significance or interest. **Care Quality Commission** Following the Trust's comprehensive inspection in September 2016, the Trust has been negotiating with the CQC the regarding the publication of our final report. It is anticipated that the report will be published 21 February 2017, however we are awaiting final confirmation from the CQC. Following the publication there will be a Quality Summit with our partners and regulators.	

	In addition, an event to celebrate the publication of the findings is being planned at the Harplands Hospital, prior to the Quality Summit. It is hoped that James Mullins, Head of Hospital Inspections for Mental Health CQC, will be able to attend along with our staff. **Flu Fighter Campaign** The Trust is the highest performing mental health trust in the country with 79.7% of our frontline staff having received the vaccine. The Flu Fighter Campaign Team have been spotlighted today and huge thanks go to all the team who went above and beyond to ensure staff could easily receive the vaccination. **Trust shortlisted in National Awards** The Trust is delighted that our staff and services have been shortlisted as below; In the ***HSJ Value in Healthcare Awards***, • ***Learning Disability services*** have been chosen as a finalist in the Community Health Service Redesign category, • ***Healthy Minds Improving Access to Psychological Therapies (IAPT)*** Stoke-on-Trent team has been shortlisted in the Improving the Value of Primary Care Services category. The awards will take place in London on 24 May 2017. In the ***Health Education West Midlands Regional Leadership Recognition Awards.*** • Our ***Growthpoint service*** has been shortlisted in the Team Outstanding Achievement Award - Non-Clinical category • ***Maureen Mayanga, Rapid Assessment Interface and Discharge (RAID) Practitioner,*** has been selected as a finalist in the Excellence in Patient Experience Award. • ***Jaymee Smith, Chair of the North Staffordshire Children and Young People's IAPT*** Youth Council, has been chosen in the Inclusive Leader category. • ***Chief Executive Caroline Donovan*** is a finalist in the Inspirational Leader Award. • ***Josie Povey, Modern Matron,*** is a finalist in the Emerging Leader Award	

	The awards take place on 28 February 2017 in Birmingham. **Enhanced Intensive Support Service for Children – Bid Submitted** The Trust submitted a bid to provide an enhanced (Intensive Support) service for children as part of NHS England's Invitation to Bid. Unfortunately, the Trust has since heard it has not been successful. A bid has also been submitted with a view to securing new transformation funding for Mental Health Liaison Services (24/7 RAID) to expand the provision of these services to provide specialist assessment and support to meet mental health needs in acute hospital settings. The Trust will be notified in March whether we have been successful. **British Deaf Association Deaf Charter signed by Trust** The Trust has recently signed up to the Deaf Charter and held a very positive event at Lawton House with the Chairman and Dr Terry Bailey, Chair of the British Deaf Association. The Trust has made great strides in supporting people with a hearing impairment and has signed up to 5 pledges. Smartphones are also now available at key access points to allow for service users with hearing loss to contact the Trust. **Raising Our Service Excellence (ROSE)** Preparations are underway for the Trust's implementation of ROSE; the electronic patient record (EPR) on 13 May 2017. A further update will be on today's agenda. **New Trust Website Launched and Twitter Account renamed** The Trust has been improving the way we communicate with our service users, carers and wider public and has launched a new and improved website. The web address is the same; www.combined.nhs.uk **Recovery and Wellness Conference** The Trust is hosting a Recovery and Wellness Conference for North Staffordshire on Monday 27th February. This exciting and thought-provoking event will showcase best practice and celebrate successes of recovery focussed care. Ms Nelligan, Director of Nursing and Quality is leading on the event and this will involve key partners and stakeholders.	

	Praise for efforts of NHS staff over the 2016/17 winter period On 27 January 2017, all NHS Trust CEOs and Chairs received a letter from the Chief Executive and Chairman of NHS England thanking staff for the way they "have worked relentlessly under great pressure, but have maintained their dedication to patients and the public with great care and compassion". Mrs C Donovan asked staff to share thanks with colleagues. **Ongoing National Debate over Funding for Health and Social Care** The national debate over funding arrangements for health and social care continues to be focused within the House of Commons. The Trust will keep this high on the agenda. Both Ms Barber and Ms Walley raised their concerns in relation to this matter. ***Received***	
577/2017	**Staff Retirements** Mrs Donovan recognised those staff who are retiring this month as follows, **Brian Shufflebotham – Community Psychiatric Nurse** Brian commenced his nurse training at the St Edwards Hospital in November 1982 and has worked for the majority of his career within North Staffs Combined Healthcare Trust, leaving the trust for a short period between 1986 and 1988 to work on the locked wards at Rubery Hill hospital after which he returned to the Trust. Much of Brian's career has been within inpatient services, spending a brief period in the Rehab CPN team. His career has particularly been within rehabilitation services, working with clients with challenging presentations and significant care needs. Brian successfully led these services to ensure that the patients under his care had positive experiences and working towards integration back into the community. Managing these services from 1997 until 2010 transitioning between the Grange, Ward 5 and then into Summers view. The nature of the role meant that he built up strong relationships with known patients over a long period of time. Profoundly affecting their lives as much as they affected his. He talks fondly of them and recounts many stories including going on runs with patients, trips to London and other experiences to support their recovery and rehabilitation.	

	In 2010 Brian's experience and skills were utilised as part of the of the nursing office to manage the hospital site and support the safe running of the wards. In 2014 he came to the Triage team where he has worked to develop the service and form strong relationships with police colleagues having a significant positive impact on the experiences of people in crisis coming into contact with the police. Always a keen footballer, Brian managed the St Edwards football team for a number of years and reports his fondest memory of services was in 1995 when they won the Tom Burn Shield, named after a former patient. ***Received***	
578/2017	**Staff Bereavement – Emma Allen** We were saddened at the end of January to hear the news that our colleague, Emma Allen, had passed away. Emma joined the Trust from September 2004 as an Occupational Health Assistant before going on to complete her Student Nurse training the following year. She made an extremely valuable contribution throughout her years of service to our Mental Health services, including working on the complex needs ward, Meadowcroft, as a Healthcare Support Worker before taking up her first nursing post as a Staff Nurse on the same ward. Emma later worked in other nursing roles across the Trust including Ward 1 and 7 before taking short break to work solely on the Trust Bank in June 2012; she then returned to work for the Trust, working in the RAID Team from October 2013 onwards, during which time she was successful in obtaining a senior post within the Team. Emma was a valued nursing colleague, respected for her knowledge and compassion towards her patients and colleagues and who will be remembered for her commitment to the nursing profession and the Trust as a whole, and whose personal values impacted on colleagues past and present. Although I did not know Emma personally, it is clear from the people I have spoken to that she was a very special person and will be deeply missed. Emma was always hard working organised and professional, but was known mostly for her warm and friendly personality that was noticed by everyone she met.	

579/2017	**Individual Spotlight – Mel Hope** Mel began working with the Trust as a Staff Nurse in 2002 and is a member of the team at the Assessment and Treatment Unit within Learning Disabilities. Her commitment to the service is reflected in so many ways. Mel works conscientiously within her role, supporting clients through a person centred recovery focused pathway. Mel's in depth knowledge and her values shine through in everything that she does. Mel is held in incredibly high regard by clients and colleagues alike. She is a great team player and models the supervisor role really well. She is admired hugely by the team. Her approach to her work has been integral in facilitating a cohesive team approach to change. Mel is hardworking and conscientious. She does not seek recognition or attention for her efforts, and what she does is recognised as high quality despite her not seeking personal attention for her delivery. Mel is an excellent role model. She provides clear leadership and embraces service change. She rises to any day to day challenge and in doing so she influences positive change and an optimistic attitude within the unit. One of Mel's key strengths is her ability to adapt her approach to support others through difficult and challenging times. The service has undergone significant change recently, Mel has not only embraced this change but has supported others in doing so, whether it has been by providing protected time for supervision or by offering encouragement and a reassuring word during a difficult situation. Mel demonstrates all of the Trust values and by far her greatest strength is her ability to take responsibility and enhance systems and processes in such a way to ensure that the individual and personal needs of our clients are never forgotten and are always the main priority. The positive outcomes for the Assessment and Treatment have been well documented in recent months and it is having people like Mel on the team that make these things possible. She is an asset to her team, the Directorate and the Trust; and a credit to her profession. Thank you and well done.	

580/2017	**Care Quality Committee/Quality Assurance Team** The first of 2 Team REACH Spotlights was awarded to the CQC Coordination Team – a team brought together to coordinate our whole approach to the CQC Comprehensive Inspection Review: Laurie Wrench Zoe Grant Kate Walker This team and their role has been a vital one for the Trust in achieving significant improvement recognised by the CQC. Their role in planning, mapping, data collection and collation of information was in the centre of our successful CQC inspection. The fact that they have done this twice in a little over 12 months is amazing. Their attitude, determination, resilience and relentless drive has been essential to our real progress. The personal leadership they have shown in engaging with the Trust teams, shaping how the information was gathered and articulated has been pivotal. They ensured that each of our teams the CQC visited were able to articulate the areas of good practice, that teams focused on quality outputs, what it meant to patients, what it meant to staff, this was a vital part of demonstrating excellence. During the inspection they coordinated 23 focus groups and 35 interviews. They met every deadline, every request for data, every request for evidence; dealing with data over 200 requests during the inspection week alone. This led to each service and directorate being fully confident that they have been portrayed accurately and fairly. They have been critical to supporting the improvement plans across our services. In terms of living the Trust Values this team demonstrated all of the values but the one that best typifies their approach is Excellent. This is demonstrated in the way in which they pursued the evidence and data, quality assured it and delivered this in the timeframe required; ensured information and data was available for each team; and coordinating the quality audits to ensure that things weren't just being done, but that they were being done well. Their experience and the learning it is helping inform our next steps Towards Outstanding. Mrs C Donovan thanked the team for their achievements.	

582/2017	**Team Spotlight Award - September 2016** The second Team Spotlight was awarded to the "Flu Vaccination Team". This year – in order to protect our patients, staff and communities, every healthcare organisation was given a target to vaccinate 75% of front line staff. For mental health Trusts this level of vaccination is unheard of. Indeed year at Combined we achieved 44.8% of frontline staff vaccinated – our best ever year. There was the added incentive to achieve this year with a national CQUIN with a financial benefit of £140,302. By **9th January 2017** our total frontline staff vaccinated was **79.7%!** This was an amazing achievement but also we are delighted to have achieved the highest Healthcare Worker uptake of 'flu vaccinations across Mental Health Trusts in England. Our vaccination uptake was higher than many Acute Trusts, with North Staffordshire Combined Healthcare NHS Trust ranked as the 6th highest Trust nationally – a great achievement! Today we are recognising the people who were at the forefront of this great achievement. The team came together from different areas of the Trust harnessed the leadership of Carol Sylvester to achieve our aim; she was supported by nearly 20 other staff, as peer vaccinators and committed and proactive administrative staff. This year the team developed a shared approach based upon personal commitment of all the members. The Infection Prevention Control Team, the Peer Vaccinator team (known fondly as **"Team Vac**") and Team Prevent worked in partnership from the outset, with a collaborative planning approach to maximise opportunities for uptake. Peer Vaccinators, in addition to vaccinating their team colleagues, returned to deliver further roving vaccinator clinics over a series of evenings, nights and weekends. No opportunity to vaccinate was left to chance and staff attending training, on Induction at night and ad hoc opportunities were all taken to achieve the target. Josie Sage, IPC Lead Nurse brought a wealth of experience and employed her knowledge within an operational plan. Milestones were developed kept and delivered, frequent motivational email encouragement was vital, setting out how many vaccines needed to achieve the next milestone. Our Admin staff made sure that regular reporting of progress was made. Motivation for a final push between Christmas and New Year was key and we	

	achieved the 75% target shortly after Christmas. The Team lived the Proud to CARE values as they recognised the need to listen to the views and anxieties of staff and to promote the benefits of the campaign for our patients and staff. They demonstrated an approachable, flexible and responsive approach to maximise vaccination uptake .The team worked flexibly, creatively and with good humour. They took responsibility for individual and collective influence on others, reflecting on what went well and small but significant gains could be made. They had an ambitious target that seemed at times a stretch too far, but, determined to achieve the target and grasp the CQUIN, the team excelled and achieved true excellence, through the achievement of being the top mental health trust nationally It is significant that we have had no ward closures due to an influenza outbreak, even though there were outbreaks in the local health economy. Carol Sylvester delivered the presentation on behalf of the team and Team Prevent with the following points highlighted: ▪ Morbidity and mortality attributed to flu is a key factor in NHS winter pressures ▪ Frontline health and social care workers also have a duty of care to themselves and their patients ▪ Flu immunisation is one of the most effective interventions we can provide to reduce harm from flu ▪ Frontline health and social care workers should be provided flu vaccination by their employer Lessons learnt: ▪ **Partnership Approach :** Infection Prevention Team and Team Prevent ▪ **Communication :** weekly coverage detailing purpose, scheduled dates, targets, progress ▪ **Flu Fighter National Campaign :** Utilising resources, ideas, initiatives, myth busting ▪ **Peer Vaccinators:** Identifying volunteers and delivering competency based training ▪ **Maximum Uptake:** Induction, plenary , training, outreach and inreach approach, incentives A script was read out from Emma Baker Ms Walley congratulated the team for their brilliant outcome. She urged that initiatives like these be used for other campaigns such as Obesity.	

	The Board also acknowledged that the Trust had encouraged our Service Users to be vaccinated either on the ward or out within the community, accessing their GPs. Mr Draycott drew attention to the Wellbeing CQUIN which includes Pilates classes, healthy eating, work with physiotherapy plus a whole range of initiatives through the 'Feel Good Friday' programme. The Trust also supports service users and runs a Physical Health Task and Finish Group with a supporting Education programme. It was noted that incentives/rewards for being vaccinated have been successful and this would be considered as part of planning for next year. The Chair thanked the team and congratulated them on their achievements ***Received***	
583/2017	**Safe Staffing Monthly report – December 2016** 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 versus actual nurse staffing levels during the data collection period (1 – 31 December 2016): The performance relating to fill rate (actual numbers of staff deployed versus numbers planned) during December 2016 was; • 85% for registered staff • 102% for care staff on day shifts • 84% and 105% 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 Managers supporting clinical duties. Ms Nelligan highlighted that there has been a reduced fill rate on Ward 5 of 57% for RGN on days. As additional context; the opening of Ward 4 has meant one RGN has been seconded from Ward 5 to Ward 4. In addition, Ward 5 staffing levels are under review and are being reviewed as part of the six month Safer Staffing Report. Ms Nelligan gave assurance that there have been no incidents resulting in harm reported during this period. The Trust recruitment campaign is continuing.	

	Mr Sullivan commented that at the Quality Committee the Intoxication Observation Unit (IOU) had recorded incidents when staff were moved to work back on the wards and whether this had impacted on the IOU. Ms Nelligan clarified that there is a piece of work being completed in this respect. Ms Nelligan also noted that directorates are working together to help provide solutions. The impact varies as sometimes the IOU has no patients. Mr Sullivan also referenced the 57 staff breaks that had been cancelled and whether this impacted on working time regulations. Mr Draycott confirmed this is under review and all staff should not work over 6 hours without a break. Ms Nelligan noted that the issues around staff breaks will be incorporated into the Six month Safer Staffing Report to be submitted to the next Trust Board. Mrs H Johnson, member of public, raised concerns with the lack of communication in respect of discharges between the ward and community teams. Ms Dutton reiterated the importance of robust discharge planning and the distress this can cause service users if not implemented. Ms Nelligan confirmed that Head of Directorates were reviewing how we can streamline the transition between wards and community services. The Trust's Care Co-ordination Policies and procedures are under review and will be strengthened. The Chair raised community services and how are staffing levels compared with demand. Ms Nelligan confirmed that on conclusion of the current inpatient staffing review, the subsequent review will incorporate RAID, Home Treatment and the Access team in the first instance as 24/7 teams. The next stage is to review community services however, the Trust is waiting for the national guidance to be released in order that this can be planned and mandated going forward. Ms Barber queried whether there is reflection in our patient experience and staff experience surveys in respect of poor communication with discharges. Mrs Donovan stated the data is not yet easily extractable. However, the Friends and Family Test gives some indicators. Mr Draycott noted that from a staff perspective, the Trust has 'Go Engage' which has been discussed at the People and Culture Development Committee. This will enable the Trust to track any issues with staff engagement and will help provide a	**Ms Nelligan**

	full picture. Mrs H Johnson, member of public, raised concerns with staff moves in the community directorate She welcomed the implementation of Multi-speciality Community Providers, but again raised concerns with the transition and the impact this may have on service users initially from a service user engagement point of view. Mr Thornber commented that he recognised the concerns and that there was now scheduled a series of engagement events at both local and broader levels. Dr Tattum noted that there is sometimes a lack of clarity with service users and professionals, whereby people have been discharged home, but GPs are not informed. He also welcomed the implementation of MCPs. ***Received***	
584/2017	**Serious Incidents Report Q3 2016/17 Strategy** Dr Adeyemo, Medical Director presented the Trust's Serious Incidents Report Q3 2016/17 for the period 1 October to 31 December 2016. There have been 14 serious incidents reported and noted the decrease from the previous quarter. There has been a deep dive into serious incidents and this will be presented to the Quality Committee in March 2017. At present there are no specific themes of trends to note. In terms of directorates the breakdown is as follows: • Substance Misuse - 4 unexpected deaths reported, one was downgraded as a natural cause death. • Adult Mental Health Community - 4 serious incidents • Neuro and Old Age Psychiatry - 5 serious incidents • Adult Inpatient - sudden unexpected death subject of ongoing investigation It has been noted that there is an increase in the number of falls for older people and there is ongoing work within the directorate to investigate. In Q3 all incidents that have met the criteria for a contractual duty of candour (DoC) have been processed accordingly. There were 71 incidents highlighted as possibly meeting the DoC, however only 13 met the criteria.	**Dr Adeyemo**

	The Trust remains committed to the 'Learning Lessons from Serious Incidents' and this work continues. Dr Adeyemo highlighted the importance of being clear about what language we use. Mr Sullivan welcomed the learning lessons and supplementary information within the report. The Mortality Surveillance report is produced quarterly in order to help monitor incidents and to review all deaths. Ms Barber suggested that the 'Learning Lessons' be communicated wider than the Trust. Dr Adeyemo confirmed this already happened. ***Received***	
585/2017	**Performance and Quality Management Framework Report (PQMF) Month 8** Miss Robinson, Director of Finance, presented this report. The report provides the Board with a detailed level of summary of performance to the end of Month 9. The following performance highlights should be noted; • 95.9% of patients are referred to intervention or treatment within 18 weeks • 100% of RAID responses to A&E are responded to within 1 hour • 97.5% of patients on a Care Programme Approach have received follow-up contact within 7 days of discharge The Board noted the exceptions in respect of Agency Spend, which are minimal and have been reduced; • Agency spend 8.4% at M9 from 7.4% at M8 The breakdown of agency was noted. The ROSE Agency is in line with what we have expected 4.9% at M9 from 4.0% at M8. Ward 4 (EMI) Nurse Agency Spend has increased due to local health economy challenges. ***Received***	
586/2017	**Raising our Service Excellence** Mr Thornber, Director of Strategy and Development and Dr Hardeep Uppal, Consultant Psychiatrist/Digital Lead delivered the presentation in respect of Raising our Service Excellence (ROSE) to provide assurance on the plan for implementation of the Lorenzo EPR system on 13 May 2017.	

	In attendance for this item were Matt Baxter, CSC and Carl Ward, NHS Digital who have supported the Trust through this process. The Board were assured with progress and thanked the Digital by Choice team. ***Received***	
587/2017	**Service User and Carer Council** Ms Dutton, Vice Chair of the Service User and Carer Council, gave a verbal update to inform the Board of the work of the Council. Ms Dutton noted that the meeting in January had been very productive. Mr Cotterill has stood down as Chair, due to work commitments and Ms Dutton will act as Chair in the interim. The Council have drafted their first leaflet in order to publish their work, their purpose and how they engage with people. The Council noted the following events; • Participating in the Recovery Event on 27 February 2017 • Open Space event on 29 March 2017 at Port Vale Football club, as a further engagement event. The Terms of Reference are currently being reviewed. The Council have been more involved in recruitment and interview panels. Debate took place regarding strengthening the membership of the Council. There is a need for the Council to have regular committed people. The Board noted the achievements during the last. Mrs B Johnson suggested that GPs could promote this through their surgeries and the Population Prevention Guidelines screened in waiting rooms to help gain a captive audience. Dr Tattum stated additionally, this could be promoted through prescriptions and GP websites. Ms Walley also mentioned publicising through media such as Radio Stoke. Ms Nelligan stated that she was working with Mr McCrea, Associate Director of Communications to take forward these initiatives. ***Received***	**Ms Nelligan**

588/2017	**Monthly Finance Reporting Suite – Month 9** Miss Robinson, Director of Finance, presented this report which contains the financial position at Month 9. • In Month 9, the Trust reported a surplus of £863k against a plan of £862k surplus; • CIP achievement in month 9 is 54% with an adverse variance of £805k from plan, with a recurrent CIP of £795k (84%); • Cash position of the Trust as at 31 December 2016 was £4.318m; • Net capital receipts in month 9 are £1,161k compared to planned net capital receipts of £1,534k; and • 'Use of resource' rating of 3 The Board approved the month 9 position reported to NHSI and the reported forecast outturn of £1.4m as per agreed Control total. There is a detailed Recovery Plan on today's Closed agenda. The Board noted that Capital is now forecasting £342,000 behind the plan of which the majority relates to the Hazlehurst Unit Development. Ms Barber queried under Table 2: Income; in respect of the variance Miss Robinson commented that this was income outside of the contract and would be resolved when the contract is varied. ***Received***	
589/2017	**Finance and Performance Committee Assurance Report –2 February 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 February 2017 All financial elements were covered in the meeting. Assurance was given and all risks are clear. In respect of Cost Improvement Programme (CIP) there is still an underachievement and this will be closely monitored. Cash is a concern and as mentioned previously, the Trust is behind on the Capital Plan. There will be regular reports going forward and a plan in place to monitor the situation.	

	Received	
590/2017	**Audit Committee Assurance Report – 2 February 2017** Mrs Johnson, Chair/Non-Executive Director, presented the Audit Committee Assurance Report from the meeting on 2 February 2017. The Audit Committee received assurance with; • ***CQC/Quality Assurance report –*** Received • ***Risk Management Assurance Report*** – Update on progress of embedding risk management and risks in respect of Lorenzo are being managed effectively. Assurance was given with regard to risks involving partnership agreements and this has been strengthened • ***Freedom of Information – Q3 Report 2016/17*** – It is anticipated that the enhanced website will ensure requests are directed to the internet. • ***Internal Audit Progress Report*** – There have been 7 reports finalised, with another 8 to be completed by March 2017. • ***Accounts Timetable*** – Noted • ***Procurement Dashboard*** – Received and very informative, this will be further developed • ***Accounting policy changes –*** Noted ***Received***	
591/2017	**Register of Members' Declared Interests** Mrs Wrench, Associate Director of Governance, presented the updated Register of Members' Declared Interests. ***Received***	
592/2017	**Partnership to multispecialty community provider** Mr Thornber, Director of Strategy and Planning, presented this information on the partnership arrangements in the delivery of new models of care. The Board noted the diagrammatic representation of the service provision of organisations across the Staffordshire STP.	

	The Trust has entered into a formal partnership with the North Staffs GP Federation in order to support the delivery of integrated care and for both organisations to work towards a MCP model of care. Mrs H Johnson, member of public, requested that North Staffs Users Group be more involved with any future discussions and to keep them in the loop. ***Received***	
593/2017	**Any other business** **People and Culture Development Committee (PCD)** Mr Draycott noted that there has not been a PCD meeting since the last Trust Board. The next meeting is due to take place on 27 February 2017 and the following items will be discussed: • 'Go Engage' to go live • Staff Survey results due imminently • The Trust is working on 'Towards Outstanding' CQC rating recently talked about in Board Development session • Recruitment; two events planned for – 4 March and 8 March 2017 **Enhanced Trust Website** Mr McCrea, Associate Director of Communications, confirmed that the Trust website has been enhanced and will be launched next week. Communications have spent time in ensuring the information is fit for purpose including all the service pages. This will also be communicated to all our partners	
594/2017	**Date and time of next meeting** The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday, 9 March 2017 at 10:00am, in the Boardroom, Lawton House, Trust HQ.	
595/2017	*** 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 1.15 pm

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
14-Jul-16	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 Commissioning Groups and will be kept informed of progress	Mr A Rogers/Mrs Donovan	09-Mar-17	To remain on the action schedule for update on 9 March 2017
09-Feb-17	583/17	**Safer Staffing Report - December 2016** - Ms Nelligan noted that the issues around staff breaks will be incorporated into the Six month Safer Staffing Report which is being finalised and will be submitted to the May Trust Board.	Ms Nelligan	11-May-17	
09-Feb-17	584/17	**Serious Incidents Q3 2016/17**- It has been noted that there is an increase in the number of falls and there is ongoing work within the directorate to investigate. This will be reflected as part of the themes and trends in the next quarterly report.	Dr Adeyemo	11-May-17	

REPORT TO Trust Board

Enclosure 4

Date of Meeting:	9th March 2017
Title of Report:	CEO Report
Presented by:	Caroline Donovan, CEO
Author of Report:	Caroline Donovan, CEO
Purpose / Intent of Report:	For Information
Executive Summary:	This report updates the Board on activities undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest.
Seen at SLT or **Exec** Meeting & date	SLT / EXEC (and date): N/A Seen by Exec Lead : CEO Document Version number: 1
Committee Approval / Review	• Quality Committee ☐ • Finance and Performance Committee ☐ • Audit Committee ☐ • People and Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐
Relationship with: *Board Assurance Framework* *Strategic Objectives*	1. To provide the highest quality services ☒ 2. Create a learning culture to continually improve.☒ 3. Encourage, inspire and implement research & innovation at all levels.☒ 4. Maximise and use our resources intelligently and efficiently.☒ 5. Attract and inspire the best people to work here.☒ 6. Continually improve our partnership working. ☒ 7. To enhance service user and carer involvement.☒ **Comments:**
Risk / Legal Implications: (Add Risk Register Ref [if applicable])	N/A
Resource Implications: Funding source:	N/A
Equality & Diversity Implications:	N/A
Recommendations:	To note the report for information purposes

Chief Executive's Report to the Trust Board
9 March 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. TRUST ACHIEVES 'GOOD' CARE QUALITY COMMISSION (CQC) RATING

The Care Quality Commission (CQC) has awarded the Trust an overall rating of 'Good' following its comprehensive inspection of our services in September 2016. Inspectors rated the care provided by staff to be 'Good' regarding whether services were effective, caring, responsive and well-led. The CQC found:

- Significant improvements had been made to the quality of care plans and risk assessments.
- The Trust showed a consistently collaborative approach to care that involved staff, patients, carers and families.
- Staff throughout the Trust displayed a caring attitude towards people who used services, showing kindness, empathy and putting peoples' needs first.
- Feedback from patients, carers and families was also very positive and staff ensured that delivery of care was carried out in a co-productive manner.
- The Trust Board has become more settled and effective which helped to ensure governance systems were embedded.
- Nursing staff spoke very highly of the new substantive Director of Nursing. Staff said they now felt they had strong nursing leadership at a senior level in the organisation who was committed to clinical and leadership development.

Following the publication of the report, a link to which can be found via our website at http://www.combined.nhs.uk/about-us/cqc-rating/,we have launched the next stage in our journey of improvement – Towards Outstanding. This is reflected in our vision - "to be outstanding"- in all we do and in how we do it.

We held a successful event at Harplands Hospital for staff, stakeholders, service users and carers to celebrate the publication of the report and unveil the launch of Towards Outstanding. It was also an opportunity for me to thank our wonderful staff. The event was livestreamed and videos of the day can be found on our YouTube page at www.youtube.com/user/NSCombinedHealthcare.

2. TRUST WINS AT HEALTH EDUCATION WEST MIDLANDS REGIONAL LEADERSHIP RECOGNITION AWARDS

I am delighted that an incredible seven individuals or teams were shortlisted as finalists in the Health Education West Midlands Regional Leadership Recognition Awards when we won in two categories.

The exciting event held on 28 February announced Combined Healthcare as the winners in two out of eight categories.The tremendous progress made by the Healthy Minds Improving Access to Psychological Therapies (IAPT) Stoke-on-Trent team in

supporting service users towards recovery was recognised with it winning the Team Outstanding Achievement: Clinical award. Healthy Minds enjoyed even more success when Team Manager Stephanie Woodall won the Leading for Service Improvement and Innovation Award. This is a fantastic achievement for our Stoke IAPT service recognising the excellent quality of services delivered to our local community. Congratulations to our other finalists, who we are also proud of in having been shortlisted in the following categories:

- Team Outstanding Achievement Award: Non-Clinical – Growthpoint
- Leading for Service Improvement and Innovation – Learning Disabilities
- Excellence in Patient Experience – Maureen Mayanga, Rapid Assessment Interface and Discharge (RAID) Practitioner
- Inclusive Leader – Jaymee Smith, Chair of the North Staffordshire Children and Young People's IAPT Youth Council
- Emerging Leader – Josey Povey, Modern Matron with NOAP

On a personal note I was humbled to be nominated and shortlisted for the Inspirational Leader award. Thank you to the Executive team for their kind recognition – being nominated felt like I was a winner!

3. SUCCESSFUL CONFERENCES HOSTED BY TRUST

Best practice and successes in recovery focussed care were showcased at our Recovery & Wellness Conference, held at Port Vale Football Club on 27 February. Among the speakers giving presentations included Barbara Wain, Chief Executive of Changes, and Chris Herbert, Director of Business Development with Brighter Futures, with whom we have been working on the development of a recovery college. Nationally, recovery colleges have clearly demonstrated their potential to provide meaningful engagement and discernible outcomes related to individual wellbeing and recovery.

We also held an Allied Health Professionals (AHP) Conference on 16 February at Port Vale, the focus of which was to promote and celebrate the range of skills, interventions and best practice provided across the Trust by our AHPs. As well as a series of presentations, the event also saw attendees contributing to the development of a new Trust AHP strategy.

4. INNOVATION THROUGH TECHNOLOGY

The Trust is developing the Be-Able app, a digital assistant for people living with mild cognitive impairment and those in the early stages of dementia to help manage their daily lives. The investment will go towards building a first model of the app, which is being designed by a local technology firm in partnership with our staff.

5. DISCOVER YOUR FUTURE RECRUITMENT CAMPAIGN

Following the great success of our Discover Your Future recruitment campaign in summer 2016, we held further one-stop events at Harplands Hospital on Saturday 4 March and Wednesday 8 March. The events were open to registered mental health nurses and registered learning disabilities nurses and attendees had the opportunity to apply for available posts on the day, be interviewed by a panel and potentially leave with a job offer.

To ensure we attracted people from as wide an area as possible, we ran a series of radio adverts on Signal Radio to promote the events and wider campaign, while adverts were also placed in a number of publications in the region. More information about our recruitment campaign can be found on our dedicated recruitment website www.discoveryourfuture.co.uk.

6. RAISING OUR SERVICE EXCELLENCE (ROSE)

The countdown to the launch of our ROSE electronic patient record (EPR) on 13 May continues. Our staff have been completing e-learning and attending face-to-face training sessions to ensure they are as ready as possible for this exciting new chapter in our journey Towards Outstanding. Staff have also been taking part in Business Validation Process sessions, which sees them test driving the new system.

Our dedicated ROSE website – www.digitalbychoice.info/rose/ - provides more information about our new EPR, while our @CombinedROSE Twitter account features all the latest news. 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 organisation to work effectively and lead to innovation in our healthcare services.

7. LAUNCH OF LEADERSHIP ACADEMY

As part of the Trust's journey Towards Outstanding we have launched a new way of developing our leaders. The Leadership Academy replaces our monthly Plenary sessions and is aimed at all team and senior leaders, both clinical and managerial, with the aim of ensuring that our strategy and operational priorities align, there is individual and organisational development and there is ongoing support provided for our leaders. Whilst the new Academy focusses on more senior leaders, we are also prioritising development for all of our staff with a range of personal development opportunities.

8. NHS STAFF SURVEY

We have received the results of our latest NHS Staff Survey which are embargoed until the 7th March and are currently working through them internally with our senior leadership team. We will bring a formal report back to the April board for wider discussion. As well as sharing them with the Board and our staff and stakeholders directly, we will also publish the results on our website in line with the national timetable.

9. INVESTMENT IN MENTAL HEALTH

We received a request from Claire Murdoch, National Mental Health Director at NHS England to all CCG accountable officers for a greater level of assurance around the Mental Health Investment Standard. This standard requires commissioners to increase spending on mental health services at least in line with the amount by which their funding allocation has been increased overall, in a bid to address the lack of parity between mental and physical health services. The request required confirmation of the investment and a jointly signed letter from CCGs and their main NHS mental health provider confirming that their mental health finance returns are an accurate reflection of health economy investment and represent a joint commitment to meeting national expectations set out in the NHS Five Year Forward View.

While the numbers provided by CCGs outlined an overall increase in mental health funding from 2017-18 to 2018-19, they identified a decrease in investment for Combined. Therefore as part of the sign off process we were only able to validate the element relating to our own Trust. The response highlighted there is still further work needed to ensure the right level of investment is made to deliver the Five Year Forward View, which needs to be a key priory for Sustainability and Transformational Plans.

10. STAFFORDSHIRE AND STOKE-ON-TRENT SUSTAINABILITY AND TRANSFORMATION PLAN (STP)

Within the Staffordshire STP we are working closely with our provider partners in the north of the county on developing new models of care based on a population based model. We have taken a significant step towards a collective approach to achieving this aim through the first provider alliance board that brings together General Practice, mental health, community and local authority services. The first Board was held at the end of February and focussed on the steps each organisation will make towards enabling integrated locality teams. In addition, the STP programme is in the process of recruiting a new chairman and programme director.

11. TOM THORNBER STEPPING DOWN AS DIRECTOR OF STRATEGY & DEVELOPMENT

Tom Thornber, our Director of Strategy and Development, will be leaving the Trust on 31 March to take up a new opportunity local to home. Tom is getting married in April and has made the decision that his extended travel time is not conducive to his desire to be closer to his family home. Tom has been a highly valued member of the Trust Board and Executive team and has made a significant contribution to our journey of improvement.

I am delighted that we will be recruiting the future Director of Strategy and Development post as a joint appointment with North Staffordshire GP Federation to support us as we move forward. This is in recognition of our closer partnership working and our ambition to continue to strengthen the integration of physical and mental health enabling a higher quality experience for our service users and carers.

NATIONAL UPDATE

The state of NHS finances and the ability of STPs to rise to the challenge of local integration and delivery have dominated the national debate in the past month, with a range of reports and analyses from key national bodies.

12. PUBLIC ACCOUNTS COMMITTEE PUBLISHES REPORT INTO "FINANCIAL SUSTAINABILITY OF THE NHS"

The Public Accounts Committee published its Report into the Financial Sustainability of the NHS on 27 February.

The committee noted that the financial performance of NHS bodies has worsened considerably—a trend which it believes is not sustainable. The committee warns that central government is asking local bodies "to solve multiple problems and deliver a range of priorities" without a proper understanding of what can be achieved, concluding "Transformation under such pressure is hard to achieve."

It says the there is much more to do before the public can feel confident that local sustainability and transformation plans (STPs) are about delivering transformation and efficiencies "and not just a cover for cuts in services.

Among its recommendations, the committee says the government should set out urgently a "clear and transparent recovery plan" targeting NHS bodies and health economies in severe financial difficulty. NHS England and NHS Improvement must explain how they will support transformation in areas where STPs fall short and take action to "convince the public of the benefits of the plans to them".

By July the government should report back to the committee on what it has done to understand the link between financial performance and the impact on patient care.

It should also analyse the impact financial pressure in social care is having on the NHS and publish its findings.

http://www.parliament.uk/business/committees/committees-a-z/commons-select/public-accounts-committee/news-parliament-2015/financial-sustainability-nhs-report-published-16-17/

13. NATIONAL AUDIT OFFICE ADVISES CAUTION ON BETTER CARE FUND

On 8 February, the National Audit Office published its Report into "Health and Social Care Integration" warning that progress with integration of health and social care has, to date, been slower and less successful than envisaged and has not delivered all of the expected benefits for patients, the NHS or local authorities.

The Departments of Health and of Local Government have not yet established a robust evidence base to show that integration leads to better outcomes for patients. The departments have not tested integration at scale and are unable to show whether any success is both sustainable and attributable to integration.

As a result, the NAO says the Government's plan for integrated health and social care services across England by 2020 is at significant risk.

The NAO says that embedding new ways of working and developing trust and understanding between organisations and their leaders are vital to successful integration. This can take many years because the cultures and working practices in the health and local government sectors are very different.

Planned reductions in rates of emergency admissions were not achieved. Furthermore, days lost to delayed transfers of care increased by 185,000, against a planned reduction of 293,000, costing £146 million more than planned.

NHS England has not assessed how pressures on adult social care may impact on the NHS. It has noted that the widening gap between the availability of, and need for, adult social care will lead to increases in delayed discharges and extra pressure on hospitals. However, the NAO did not see any estimate of the impact on NHS bodies of pressures on social care spending.

The report also found that new care models are as yet unproven and their impact is still being evaluated. According to the NAO, while the departments and their partners have set up an array of initiatives examining different ways to transform care and create a financially sustainable care system, their governance and oversight of the initiatives is poor.

The NAO reiterated its emphasis from its 2014 report on the Better Care Fund that there is a need for robust evidence on how best to improve care and save money.

https://www.nao.org.uk/report/health-and-social-care-integration/

14. NHS KINGS FUND SEEKS TO STRIKE MORE POSITIVE NOTE ON STPS

In contrast to the NAO's pessimism, the Kings Fund sought to strike a more positive note in regard to STPs. Its report published on 21 February on "Delivering sustainability and transformation plans - From ambitious proposals to credible plans" concluded:

- STPs offer the best hope for the NHS and its partners to sustain services and transform the delivery of health and care.
- STPs are wide-reaching and propose changes in a number of areas – from prevention through to acute and specialised services. A high priority for many STPs is to redesign services in the community to moderate demand for hospital care.
- Proposals to reconfigure hospitals could improve quality but need to be closely scrutinised and considered on their merits.
- Proposals to reduce capacity in hospitals will only be credible if there are robust plans to provide alternatives in the community.
- Cuts in social care and public health and a lack of earmarked funds to support transformation will affect the ability of NHS organisations and their partners to implement STPs.

The Kings Fund proposed the following policy responses to the challenges of making STPs work:

- The proposals in STPs now need to be developed into credible plans, with clarity about the most important priorities in each footprint.
- The NHS should engage meaningfully with staff, patients and the public, local authorities and the third sector in discussing the proposals.
- The governance and leadership of STPs needs to be strengthened and more realistic timescales adopted for implementation, given the time it takes for innovations in care to become established and deliver results.
- National bodies should work together to support the NHS and local authorities to implement the plans and send out consistent messages on what they now expect.
- The government should reiterate its commitment to STPs and support their proposals where the case for change has been made. It should recognise the need for additional resources for the NHS and social care if the STPs are to deliver the proposed transformations in care.

https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/STPs_proposals_to_plans_Kings_Fund_Feb_2017_0.pdf

Encl. 5

REPORT TO: Trust Board

Date of Meeting:	09 March 2017
Title of Report:	Summary of the Quality Committee meeting held on 28 February 2017
Presented by:	Tony Gadsby Non-Executive Director & Vice Chair of Quality Committee
Author of Report:	Laurie Wrench Associate Director of Governance
Purpose / Intent of Report:	For approval (policies and terms of reference) and information and assurance in terms of work of the committee
Executive Summary:	This report provides a high level summary of the key headlines from the Quality Committee meeting held on the 28 February 2017. The full papers are available to Trust Board members, as required
Seen at SLT or **Exec** Meeting & date	n/a
Committee Approval / Review	Reviewed by Medical Director and Vice Chair of Quality Committee
Relationship with: *Board Assurance Framework* *Strategic Objectives*	• To provide the highest quality services • Create a learning culture to continually improve. • Encourage, inspire and implement research and innovation at all levels • Maximise and use our resources intelligently and efficiently • Attract and inspire the best people to work here • To continually improve our partnership working. • To enhance service user and carer involvement.
Risk / Legal Implications: (Add Risk Register Ref [if applicable])	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
Equality & Diversity Implications:	N/A
Recommendations:	• Receive for assurance purposes and approve policies and terms of reference highlighted in the report.

North Staffordshire Combined Healthcare NHS
NHS Trust

Key points from the Quality Committee held 28th February 2017 for the Trust Board 9th March 2017

1. Introduction

This is the regular report to the Trust Board that has been produced following the last meeting of the Quality Committee.

2. QIA of CIPS for 2016/17

The committee received the above report as a progress update. The report presented the Project Initiation Document (PID) and Quality Impact Assessment (QIA) position for the delivery of the 2016-17 CIP programme as at January 2017 and included:

- Description of Quality Impact Assessment Metrics
- Financial Summary for January 2017
- QIA assessments for each Directorate, summarised at scheme level

The Quality Committee approved the Quality Impact Assessment year to date position as at Month 10.

3. Policy Review

The recommendations were supported by the committee for ratification of policies by the Trust Board for 3 years or otherwise stated, as follows:

- 1.02 - Professional Registration
- 1.17 - Admission, Discharge and Transfer Policy
- 1.75 - Domestic Abuse Policy
- Business Continuity Policy
- Policy on Voting Rights
- 1.71 - Duty to co-operate with MAPPA
- 4.01a - Preventing Harm to Children

Recommendation to Trust Board – that the above Policies are ratified by the Trust Board for a further 3 years.

The Committee gave support to a request to extend a suite of Infection, Prevention & Control Policies whilst under review until 30th April 2017 as follows:

- IC4a Hand Hygiene
- IC4B Personal Protective Equipment
- IC5 Isolation
- IC7 Inoculation
- IC8 Cleaning
- IC11 MRSA
- IC12 Outbreak
- IC13 Linen & Laundry
- IC17 Specimen Management

4. Data quality Forum Terms of Reference

The committee received the above terms of reference for approval. The Forum will oversee all data quality issues across the Trust and during the ROSE implementation will take a specific interest in the data quality issues that cause a direct risk to the programme. The Forum will report into the Quality Committee and will receive regular reports on data quality. The Quality Committee approved the Data Quality Forum Terms of Reference.

5. Nurse Staffing Performance monthly report – January 2017

Ms Sylvester, Deputy Director of Nursing & Quality presented the above report which outlined the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during January 2017 in line with the National Quality Board expectation.

6. Reports received for Information and Assurance

- Learning from Patient Experience December 2016 and January 2017
- Clinical Effectiveness Domain report – reporting on outputs of committee sub-groups
- Serious Incident Report Quarter 3
- Restraint Monitoring Report
- Director of Infection Prevention Control Quarter 3 report

7. SI Thematic Review – Unexpected Deaths Relating to Greenfields Integrated Community Mental Health Team

Dr Adeyemo advised members that the above review had taken place due to the level of serious incidents that occurred during the nine month period from April to December 2016.

Serious incident reviews using the principles of Root Cause Analysis were undertaken for each incident and the completed reports used to undertake the SI Thematic Review. Three themes were identified as follows:

- Drug or alcohol use/substance misuse.
- Communication and involvement with families regarding risk assessments
- Risk assessments and quality

The committee noted that the action plan following the review would be presented to the April Quality Committee.

8. Risks to the Quality of Services M10

Committee members considered the report for quality risks, particularly those scoring 12, which have been reported to the committee previously and how they interrelate to Directorate risks. Members discussed the risk treatment plans in place and took assurance about the actions being taken. Mrs Wrench advised that there are two new risks, one concerning the diverse nature of our service users and their access of services and the second concerning the delayed transfer of care for patients leaving our in-patient facilities. In both cases the committee were satisfied with the actions taking place to mitigate these risks. For all other risks the score remains as shown in previous reports.

9. Board Assurance Framework Q3

The Board Assurance Framework for Q3 was presented which aligns the Trust strategic objectives to our quality priorities and key risks including the Board`s level of risk appetite. The BAF provides an update and RAG rating for those actions due during Q3 and provides an update against future actions including gaps and challenges to be addressed.

This paper details the strategic objectives and risks associated with the Quality Committee and provides an update at Q3.

There are 3 strategic objectives tagged to the Quality Committee and overall good progress has been made in this particular quarter.

10. Directorate Performance Reports

Members discussed in detail the risks that were identified and assurances received. Notable highlights for each directorate were:

- ***Adult Mental Health Community***
    - Sickness absence is below Trust target and continues to improve
- ***Adult Mental Health Inpatient***
    - Relatively high sickness at 5.99%
    - 7 SIs currently ongoing – 4 new since the last committee
    - Ongoing work on service development and transformation
- ***Children and Young People***
    - Workforce strategy underway with commissioners
    - Audits of NICE guidance adherence are underway
- ***Learning Disabilities***
    - OFSTED application underway
- ***Neuro and Old Age Psychiatry***
    - Low sickness absence
    - MCP pilots continue
- ***Substance Misuse***
    - Management of change as a result of significant funding cuts ongoing

11. CQC Quality Assurance Update

The committee received the above paper which provided an update as to the progress and position statement for the CQC Comprehensive Inspection undertaken during week commencing 12 September 2016.

12. 2016/17 Quality Account

Mrs Wrench advised the Quality Committee that by 30 June 2017, all organisations are required to develop and publish a Quality Account which if designed well, will assure Commissioners, patients and the public that Trust Boards are regularly scrutinising each and every one of their services. This will be the Trust`s fifth Quality Account.

The Quality Account is produced annually to report to the public about the quality of services and should address; what an organisation is doing well; where improvements in the quality of services are required; the priorities for improvement in the coming year and how the Trust has involved service users, staff and others in determining these priorities for improvement.

Mrs Wrench requested support to make a recommendation to the Trust Board that the Quality Committee takes oversight and have delegated responsibility from the Trust Board for the Quality Account, going forward, which is normal practice. The Committee agreed to making the recommendation to the Trust Board.

Recommendation to Trust Board - that the Quality Committee takes oversight and have delegated responsibility from the Trust Board for the Quality Account

On behalf of the Committee Vice Chair, Mr Tony Gadsby, Non-Executive Director
Laurie Wrench, Associate Director of Governance,
6th March 2017

Enc. 6

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: Trust Board

Date of Meeting:	9 March 2017
Title of Report:	Safer Staffing Monthly Report for January 2017
Presented by:	Maria Nelligan, Executive Director of Nursing and Quality
Author of Report:	Julie Anne Murray, Head of Nursing & Professional Practice
Purpose / Intent of Report:	For assurance
Executive Summary:	This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during January 2017 in line with the National Quality Board expectation that: The Board: • Receives an update containing details and summary of planned and actual staffing on a shift-by-shift basis. • Is advised about those wards where staffing falls short of what is required to provide quality care, the reasons for the gap, the impact and the actions being taken to address the gap. • Evaluates risks associated with staffing issues. • Seeks assurances regarding contingency planning, mitigating actions and incident reporting. • Ensures that the Executive Team is supported to take decisive action to protect patient safety and experience. • Publishes the report in a form accessible to patients and the public on their Trust website (which could be supplemented by a dedicated patient friendly `safe staffing` area on a Trust website). The performance relating to fill rate (actual numbers of staff deployed vs numbers planned) during January 2017 was 86% for registered staff and 102% for care staff on day shifts and 87% and 105% 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. The position reflects that Ward Manages are effectively deploying additional staff to meet increasing patient needs as necessary.
Seen at SLT or **Exec** Meeting & date	SLT/EXEC: Execs on 21 February 2017 Seen by Exec Lead: Maria Nelligan Document Version number: 1
Committee Approval / Review	• Quality Committee ✓ • Finance and Performance Committee • Audit Committee • People and Culture Development Committee • Charitable Funds Committee • Business Development Committee
Relationship with: *Board Assurance Framework* *Strategic Objectives*	1. To provide the highest quality services ✓ 2. Create a learning culture to continually improve. 3. Encourage, inspire and implement research at all levels. 4. Maximise and use our resources intelligently and efficiently. 5. Attract and inspire the best people to work here. 6. Continually improve our partnership working. 7. To enhance service user and carer involvement. **Comments:**
Risk / Legal Implications: (Add Risk Register Ref [if applicable])	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.
Equality & Diversity Implications:	None
Recommendations:	To receive the report for assurance and information.

1 Introduction

This report details the ward daily staffing levels during the month of January 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 carried out and will be reported to SLT and Board of Directors in March 2017.

3 Trust Performance

During January 2017 the Trust achieved staffing levels of 86% for registered staff and 102% for care staff on day shifts and 87% and 105% 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. Established, planned (clinically required) and actual hours alongside details of vacancies, bed occupancy and actions taken to maintain safer staffing are in Appendix 1. A summary from WMs of issues, patient safety, patient experience, staff experience and mitigating actions is set out below.

4 Summary

WMs report the impact of unfilled shifts on a shift by shift basis. Themes and mitigating actions are summarised below:

4.1 Staffing Issues

Wards 1, 2 and 3 have B5 vacancies of 1, 4.6 and 3.6 WTE respectively; these posts have been advertised externally however they have not been appointed to. The teams continue to attempt to recruit to these vacancies and 2 ‘one stop shop’ recruitment events have been arranged for March 2017. Return to practice nurses will also be encouraged to apply.

Ward 4 opening temporarily, to support the local health economy, has impacted on the ability to source temporary staff for other wards when needed. Additionally Ward 5, 6 and 7 released 1 WTE RN each to provide Ward 4 with stable RN leadership.

Ward 5 RN fill rate on days is 68%. Ward 5 safe staffing recommendations indicate that they require an additional 4.26 RNs, additionally Ward 5 have 1 RN seconded to Ward 4 and 1 RN seconded to RAID. This is impacting on the RN fill rate. Both the Ward 4 and RAID secondments are due to end by the end of March 2017.

Ward teams are supported by Modern Matrons and a Duty Senior Nurse who are further supported by an on-call manager out of hours. These staff are not included in the safer staffing returns.

Increasing the planned RN night shift cover from 1 to 2 RNs on the acute wards (1, 2 and 3) has led to a temporary decreased RN nightshift fill rate on these wards.
Whilst the additional RN posts, to meet this demand, have been recruited some of these nurses are currently on preceptorship. Staff turnover has resulted in further vacancies arising and recruitment has been challenging. As a result it has been difficult to consistently achieve planned RN staffing. Temporary staff have backfilled a number of RN shifts and skill mix has been altered to backfill with health care support workers (HCSWs) where gaps have remained.

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

4.2 Impact on Patient Safety

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

Ward	Incident
A&T	One incident due to short notice sickness of bank staff which was not able to be re-covered.
Edward Myers	Four incidents where the IOU member of staff has been moved to support unfilled shortfalls in other areas of the hospital.
Ward 2	One incident where access RN had to cover the ward due to short notice sickness (1st Jan 2017), this left access team short.
Ward 5	One incident where the ward was unable to source bank to support increased observation levels.

4.3 Impact on Patient Experience

Staff prioritise patient experience and direct patient care, however during January 2017 ten activities were shortened due to nurse staffing levels.

4.4 Impact on Staff Experience

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

- 102 staff breaks were cancelled (equivalent to approximately 0.02% of breaks)
- 39 staff breaks were shortened (equivalent to approximately 0.008% of breaks)
- 177 hrs of ward cross cover (nursing staff were reallocated to cover shortfall within other clinical areas)

4.5 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 155 RN shifts were covered by HCSW where RN temporary staffing was unavailable.

A total of 26 HCSW shifts were covered by RN staff where HCSW temporary staffing was unavailable. Additionally, as outlined in section 4.4, staff breaks have been shortened (time is given in lieu) or not taken and wards have cross covered to support safe staffing levels.

Appendix 1 January 2017 Safer Staffing

2017 JANUARY	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	1556	1556	1064	1395	1395	1883	665	665	503	997	997	1158	68%	135%	76%	116%	Nursing staff working additional unplanned hours and altering skill mix.	1 B5 1 B3	91%	↓	10.00%
Ward 2	1448	1448	1160	1395	1395	1516	665	665	504	665	665	793	80%	109%	76%	119%	Nursing staff working additional unplanned hours, canceleling non direct care activity and altering skill mix. Cross cover was also provided to other wards.	4.6 B5 2 B2	93%	↓	3.16%
Ward 3	1560	1560	1395	1395	1560	1653	665	665	364	665	1027	1316	89%	106%	55%	128%	Nursing staff working additional unplanned hours and altering skill mix. Cross cover was also provided to other wards.	3.6 B5, 1.24 B3, 1 B2	94%	↑	0.00%
Ward 5	1103	1568	1064	930	1935	1591	290	290	308	871	956	926	68%	82%	106%	97%	Nursing staff working additional unplanned hours and altering skill mix. Some patient activities were shortened.	0	104%	↑	2.68%
Ward 6	1095	1163	968	1860	1905	1905	291	291	291	872	1041	1032	83%	100%	100%	99%	Nursing staff working additional unplanned hours.	0	100%	↑	13.59%
Ward 7	1088	993	837	1395	1395	1527	290	290	290	582	581	590	84%	109%	100%	102%	Nursing staff working additional unplanned hours and altering skill mix.	1 B5	99%	↑	4.13%
A&T	1570	1369	1140	1395	1465	1638	333	333	333	1000	1441	1419	83%	112%	100%	99%	Altering skill mix.	2 B5	91%	↓	9.17%
Edward Myers	1146	1121	1107	930	928	869	291	291	310	581	581	559	99%	94%	106%	96%	Altering skill mix. Cross cover was also provided to other wards.	1 B3	87%	↑	11.76%
Darwin Centre	1095	1218	1286	1395	1116	1101	324	324	324	667	981	959	106%	99%	100%	98%	*	1 B5 1 B3	104%	↑	2.84%
Summers View	1005	1005	943	930	928	849	332	332	332	665	665	665	94%	91%	100%	100%	The MDT helped support nuring staff.	0	88%	↓	5.19%
Florence House	540	540	619	930	930	787	332	332	332	332	332	332	115%	85%	100%	100%	Altering skill mix.	0	100%	↑	2.33%
Trust total	**13204**	**13538**	**11582**	**13950**	**14951**	**15317**	**4478**	**4478**	**3892**	**7897**	**9266**	**9748**	**86%**	**102%**	**87%**	**105%**	*** Staffing above 95%**				

Enclosure 7

REPORT TO : Trust Board

Date of Meeting:	9 March 2017
Title of Report:	Director of Infection Prevention and Control (DIPC) Quarter 3 - October - December 2016
Presented by:	Ms M Nelligan, Executive Director of Nursing and Quality & DIPC
Author of Report:	Amanda Miskell, Consultant Nurse for Physical Health & Deputy DIPC
Purpose / Intent of Report:	For information/assurance
Executive Summary:	The DIPC delivers a quarterly report to appraise the Board of Directors regarding IPC activity and any associated risks. The report includes our performance and the assurances in line with the requirements set out in the Health and Social Care Act 2008 - Code of Practice on the prevention and control of infections and related guidance (revised 2015). The report will reiterate that our IPC team continue to work effectively and are compliant with both our internal and external reporting requirements.
Seen at SLT or **Exec** Meeting & date	SLT / EXEC (and date): Due to be seen by Infection and Prevention Control on 6 March 2017 Seen by Exec Lead : N/A Document Version number: v1
Committee Approval / Review	• Quality Committee ☒ • Finance and Performance Committee ☐ • Audit Committee ☐ • People and Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐
Relationship with: *Board Assurance Framework* *Strategic Objectives*	1. To provide the highest quality services ☒ 2. Create a learning culture to continually improve.☒ 3. Encourage, inspire and implement research at all levels.☐ 4. Maximise and use our resources intelligently and efficiently.☒ 5. Attract and inspire the best people to work here.☐ 6. Continually improve our partnership working. ☐ 7. To enhance service user and carer involvement.☐ **Comments:**
Risk / Legal Implications: (Add Risk Register Ref [if applicable])	None

Resource Implications: Funding source:	Influenza Vaccination Programme
Equality & Diversity Implications:	None
Recommendations:	For information and assurance

North Staffordshire Combined Healthcare NHS
NHS Trust

DIRECTOR OF INFECTION PREVENTION AND CONTROL (DIPC) QUARTERLY REPORT TO THE BOARD OF DIRECTORS

Quarter Three (October – December 2016)

2/20/2017

1. **Purpose of the report**
   This report will inform the Board of the changes and achievements during the quarter three (Q3) period of 2016 – 2017. The Board will also be apprised of our position in relation to Health Care Acquired Infections and any other incidents.

2. **Health Care Acquired Infections (HCAI)**
   There were no HCAIs to report, including incidents of MRSA Bacteraemia or C-*difficile* in the Q3 period.

3. **Incidents & Outbreaks**
   In addition there have been no incidence of infection risks, or outbreaks of infection, therefore there is nothing to report by exception to our commissioners.

4. **Infection Prevention & Control Service (IPCS)**
   From December 1st 2016, the IPC service has been provided by our own staff and the previous Service Level Agreement (SLA) with UHNM has ceased. This has been possible due to the appointment of our Consultant Nurse for Physical Health who will also take up the role of Deputy DIPC. The service will be further supported by two nurses who will commence employment in May 2016.

   The service will ensure our organisation has excellent governance and assurance in relation to Regulation 12 and 15. The work programme for the coming period will be extensive, and include development of an IPC strategy.

   Work has already started, and the management of outbreaks and exposure incidents is now managed by our own staff which is fit for purpose for mental health.

   The pathology SLA has also been reviewed and Microbiology support and advice will continue for all patients within our care, including interpretation and advice on diagnostics.

   The service is actively involved in the regional networks for IPC, Clostridium Difficile reduction programme and Antimicrobial Stewardship.

5. **Infection Prevention & Control Group**
   The Infection Prevention and Control Group (IPCG) met on the 19th September 2016 and the chairs summary comprises:

- An annual IP&C audit programme has continued with all in-patient areas and the majority of the community sites assessed, scored and actions agreed where required.
- Antimicrobial resistance remains high on the agenda which links across the local health economy and is being strengthened by collaborative working.
- All IPC policies have been revised in line with scheduled policy revision dates and progressed through the trust governance processes.

6. Influenza Vaccination programme

Our organisation became the best performing Mental Health Trust for the annual Influenza Vaccination Programme, and the sixth highest performing trust in England. The full CQUIN amount was recommended by our commissioners. This is a massive achievement and acknowledgment goes to key vaccinators, and IPC nurse. Planning has already started for this year's programme.

7. Recommendations

The Board is asked to note the DIPC Quarter 3 Report for 2016/17.

REPORT TO TRUST BOARD Enclosure 8

Date of Meeting:	9th March 2017
Title of Report:	Board Assurance Framework Quarter 3 2016/17
Presented by:	Laurie Wrench, Associate Director of Governance
Author of Report:	Laurie Wrench, Associate Director of Governance
Purpose / Intent of Report:	Assurance and information.
Executive Summary:	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 provides an update and RAG rating for those actions due during quarter 3.
Seen at SLT or **Exec** Meeting & date	SLT/EXEC: Discussed during Exec 1:1s Date: Various Document Version number: 5
Committee Approval / Review	✓ Quality Committee ✓ Finance and Performance Committee ✓ Business Development Committee ✓ People and Culture Development Committee ✓ Audit Committee
Relationship with: *Board Assurance Framework* *Strategic Objectives*	1. To provide the highest quality services ☒ 2. Create a learning culture to continually improve.☒ 3. Encourage, inspire and implement research and innovation at all levels.☒ 4. Maximise and use our resources intelligently and efficiently.☒ 5. Attract and inspire the best people to work here.☒ 6. Continually improve our partnership working. ☒ 7. To enhance service user and carer involvement.☒ **Comments:**
Risk / Legal Implications: (Add Risk Register Ref [if applicable])	The BAF describes the risks associated with the delivery of the strategic objectives
Resource Implications: Funding source:	None
Equality & Diversity Implications:	None
Recommendations:	• The Board receive the Quarter 3 Board Assurance Framework 2016/17 for assurance and information purposes.

North Staffordshire Combined Healthcare NHS Trust

Board Assurance Framework (BAF) 2016/2017

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

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

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

Those key risks, mapped against our two strategic goals and 7 objectives are set out in the following pages. We have also categorised each objective against our quality priorities – SPAR.

Objective 1:	**To provide the highest quality services**								
SPAR PRIORITY									
Exec owner:	Medical Director (MD) and Director of Nursing & Quality (DoN)								
Assurance Committee:	Quality Committee								
Risk appetite	Financial	3	Quality (Innovation)	3	Regulation	2	Reputation	3	

RISK: *The Trust fails to improve patient safety, eliminate avoidable harm and deliver high quality services, resulting in less than optimal care, reputational harm, increased scrutiny and regulatory restrictions* 	**Gross Risk (no mitigation)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/17)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	4	4	16	3	4	12	2	4	8

Links to 12+ Trust Risks	**Description of linked 12+ Trust Risks**
	• 423 – Compliance with MHA/MCA • 441 – PICU • 440 – Place of Safety • 662 – CQC rating 'Good'

Internal Assurance		**External Assurance**
1	**2**	**3**
• **Corporate Performance Report/ Dashboard** • **Internal Performance** • **Reportable Issues Alert** • **Quality Account**	• **Internal Audit**	• **National Patient Satisfaction Surveys (F & F Test)** • **Healthwatch Reports** • **Independent Reviews (e.g. Ombudsman Reports)** • **External Visits / Inspection Reports**

• **Internal Audit Reports** • **Practice Improvement & Lessons Learnt Report** • **Complaints and Concerns Report** • **Incident Reports** • **SI Reports**				• **CQC** • **External Audit** • **Benchmarking**				
SPAR Reference	**CONTROLS**	**ASSURANCES**	**TIMESCALE**	**Progress against assurance**	**Lead Director**	**End Q3 RAG status**	**On Target RAG Status**	**End Year RAG Forecast**
1. Safe Personalised Accessible Recovery	Improvement in CQC core service rating in September 2016	The Trust will achieve improvements in core service ratings	Quarter 2	CQC inspection held. Initial feedback shows positive improvements	CEO			
2. Recovery	Development of a Nursing Strategy	A Nursing Strategy is developed underpinned by the principles of SPAR, the Trust values and the six Cs	Quarter 2	Nursing Strategy ratified by Board. Four launch events held across the Trust. Action plan monitored by the Nursing Network forum.	DON			
3. Recovery	Strengthened governance and leadership	A strengthened approach to governance and professional leadership within Directorates to support operational management	Quarter 4	Discussion taken place with directorates and Professional Groups, paper in development	DON			

		Development of an assessment and accreditation framework for inpatient wards to enhance the clinical leadership of ward managers which will include KPIs for: • Practice • Patient experience • Leadership Clear professional and governance leadership across directorates	Quarter 4	Ward Manager Leadership Programme delivered and concluded October 2016. Collaborative work commenced with Merseycare Trust	DON			
		Develop a model for psychological therapies within Substance Misuse services	Quarter 2	Due to the cuts by Staffordshire County Council it will not be possible to integrate Psychological Service into Substance Misuse Services	MD	No RAG rating provided as assurance no longer possible to deliver		
4. Safe	Embedded safety culture and safe environments	The introduction of an inpatient safety matrix across all wards	Quarter 1 - ongoing	Developed for inpatient areas. Piloted in Quarter 1 and implemented in Quarter 2. Dashboard provided to wards and Directorates	DON			

		The implementation of a patient safety campaign.	Quarter 2	Annual schedule of planned visits with one pilot visit undertaken – pilot completed Q2 with annual plan in place.	DON			
		Monthly unannounced assurance visits using peer review and Board to Team principles	Quarter 2 Ongoing	Full schedule of visits planned with ward managers, NEDs, Execs and service user / carer representatives. Quarterly reports to Board. To date visits completed for Wards 3, 6 and 7.	DON			
		Delivery of the safety culture CQUIN for 2016/17	Quarterly milestones to be achieved	Q3 achieved	DON			
		Develop and prioritise a plan for the reduction of ligature risks	Quarter 1	Complete – Annual Risk Assessment and Plan approved by Quality Committee	DO			
		Enhance skills in physical health across the workforce	Quarter 3	• Physical Health Task and Finish Group (multidisciplinary) continues, including a review of all policies, practice and training. • Work plan for 2016/17 on target to be signed off in Q4 and new work plan will be developed	MD			

				and approved for 2017/2018. • One day "fundamentals of PH care" will commence for all clinical staff from April 2017 as part of inpatient clinical block. • Care certificate competencies already in place • New PH competencies for all registered nurses to commence from April 2017 following attendance at "fundamentals of PH care". • Consultant Nurse has commenced (December 2016). • Initial briefing for "Smoke Free 2018" will be submitted to SLT on the 14.01.17 • PH assessments commenced for ROSE to standardise all current documents and risk assessments. • Collaboration with Keele in relation to developing a Physical				

				Health module for Mental Health Nurses for the next Academic year.				
		Ensure safer staffing levels within in-patient environments.	Quarter 1 - ongoing	Monthly safer staffing report demonstrates safe staffing levels. Six monthly reviews complete in line with national quality board requirements. Next due to March 2017 Board. E-Rostering project to be implemented in April 2017	DON			
5. Safe	Ensure infection free environments	Strengthen infection prevention control surveillance within inpatient wards	Quarter 2 - ongoing	DIPC walkabouts followed by improvements in environment via capital investment spend and support PLACE performance.	DON			
		Quarterly DIPC Report to the Board	Quarter 1 - ongoing	Report to Board demonstrating compliance with IPC standards – ongoing with Q2 submission to October Board.	DON			
6. Safe	A reduction in harm	To maintain incident reporting levels above the national average	Quarter 4 Ongoing	NRLS data released October 2016 covering period October 2015 to March 2016. Trust reporting rate remains above the national median for mental health	DON			

				trusts. Self-harming behaviour has reduced.				
7. Safe		Ensure 90% of eligible staff receive medicines optimisation training	90% of staff by Quarter 4	Performance at 24% for Q3 To improve compliance, further cascade trainers have been identified within Teams and additional training sessions planned through to end of March 17. Revised trajectory based on additional training sessions is 70% by end of Q4. Clarification of 'eligible' nurses to ensure staff who do not handle medicines are excluded from count. This will conclude on 5th of February. E learning will commence in April in line with Trust E-learning strategy	MD			
8. Safe		To increase the number of reported medication errors by 20% by end of Q4	15% increase for Quarter 3	36 reports for Q3 (baseline 23) which shows a continuing improving picture. 56% increase compared to baseline	MD			
9. Safe		To reduce the number of medication omitted doses by 10% from	By Q4 there will be a 10% reduction from the	November result 5.9% Q1 8.3% and Q2 4.9% (30% reduction from baseline. Teams monitor using	MD			

		the baseline of 8.38% by clinical teams	baseline of 8.38%	Medication Safety Thermometer (MST) 1 day per month. This is overseen by the Medicines Optimisation group. .				
10. Personalised		Consent to treatment to be recorded for 100% in partnership with patients	Quarter 1	Q3 update - The Consent Policy has been reviewed and compliance is overseen by the Mental Health Law Governance Group. Policy will subject to re-audit by RSM during Q2 of 2017/2018 Quality Assurance Audit results for Inpatient services demonstrate compliance of 94% at end of December 16.	MD			
11. Personalised		Section 17 Leave forms to be completed for 100% in partnership with patients	Quarter 1	Is included as part of the care planning checks, and compliance overseen by the Mental Health Law Governance Group. Quality Assurance Audit results December 2016 demonstrates compliance of 100%. (30/30 cases).	MD			
12. Recovery		90% of appropriate staff will receive training on the Mental Health Act and Mental	Quarterly	Validated at end of Quarter 3 overall compliance is at 87%. Development of e-learning packages to be available	MD			

		Capacity Act		from April 2017.				
13. Accessible		To increase the number of patients seen within 3 hours for a section 136 assessment by 50% by Quarter 4 baseline of 43%. Year end target 66%	37.5% increase by Quarter 3	Q2 target 55% Q2 actual: 58.3% Q3 target 60% Q3 actual: 71% Q4 target 66%	DO			
14. Safe Personalised Accessible Recovery	Delivery of CQUIN Programme	100% CQUIN milestones are achieved 1. Physical Health(S,R) 2. Communication with GPs (A) 3. Staff Well-being (P) 4. Safety Culture (S) 5. Green Light Toolkit (P) 6. Care Planning (SPAR)	Quarter 3	There is no risk to achievement currently identified for CQUINS at Quarter 3. CQUIN 1c (Flu vaccination) – Internal figures suggest that the 75% target has been achieved, with 79.9% of frontline clinical staff having been vaccinated within the time period. However, this is subject to validation and sign-off by NHS England	MD			
					1			
					2			
					3			
					4			
					5			
					6			
15. Accessible	Delivery of new national mental health access targets and ensure comprehensive access to all services	Early Intervention Team target of 50% patients having accepted a NICE approved package of care within 2 weeks	To be monitored Quarterly	Q1 actual: 73% Q2 actual: 73.3% Q3 actual: 86%	DO			

		IAPT target of 75% patients having commenced treatment within 6 weeks of date of referral	To be monitored Quarterly	Q1 actual: 98.5% Q2 actual: 98.4% Q3 actual: 94%	DO			
		IAPT target of 95% patients having commenced treatment within 18 weeks of date of referral	To be monitored Quarterly	Q1 actual: 100% Q2 actual: 100% Q3 actual: 99%	DO			
		Achievement of waiting times initiatives - 92% patients are seen within 18 weeks	To be monitored Quarterly	Q1 actual: 82.5% Q2 actual: 90.4% Q3 actual: 96%	DO			
16. Safe Personalised Accessible Recovery	Care Planning and Risk Assessments	95% patients to have a Care Plan and Risk Assessment	To be monitored Quarterly	Q1 actual: 96.9% Q2 actual: 97.2% Q3 actual: 94.7%	DO			
		The Trust can evidence 95% patients have been involved in the development of their care plan who wish to be	To be monitored Quarterly	Q3 actual: Community Services 86% Inpatient Services 88%	DO			
		Support the development of the quality of care plans and risk assessments across	Quarter 1 - ongoing	Audit programme in place demonstrating improvement in quality. Inpatient Safety Matrix feeds into performance	DON			

		the Trust measured by monthly audits.		data. Audits of care plans continue and Patient Safety Matrix used to inform performance.				
17. Safe	Emergency Planning	Development of Emergency Planning Process and business continuity plans to be completed across all directorates.	Quarter 2	Confirm and challenge session with NHS England and CCG carried out in Q3 based on Q2 submission confirms good progress. Trust self- assessment was upgraded by NHSE. Work plan on target. Meeting planned 17th March to develop Directorate Business Continuity plans	DO			

Objective 2:	**Encourage, inspire and implement research and innovation at all levels**								
SPAR PRIORITY	  								
Exec owner:	Medical Director (MD)								
Assurance Committee:	Quality								
Risk appetite	Financial	2	Quality (Innovation)	2	Regulation	2	Reputation	3	

***RISK**: The Trust fails to exploit its potential in research and innovation, losing credibility and reputation and under achieving in delivering evidence based care.*	**Gross Risk (no mitigation)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/17)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	4	4	16	3	4	12	2	4	8

Links to 12+ Trust Risks	**Description of linked 12+ Trust Risks (e.g.)**

Internal Assurance		**External Assurance**
1	**2**	**3**
• **Quality Account** • **Staff Survey Results** • **Patient Experience Report**	• **Internal Audit**	• **Internal Audit Reports** • **External Visits / Inspection Reports** • **National Staff Surveys**

• **Clinical Audit Reports** • **Practice Improvement & Lessons Learnt Report** • **Annual Governance Statement** • **Internal Audit Reports** •		• **Annual Audit Letter** • **External Audit** • **Benchmarking**

	CONTROLS	ASSURANCES	TIMESCALE	GAPS AND ACTIONS	Lead Director	End Q3 RAG status	On Target RAG Status	End Year RAG Forecast
1	Strengthen integration of Mental Health with Primary Care services	Engage in all MCP adoption in North Staffs and Stoke	Quarter 4	3 further localities to be rolled out in addition to Leek. Lead role in Enhanced Community Care. The Meir partnership commencement and alignment with co-operative working. Joint paper for the setup of provider board with SSOTP , GP Fed and Stoke CC	DSD			
		Engage GP federation with Memorandum of Understanding (MOU)	Quarter 1	Joint Paper developed and representation on transformation board. Joint tender for Out Of Hours and Front Of House. Formal partnership arrangement in work up. To be completed by end of November. Clinical partnership board setup Partnership bid for UCC and OOH	DSD			
		Contribute to the portfolio of services to support primary care is developed and implemented	Quarter 4	MIDOS being developed Partnership agreement signed Review of support services following UCC bid	DSD			
		Deploy risk prevention research into MCP model	Quarter 3	Initial Research bid unsuccessful. Further submissions to be considered.	DSD			

2	Participate in the Staffordshire wide research strategy and West Midlands Academic Health Sciences Network.	To develop partnership agreement with Higher Education Institution in areas of mutual interest will demonstrate reputation and profile as an influential mental health research organisation that builds meaningful collaborations and is successful in achieving external research funding.	Quarter 4	Work remains on-going: • R&D team have signed up as a friend of CHAD (Centre for health and development) at Staffordshire University and attended launch event in September 16 and meetings in December 2016. • Collaboration agreed with Staffordshire University Head of Research to develop joint bids in next financial year • R&D team have attended WM AHSN Dementia group to develop further links with the AHSN and other members	MD			
3	Increased research activity and profile	Increase the number of research partners by 50% from baseline by Quarter 4 (n=20)	37.5% increase by Quarter 3	Annual target exceeded at Q3 Working with 35 partners	MD			
		Increase the number of publications by 50% from baseline by Quarter 4 (n=8)	Quarter 4	Annual target of 3 each quarter exceeded at Q3 14 Publications and presentations to date	MD			
		Increase the number of staff / teams engaged in research and evaluation by 50% from baseline by Quarter 4 (n=27)	37.5% increase by Quarter 3	Annual target exceeded at Q3 Current number of new teams & indviduals is 17	MD			
		Increase the number of home grown research and evaluation projects by 50% from baseline by Quarter 4 (n=14)	37.5% increase by Quarter 3, a total of 21 by	Annual target exceeded at Q3 Number if new projects initiated this year is 30	MD			

			Quarter 4					
		Increase the number of returns for student satisfaction surveys by 50% from baseline by Quarter 4	37.5% increase by Quarter 3	100% returns to date to Keele. In addition, R&D team have begun to gain feedback from students/DClin Psych students in relation to the quality of support in terms of governance and/or also any R&D support accessed. Will be collated quarterly and will help inform future reports and development of relationships.	MD			
4	Increased productivity and efficiency	Using Meridian Productivity to redefine work practices to reduce administrative burden and maximise service user facing time for our clinicians. Develop the skill sets to apply the principles across all clinical services	Quarter 2	Meridian data shows additional capacity. Targeted work around CAMHS waiting list reduction. CAMHS community, job planning, case management tool and capacity and demand modelling complete. New ways of working to be deployed October. Increase capacity and sustainable reduction in waiting list anticipated. Adult community released 470k cash releasing savings CAMHS productivity improvement between 10 and 15% Second phase proposed	DSD			
5	National Digital Exemplar	Deploy novel technologies and expand the use of digital	Quarter 4	Access Phase 1 implementation complete.	DSD			

		technology to enhance quality and efficiency of service delivery • Access Programme • Autographer Programme		Access phase 2 collaborative joint model with health care providers across North Staffordshire and Stoke-on-Trent. To be rolled out in line with CCC				

Objective 3:	**To create a learning culture to continually improve**
SPAR PRIORITY	
Exec owner:	Director of Leadership and Workforce (DLW)
Assurance Committee:	People and Culture Development

Risk appetite	Financial	3	Quality (Innovation)	3	Regulation	2	Reputation	4

***RISK**: The Trust fails to support its workforce to continually learn and develop resulting in poor staff experience.* 	**Gross Risk (no mitigation)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/17)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	3	4	12	2	4	8	2	4	8

Links to 12+ Trust Risks	**Description of linked 12+ Trust Risks (e.g.)** 838 – ROSE/Lorenzo (training)345 - LHE

Internal Assurance		**External Assurance**
1	**2**	**3**
• **Staff Survey Results** • **Complaints and Concerns Report** • **Incident Reports** • **Practice Improvement and Lessons Learnt Report**	• • **Internal Audit**	• **National Staff Surveys** • **LCFS** • **National Patient Satisfaction Surveys (F&F Test)** • **Internal Audit Reports** • **External Audit Reports**

• **Internal Audit Reports** • **Reportable Issues Alert** • **Board Committee Assurance Reports** • **Corporate Performance Reports/ Dashboard** •		• **External Visits / Inspection Reports** • **External Audit** • **Benchmarking**

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q3 RAG status**	**On Target RAG Status**	**End Year RAG Forecast**
1	Appropriate values and behaviours demonstrated within our people	Values and Behaviour Framework is developed, approved and embedded. Assurance obtained via embedding the values via the following mechanisms: • Reach Awards (Lead: Joe McCrae) • Values Based Recruitment (Lead: Georgie Evans) • Induction (Lead: Marie Barley) • Appraisal/PDR (Lead: Marie Bailey) • Training Courses (Lead: Sue Slater) • HR Policies and Procedures (Lead: Kerry Smith)	Quarter 4	Behaviour framework in development Q-Sorts to be completed by end of Jan Analysis of data gathered Draft behaviour framework created from results Paper written and presented at the following for ratification: • Execs (21.2.17) • PCD (27.2.17) • Trust board (9.3.17) Workshop being arranged with leads for each embedding activity to develop roll-out plan	DLW			

		Clinical Director and Clinical Leadership Development programmes are developed quarter 1 and assurance obtained via • Clinical Director's completion of programme (Q4) • All identified Senior Clinical future talent on a rolling leadership programme (Q4)	Quarter 4	CD and CL Programme Proposal in development. After receiving multiple proposals for the programme is now in design with NHS Elect. The in-house programme will commence in the new financial year due to financial plan. Six senior leaders have taken part in Advancing Talent cross health economy senior leaders programme.	DLW			
		A Leadership Competency Framework 360 review is undertaken for 50% Band 8a leaders and above	Quarter 4	Given other priorities and changes within the service this process will now be delivered in 2017/18. However we are developing a sustainable model to train assessors in Q4 (senior leaders from across the Trust) to enable launch as part of Towards Outstanding in Q1.	DLW			
2	Teams are supported effectively to learn and develop and to become high level performing teams	To complete two further cohorts of the Aston Team development programme utilising IT in the training delivery. To complete the training with new leaders and managers and/or nominated deputies.	Quarter 4	2 cohorts completed (10 & 11) Cohort 12 will be advertised in Feb.	DLW			

		Increase by 20% the teams that have undertaken the ARTP review process. Show improvement in 80% of all of those teams	Quarter 4	Improvement appears to correlate to the 5 Day Aston Course at the beginning of the process. Where teams have undertaken the process they show improvements in 84% of teams.	DLW			
		The WWL model is launched within the Trust	Quarter 2	Business case and implementation plan being finalised. Capital funding identified. Business case to SIG on the 10th of Feb for completion by year end.	DLW			
		At least 10 teams are working with the WWL tool	Quarter 4	All but essential Mandatory training is delivered. Work will have commenced in gaining the trusts first quarterly diagnostic. Teams will be identified during February to commence their Journey by year end. Directorates are actively considering teams we wish to adopt the offer prior to expression of interest being launched.	DLW			
3	E-Learning - All but essential face to face training is delivered via e-learning	All but essential face to face mandatory training is delivered via e-learning.	Quarter 4	All mandatory training is now delivered via e-learning with the exception of Fire (clinical areas), Manual Handling (clinical areas, CPR/In Hospital Resus and MAPA – these are required to be delivered face-to-face because of the nature of the training.	DLW			
4	Staff have role clarity and are developed effectively within their role	Improved quality as assessed by re-audit of PDR's in 2016	Quarter 4	Audit received with improvements demonstrated. Embargoed staff survey data also shows a marginal enhancement in PDR rates between	DLW			

				2015 and 2016, also showing improved valued and increase reference to trust values.				
		Implement Talent Management approach via PDR	Quarter 1	Talent management incorporated into PDR process. An engagement process was undertaken to ensure greater take up which is currently being quantified. This is being reviewed in Q4	DLW			
		90% staff providing clinical services have Clinical Supervision at least every 2 months Compliance with clinical supervision target is 80% as of Quarter 1 and 90% at end Quarter 2	Quarter 2	At December 2015 the Trust stood at 12% of staff with Clinical Supervision in place. Q1 target of 80% was achieved. Q3 actual: 78% so underperformance. Rectification Plans in place and managed through performance management sessions.	DLW			
5	Widening Participation	1. To develop a plan to prepare the Trust for the implementation of the apprentice levy in April 2017. To engage with Directorate and Corporate Mangers to ensure there is a clear understanding about the steps we need to take to take to develop a robust plan.	Quarter 4	Regular reports to SLT throughout the year. Meetings held with Heads of Directorate. Trust Apprenticeship Group formed with representation from each Directorate to widen understanding and build directorate action plans. Plan in place for April 2017 onwards	DLW			
		2. To develop processes, systems and relationships within the	Quarter 4	Through preparation for the levy, it is prudent to have been made to defer some recruitment until after 1st May	DLW	No RAG rating as assurance to be delivered in 2017/18		

		Trust, Training Providers and other stakeholders to commence apprentice recruitment to meet regional targets for 2016/17 of 22 new apprenticeships.		to maximise levy income which may be jeopardised if over achievement prior to May – it would pose a greater risk if we were not to do this. Work has taken place to get Directorates prepared for the introduction of the levy.				
	An organisation that is diverse and inclusive to support an open, welcoming, compassionate culture	Develop a strategy for Equality, Diversity and Inclusion to achieve strategic aims by 2020	Quarter 1	Complete	DLW			
		To progress the implementation of the EDS2 across the Trust over the period of 2016EDS2 compliant as assessed by commissioners	Quarter 4	This has been completed and progress will be monitored through PCD. An Action Plan related to the CQC inspection is being developed in Q4 to inform BAF for 17/18.	DLW			
	Improved benchmarked data for junior doctors	Improve our ranking when benchmark with Trusts in the West Midlands with responses in the Junior doctors 'Job Evaluation Survey Tool, (JEST)	Quarter 3	The Trust ranked highest in the West Midlands for positive responses from Junior Doctors	MD			

Objective 4:	**Attract and inspire the best people to work here**								
SPAR PRIORITY									
Exec owner:	Director of Leadership and Workforce (DLW)								
Assurance Committee:	People and Culture Development								
Risk appetite	Financial	4	Quality (Innovation)	3	Regulation	2	Reputation	3	

***RISK**: The Trust fails to attract and retain talented people resulting in reduced quality and increased cost of services.*	**Gross Risk (no mitigation)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/17)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	3	5	15	2	5	10	1	5	5

Links to 12+ Trust Risks	**Description of linked 12+ Trust Risks** 868 – Temporary staffing

Internal Assurance		**External Assurance**
1	**2**	**3**
• **Board Committee Assurance Reports** • **Exec Led Group Update Reports** • **Corporate Performance Report/ Dashboard**	• • **Internal Audit**	• **External Visits / Inspection Reports** • **National Staff Surveys** • **Healthwatch Reports** • **Internal Audit Reports**

• **Internal Audit Reports** • **Quality Account** • **Staff Survey Results** • **Patient Experience Report** • **Incident Reports** • **Complaints and Concerns Report** •		• **External Audit Reports** • **National Patient Satisfaction Surveys (F&F Test)** • **Network Reviews**

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q3 RAG status**	**On Target RAG Status**	**End Year RAG Forecast**
1	Recruitment and retention of talented staff	Recruitment and Retention Strategy and Plan is developed and implemented	Quarter 1	Recruitment plan developed and implemented – campaign ongoing	DLW			
		Vacancies are reduced to 5%	Quarter 2 onwards	Q2 actual: 3.5% Q3 actual: 4.5%	DLW			
		Develop transformational Workforce Plans to create roles that deliver outstanding services and attract staff	Quarter 3	Workforce plans have been developed at Directorate and Trust level to support the 2 year plan. Plans not yet fully operational	DLW			
2	Improving Staff Engagement	Complete Wave 3 LIA and evaluate impact	Quarter 1	Completed and evaluated. 33% increase for Pulse Check from original survey.	DLW			
		Further enhance the engagement process through coordinating the "Towards Outstanding" approach linking engagement LIA, Go Engage and wider leadership development.	Quarter 4	Agreement within the Towards Outstanding brand to run two listening events trust wide every year. April and October 2017 are the next two events.	DLW			

		Launch LIA Wave 4	Quarter 3	This was reassessed and agreed to delay with the CQC visit. The 'Towards Outstanding OD approach will now incorporate LiA and we plan to launch Wave 4 in Q1 17/18.	DLW	No RAG rating as assurance to be delivered in 2017/18		
		Trust Engagement scores within the Staff Survey for 2016 continue to be improved (score of above 3.7).	Quarter 4	Initial Staff Survey results show overall improvement from 2015 in engagement as do the mid-year Pulse Check result. CQC have also commented directly on improved engagement. 2016 Score 3.73	DLW			
3	Effective marketing of the trust as a service provider and place to work	Review structure of the Communications function to deliver the strategy and plan	Quarter 1	Interim plan in place. Completion due in Q2.	DLW			
		A New Website is in place	Quarter 2	Enhanced new website to be in place by September - achieved. New Website in place by end of January 2017.	DLW			
		Develop an effective online presence and increase online traffic by 26k hits by Quarter 4 from 12.9k	26k hits by Quarter 4	Social Media approach enhanced with introduction of Twitter, Facebook, enhanced website, use of local media	DLW			
		Develop clear Trust branding and marketing approach through social media	Quarter 1	The Trust Branding - linked to SPAR and Proud to CARE with the distinctive 4 colours Purple, Blue, Pink and Green - has become established and is recognised across the Trust and externally.	DLW			

		Raised awareness of the Trust and the services it provides within the local community with GPs and patients. Exercise is undertaken to ensure: • Website clear and utilised • Articles produced every week for local press and radio	Quarter 3	Website enhanced with positive feedback. New website to launch end January 2017. Articles produced every week for local press and radio. 3 articles achieved financial year to date as well as 2 BBC Radio Stoke positive pieces. GP News is also produced and distributed across practices.	DLW			
		Engage staff in two way communication - Increasing feedback from staff by 100% through various media. Twitter followership is increased from 442 to 900 The number traffic to our website is doubled from 650 to 1300	Quarter 4	Q1 twitter followers increased to 554. Q2 Twitter followers increased to 645 and in Q3 this has increased to 728. The new Associate Director of Communications now in place and enhancing our Social Media approach.	DLW			

Objective 5:	**Maximise and use our resources intelligently and efficiently**								
SPAR PRIORITY									
Exec owner:	Director of Finance (DF)								
Assurance Committee:	Finance and Performance								
Risk appetite	Financial	3	Quality (Innovation)	3	Regulation	2	Reputation	4	

***RISK**: The Trust fails to optimise its resources resulting in an inability to be a sustainable service.* 	**Gross Risk (no mitigation)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/17)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	4	4	16	2	4	8	2	4	8

Links to 12+ Trust Risks	**Description of linked 12+ Trust Risks** • 747 – ROSE • 876 – Business continuity • 724 – 2016/17 Control target • 807 – 2017/18 Control target • 473 – CIP • 701 – Building work at Darwin • 857 – Sustainability of Estates Agency

Internal Assurance		**External Assurance**
1	**2**	**3**

• **Board Committee Assurance Reports** • **Exec Led Group Update Reports** • **Corporate Performance Report/ Dashboard** • **SI Reports** • **Finance Report** • **Reportable Issues Alert** • **Minutes (of key meetings)** • **Quality Account** • **Annual Governance Statement** • **Internal Audit Reports** • **LCFS Reports** • **Practice Improvement & Lessons Learnt Report** • **CIP / QIA** • **Complaints / Concerns Report** • **IG Toolkit** • **Clinical Audit Reports** • **Exception Reports** • **Evaluation and Review of documents relating to the Board Committees**	• **Internal Audit**	• **External Visits / Inspection Reports** • **National Audit Reports** • **Network Reviews** • **Independent Reviews (e.g. Ombudsman Reports)** • **Annual Audit Letter** • **Healthwatch Reports** • **External Audit Reports** • **Internal Audit Reports** • **LCFS**

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q3 RAG status**	**On Target RAG Status**	**End Year RAG Forecast**
1	Deliver the Financial Plan	Implementation of robust business decision making process	Quarter 1	Decision making process developed, agreed and implemented	DF			
		Development of robust CIP plans for 2017/18	Quarter 3	CIP plans in development for 2017/18. Schemes under identification.	DO			

		QIA to take place during Quarter 4	Quarter 4	Progress report submitted to Quality Committee	MD and DON			
		Development and implementation of financial assurance model for all investments	Quarter 2	Single Oversight Framework launched and new metrics. Routinely reported through monthly finance report. All capital affordability to be measured alongside assurance model	DF			
		Introduction of financial sustainability strategy	Quarter 2	Strategy introduced to F&P and Board in July 2016	DF			
2	Focus on efficiency and productivity	Creation of a 'model hospital' in line with Lord Carter and national benchmarking data	Quarter 2	Model hospital developed. Request made to join Carter Team to join National programme. Principles of Carter introduced through Finance Recovery Plan.	DF			
		Effective Trust wide efficiency programme reporting	Quarter 1	Reporting at Trust, Committee, Senior Leadership Team and individual directorate level complete. Routinely provided in all relevant meetings.	DF			
		Delivery of Trust wide CIP efficiency programme as per operational plan	To be monitored quarterly	CIP remains a major challenge. Not on track at end of Q3, with further savings to be identified.	DO			
		Attain below average reference costs	Quarter 3	Score of 96 unadjusted and 100.9 adjusted.	DF			
		Review the Performance Team Function to support the delivery of Trust strategic goals	Quarter 2	Review of future structure complete – Associate Director of Performance starting 30.01.17. Review of existing team awaiting overview from new AdoP.	DF			

		Seek best value for money in the PFI contract, identifying savings that could be realised. Review of negotiations with THL and Carillion re catering Costs	Quarterly	Savings identified @ £15k to be negotiated with Carillion. Energy cost reduction realised with Semperian Additional £7.5k reduction achieved on vending machine costs. Catering offer of £15k with an extension of contract turned down. Awaiting amended proposal from Carillion.	DO			
		Review of negotiations with THL and Carillion re catering costs.	Quarter 1	This is included as above and can come out of above contract.				
3	Deliver the Capital Plan	Completion of the Darwin Centre Redevelopment	Quarter 2	This has met with delay. Now due for completion during December 2016 but will complete during financial year	DO			
		Completion of A&T Telford Purchase	Quarter 1	Funding transferred to solicitors	DSD	**No RAG rating as delays for completion not in the control of the Trust**		
		Implement and ensure delivery of robust implementation plans for key estates schemes: 1. PICU (planning and commencement of work)	Quarter 1	Implementation plan required	DO			

		2. A&T Telford Redesign (subject to agreement)	Quarter 3	Plan not deliverable within resource envelope. Being reviewed in line with wider estates update during Q3	DO	**No RAG rating as delays for completion not in the control of the Trust**
		3. Urgent Care Centre (NYD)	Quarter 4	Business case due in Q3 as per original plan	DO	
4	Progress is made with Digital Programme	4. Sign off by HSCIC for Lorenzo investment case including EPMA	Quarter 1	Complete	DSD	
		Access innovation project is implemented	Quarter 1	Access project plan implemented September - complete	DSD	
		Combined app is developed.	Quarter 2	No longer viable in current model. To be developed in line with locality delivery.	DSD	**No RAG rating as assurance no longer deliverable**
		Contribute to Digital road map STP	Quarter 1	Completed	DSD	
		Staffordshire wide Design Authority is established	Quarter 3	In line with STP. Concept has been agreed and is supported. First meeting November 2016. Complete	DSD	

		EPR Project is completed by March 2017	Quarter 4	DH & HSCIC 8 week delay approval process resulting in revised timeframe of May 2017. Rose stocktake with NHS digital complete	DSD	**No RAG as assurance delayed outside of Trust control to May 2017**		
		Develop plan for mobile technology for all clinical community staff	Quarter 4	Bring your own proposal being reviewed Reviewed through digital board not proceeding at this point.	DSD			
5	Better use of the Estate	A review of the Estates function will be undertaken	Quarter 1	Review of Estates function ongoing however delayed against original timeframe	DO			
		Estates rationalisation plan is developed. Plan approved by Board, with clear trajectories and milestones to reduce accommodation footprint linked to a mixed economy of freehold and leasehold properties.	Quarter 2	CHC Estates strategy produced. Plan in development aligned with partners to deliver new models of care. To be developed over North Staffs and Stoke footprint aligned with the STP and MCP	DSD			

6	Implementation of Manager self service	Deliver Business Case for enabling Financial Ledger and ESR to link	Quarter 1	There have been challenges with supplier and agreeing remit of the project. There are also challenges with the Ledger that mean that this is no longer seen as a priority for 17/18.	DLW			
		Develop Implementation Plan for ESR staff and manager Self Service	Quarter 2	This has been reprioritised given differing priorities in year. There will now be a review and planning in Q4 that will look to streamline workforce information processes and systems for implementation during 2017/18.	DLW			
7	Consistent performance	90% performance metrics are RAG green	Monitored quarterly.	Qtr 1 53 / 68 = 78% metrics were rated as Green Qtr 2 41 / 47 = 87% metrics were rated as Green Qtr 3 58/67 = 87% metrics were rated as Green	DO			

Objective 6:	**To continually improve our partnership working**							
SPAR PRIORITY								
Exec owner:	Director of Strategy and Development (DSD)							
Assurance Committee:	Business Development							
Risk appetite	Financial	3	Quality (Innovation)	4	Regulation	3	Reputation	4

***RISK**: The Trust fails to engage its partners resulting in fragmented care pathways.*	**Gross Risk (no mitigation)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/17)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	3	4	12	2	4	12	1	4	4

Links to 12+ Trust Risks	**Description of linked 12+ Trust Risks**
	• 792 – MCP • 834 - STP

Internal Assurance		**External Assurance**
1	**2**	**3**
• **Board Committee Assurance Reports** • **Exec Led Group Update Reports**	• **Internal Audit**	• **Internal Audit Reports** • **External Audit Reports** • **LCFS**

• **Corporate Performance Report/ Dashboard** • **SI Reports** • **Finance Report** • **Minutes (of key meetings)** • **Quality Account** • **Annual Governance Statement** • **Internal Audit Reports** • **Practice Improvement and Lessons Learnt Report** • **Complaints and Concerns Report** • **Incident Reports** • **IG Toolkit** • **Exception Reports**		• **External Visits / Inspection Reports** • **Network Reviews** • **Healthwatch Reports**

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q3 RAG status**	**On Target RAG Status**	**End Year RAG Forecast**
1	Development of Trust plans demonstrating partnership working	Development of Five Year IBP in line with Staffordshire Transformation Plan "Together we're better"	Quarter 1	Agreed with NHSI. Trust IBP will be developed. Refresh strategy in line with STP development. Trustwide Strategic frameworks produced as well as underpinning strategies National requirement for 2 year plan submitted Dec 23rd, awaiting feedback	DSD	No RAG rating as STP process delayed		
		Framework for business planning for clinical and corporate directorates is implemented	Quarter 1	Completed but not fully operational	DSD			
		Approval of 2016/17 plan and Development of 2017/18 plan	Quarter 4	To be developed - National requirement for 2 year plan in work up for November. Completed	DSD			

2	Robust partnerships are developed with the Third sector	Develop 5 Year Joint strategic intentions with Brighter Futures and Staffordshire Housing Association	Quarter 2	Initial joint paper produced to be developed further Initial engagement and support from both organisations. CAMHS plans in development.	DSD			
		Develop 5 Year Joint strategic intentions with Changes	Quarter 2		DSD			
		Explore Prime provider model with commissioners	Quarter 4	CAMHS case submitted and to be considered in September Second phase submission with Bham underway	DSD			
3	Robust partnerships are developed with Social Care	Support delivery of joint Learning Disability model with Stoke Local Authority	Quarter 1	Joint management structure in place, further integration discussions are underway. Stoke CC restructure –integration process re-initiated	DSD	No RAG rating as process delayed outside of Trust control		
		Strengthen integration with Staffs Social care	Quarter 2	Notification of withdrawal of staffs social care from Combined	DSD			
		Develop Joint digital road map with local authorities	Quarter 2	Completed	DSD			
		Integration of Learning Disability services and Social Care	Quarter 4	Draft paper complete. Council changes in leadership have created potential risk that needs to be worked through.	DO			
4	Robust partnerships are developed with the Acute sector	Develop joint proposal for Emergency care centre	Quarter 1	Phase 1 internal business case developed and delivered however to be considered in line with urgent care work stream. Included in commissioning intentions.	DSD			

		Develop extension of Psychiatric liaison services	Quarter 3	Achievement of Core 24 funding with drawn Included in commissioning intentions. RAID transformation bid submitted to NHSE for 24/7 service	DSD			
5	Specialist Mental Health Services	Protect the specialist mental health services of the trust.	Quarter 4	CAMHS commissioning model Substance misuse funding cuts Private bed utilisation in place Additional services developed with partners	DSD	No RAG rating as external cuts mean assurance not deliverable by Trust		
		Develop joint proposal for expansion of key services in line with population need. Commercial model to be delivered	Quarter 4	Mental health STP workstream and specialist health capacity demand modelling Commissioner budget proposals for transfer of funding	DSD			
6	Enhanced Primary and Community Care	Integrated Adult and NOAP community services into place based care model.	Quarter 4	Staffing modelled across 10 localities and early stage communications in place Pilot in place in Leek and Meir rolling out to additional localities under NS provider board	DSD			
		Work with partner organisations to deliver a model of place based care. Support the design of the governance and infrastructure arrangements for place based care across Northern Staffordshire	Quarter 4	In line with STP and North staffs steering group and the ECC STP delivery programme. Submission of joint tender with the GP federation and Shrop doc for UCC and FOh tender	DSD			

Objective 7:	**To enhance service user and carer involvement**								
SPAR PRIORITY									
Exec owner:	Director of Nursing and Quality (DON)								
Assurance Committee:	Quality Committee								
Risk appetite	Financial	3	Quality (Innovation)	3	Regulation	2	Reputation	2	

***RISK**: The Trust fails to listen and act upon service user and carer involvement resulting in an inability to deliver responsive services.*	**Gross Risk (no mitigation)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/17)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	3	4	12	2	4	8	2	4	8

Links to 12+ Trust Risks	**Description of linked 12+ Trust Risks**

Internal Assurance		**External Assurance**
1	**2**	**3**
• **Complaints and Concerns Report** • **Patient Experience Report** • **Incident Reports** • **Practice Improvement and Lessons Learnt Report** • **SI Reports**		• **External Visits / Inspection Reports (e.g. CQC)** • **Independent Reviews (e.g. Ombudsman Reports)** • **National Patient Satisfaction Surveys (F&F Test)** • **Healthwatch Reports**

• **Reportable Issues Alert** • **Quality Account**								
	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q3 RAG status**	**On Target RAG Status**	**End Year RAG Forecast**
1	Strengthened patient and carer engagement	A Carers strategy is developed supported by the establishment of a Patient Experience Group	Quarter 4 - ongoing	Strategy approved by SUCC and ratified by Board in September .Strategy underpinned by annual programme of work ,monitored via Patient Experience Group.	DON			
		Further embedding of the Service User and Carer Council to demonstrate impact upon person centred delivery of care within Directorates	Quarter 4 - ongoing	SUCC meet monthly. Increase in SU representation October 2016. Refresh of Terms of Reference and membership with workshop 29th March 2017 Recovery conference planned for February 2017	DON			
		FFT response rate increased by 50% by quarter 4. Quarter 3 2016 baseline shows inpatient response rate is 23%	Target 34.5% by Quarter 3	There continues to be a marked improvement in the uptake of the FFT feedback over the past two months with 331 returns in this timeframe. Another prize of a cream tea was awarded to Ward 5; with media communications around this good news story. Teams also now receive a 'well done!' poster with number of their FFT returns for that month in the post to further reinforce the FFT process. The Patient Experience Facilitator has facilitated two FFT Events this year at Resource Centres to further promote the FFT agenda. Feedback overall remains	DON			

				positive.				
		Community Mental Health survey results improved in 20% of areas	Quarter 4	Action plan in place to achieve improvements. 2017/18 survey distributed February 2017.	DO			
		An increase in the number of service users employed by the Trust	Quarter 4	Step On employment specialists work closely with employers to identify job opportunities and to match suitably skilled candidates. If the service user expresses an interest or aptitude in working for the NHS we support them in applying for our Bank Service to give them experience opportunities. **Current position:** • April 2016 to date: 77 referrals actioned • Supported into Employment: 106 • Of those: 4 have been employed in NSCHT Others: referred to voluntary and educational organisations	DLW			
2		Service Users and Carers are invited onto every interview panel	Q3 onwards	Policy amended and Service Users and Carers are invited onto every interview panel including senior appointments.	DLW			

Enclosure 9

REPORT TO Trust Board

Date of Meeting:	09 March 2017
Title of Report:	Performance Report - Month10 2016/17
Presented by:	Suzanne Robinson, Director of Finance and Performance
Author of Report:	Performance Team
Purpose / Intent of Report:	Performance Monitoring
Executive Summary:	This report provides the Board with a summary of performance to the end of Month 10 (January 2017). Performance against NHSI metrics and key National Targets is included within the report. At Month 10 there are 2 metrics rated as Red and 2 as Amber.
Seen at SLT or **Exec** Meeting & date	SLT / EXEC (and date): SLT on 28 February 2017 Seen by Exec Lead : Director of Finance Document Version number:
Committee Approval / Review	• Quality Committee ☐ • Finance and Performance Committee ☒ • Audit Committee ☐ • People and Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐
Relationship with: *Board Assurance Framework* *Strategic Objectives*	1. To provide the highest quality services ☒ 2. Create a learning culture to continually improve.☒ 3. Encourage, inspire and implement research at all levels.☐ 4. Maximise and use our resources intelligently and efficiently.☒ 5. Attract and inspire the best people to work here.☐ 6. Continually improve our partnership working. ☐ 7. To enhance service user and carer involvement.☐ **Comments:**
Risk / Legal Implications: (Add Risk Register Ref [if applicable])	All areas of underperformance are separately risk assessed and added to the risk register dependent on the outcome of the risk assessments.
Resource Implications: Funding source:	Not directly
Equality & Diversity Implications:	Not directly
Recommendations:	The Board is asked to

	• Note the performance reported • Review areas of underperformance as summarised in this report and identify further action required

North Staffordshire Combined Healthcare NHS
NHS Trust

PERFORMANCE MANAGEMENT REPORT TO TRUST BOARD

Date of meeting:	09 March 2017
Report title:	**Performance & Quality Management Framework** **Performance Report – Month 10** **2016/17**
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 January 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.

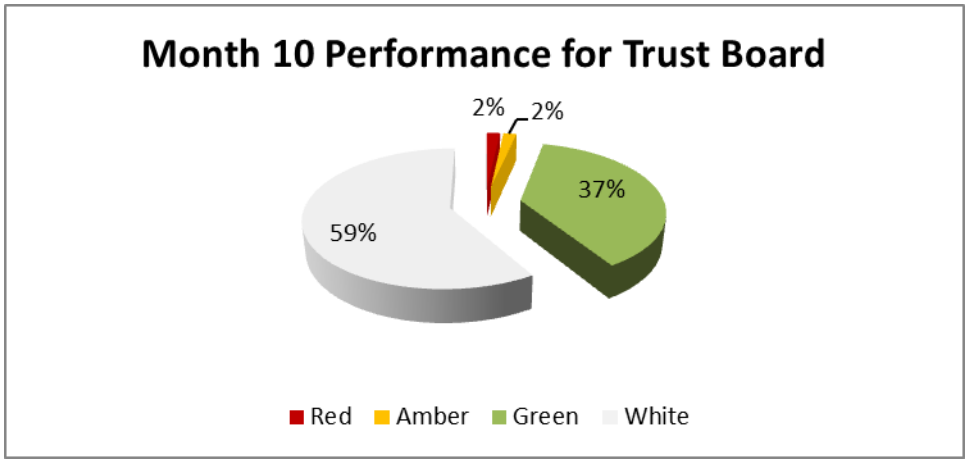
2 Executive Summary – Exception Reporting

The following performance highlights should be noted;

- 100% of patients referred to IAPT have been treated within 6 weeks of referral
- 95.7% of patients referred for treatment or intervention have been seen within 18 weeks
- 100% of patients have been assessed within 12 weeks of referral to the Memory Assessment Service
- 95.1% of patients on a Care Programme Approach (CPA) for at least 12 months have received a HONOS assessment within the last 12 months

In Month 10 there are 2 targets related metric 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 8	2	1	43	58	104
Exceptions-Month 9	1	1	45	63	110
Exceptions – Month 10	2	2	43	67	114



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 10

KPI Classification	Metric	Exec/Op Lead	Target	M9	M10	Trend	Commentary
NHSI	**Delayed Transfers of Care:** Delayed Transfers of Care (DTOC)	Dir of Ops	**5.4%**	**AMBER** **6.6%**	**RED** **9.0%**	↗	**9.0% at M10 from 6.6% at M9** AMH IP – 12.1% at M10 from 9.2% at M9 Learning Disabilities – 26.5% at M10 from 15.6% at M9 NOAP – 13.7% at M10 from 8.8% at M9 Delays in Adult IP pertain to health (151 days) due to placement, non-acute care, housing and choice of long term care. Delays in LD pertain to 26 days to health and 7 days for social care, due to placement. Delays in NOAP pertain to 100 days to health, 82 days to social care due to care package, placement and assessments, of which 34 days related to choice-awaiting decision).

KPI Classification	Metric	Exec/Op Lead	Target	M9	M10	Trend	Commentary
NHSI	**Safety Thermometer** Percentage of Harm Free Care	Dir of Nursing	**95%**	**GREEN** **100.0%**	**AMBER** **94.1%**	↘	**94.1% at M10 from 100% at M9** We have fallen below 95% this month due to the following: Ward 6 3 x no harm falls – all patients continue to be monitored by physiotherapy. Pharmacy are delivering medication and falls awareness training and matron is reviewing all fall incidents and closely monitoring particularly if there is any association with the use of medication. 1 x old UTI & 1 patient with a catheter. Ward 7 New UTI but patient does suffer from recurrent UTI's 1 x long standing catheter 2 x Pressure ulcers – reported to be unavoidable with learning around use of the assessment tool currently in use, escalation and the need for increasing staff knowledge. This will be covered in the planned physical health training due to start in April with all in-patient staff.

KPI Classification	Metric	Exec/Op Lead	Target	M9	M10	Trend	Commentary
NHSI	**Agency Spend:**	Dir of Workforce	**M10 2.8%**	**RED 8.4%**	**RED 7.0%**	↘	**7.0% at M10 from 8.4% at M9.** The Agency spend is broken down into 3 main areas as summarised below:
	Core Agency Spend			**2.9%**	**1.3%**	↘	**Core Agency – 1.3% at M10 from 2.9% at M9** This is agency spend incurred as part of normal trust operations.
	ROSE Agency Spend			**4.9%**	**5.0%**	↗	**ROSE – 5.0% at M10 from 4.9% at M9** Agency spends on ROSE remains below the planned trajectory. At month 9, year to date spend is £986k compared to planned expenditure of £1,091k.
	Ward 4 (EMI) Nurse Agency Spend			**0.6%**	**0.8%**	↗	**Ward 4 - 0.8% at M10 from 0.6% at M9** A detailed agency plan has previously been submitted to the Trust Board. **Rectification plan: received at Finance & Performance Committee and People and Cultural Development Committee.**

KPI Classification	Metric	Exec/Op Lead	Target	M9	M10	Trend	Commentary
Local Quality	**Readmissions:** Patients readmitted within 28 days of discharge	Dir of Ops	**7.5%**	**AMBER** **7.6%**	**AMBER** **7.6%**	↔	**7.6% at M10 the same as at M9** Adult IP – 11.3% at M10 from 10.3% at M9 OA IP – 0.0% at M10 the same as at M9 Neuro Rehab – 0.0% at M10 the same as at M9 Learning Disabilities – 0.0% at M10 the same as at M9 MH Rehab – 0.0% at M10 the same as at M9 All readmissions have been validated by the directorate. A new consultant is actively managing discharges; the wards are working closely with the Community and Home Treatment Team to ensure appropriate support is in place.

5 Recommendations

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

Trust Dashboard
Month: **Jan-17**

10
Key:-

North Staffordshire Combined Healthcare NHS
NHS Trust

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)

				2016-17												
	Metric	**Frequency**	**Target**	**April**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**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%	63.6%	75.0%	73.0%	75.0%	87.5%	73.3%	53.8%	75.0%	85.7%	90.0%			↗
National Quality	IAPT % of service users referred treated within 6 weeks of referral	Monthly	75%	99.0%	99.4%	98.5%	98.4%	100.0%	98.4%	99.1%	100.0%	100.0%	100.0%			↔
National Quality	IAPT % of service users referred treated within 18 weeks of referral	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			↔
National Quality	Zero tolerance RTT waits over 52 weeks for incomplete pathways	Monthly	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			↔
Local Quality	Compliance with 18 week waits (Referral to Treatment or Intervention) (Excluding ASD)	Monthly	92%	86.4%	87.2%	83.3%	87.4%	88.6%	90.4%	92.1%	92.0%	95.9%	95.7%			↘
Local Quality	AMH IP	Monthly	92%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			↔
Local Quality	AMH Community	Monthly	92%	95.8%	91.7%	89.9%	92.9%	95.1%	96.0%	95.9%	92.8%	95.5%	93.1%			↘
Local Quality	Substance Misuse	Monthly	92%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			↔
Local Quality	LD	Monthly	92%	96.8%	93.1%	100.0%	96.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			↔
Local Quality	Neuro and Old Age Psychiatry	Monthly	92%	93.6%	90.9%	94.0%	90.1%	95.0%	99.4%	98.2%	99.3%	98.9%	98.9%			↔
Local Quality	C&YP	Monthly	92%	77.6%	82.6%	74.6%	81.8%	77.7%	79.5%	82.8%	84.8%	93.2%	97.9%			↗
Local Quality	Patients will be assessed within 12 weeks of referral to the Memory Assessment service	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	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 ***ADJUSTED***	Monthly	95%	95.7%	95.0%	95.1%	94.9%	94.5%	93.6%	94.6%	95.9%	95.6%	96.5%			↗
Local Quality	RAID response to A&E referrals within 1 hour	Monthly	95%	83.0%	91.0%	90.0%	91.0%	89.0%	80.0%	93.0%	97.0%	100.0%	96.0%			↘
Local Quality	RAID: Referrals in FEAU, other portals and urgent wards seen within 4 hours	Monthly	90%	92.0%	94.0%	97.0%	96.0%	95.0%	100.0%	94.0%	94.0%	100.0%	100.0%			↔
Local Quality	RAID : All other referrals seen on same day or within 24 hours	Monthly	90%	83.0%	84.0%	94.0%	90.0%	93.0%	91.0%	91.0%	95.0%	99.0%	96.0%			↘
Local Quality	Percentage of inpatient admissions that have been gatekept by crisis resolution/ home treatment team	Monthly	95%	100.0%	100.0%	96.6%	100.0%	100.0%	98.4%	92.3%	97.7%	100.0%	100.0%			↔
Local Quality	Patients seen within 7 days of discharge from hospital	Monthly	90%	97.5%	96.8%	96.9%	100.0%	96.2%	97.4%	100.0%	92.3%	97.5%	95.8%			↘
Local Quality	IAPT : All Service Users contacted within 3 working days of referral	Monthly	95%	98.0%	98.0%	98.8%	98.9%	100.0%	98.8%	98.4%	98.6%	97.6%	99.5%			↗
Local Quality	IAPT : Service Users are assessed within 14 days of referral	Monthly	95%	99.7%	99.0%	99.4%	99.1%	97.0%	99.4%	99.2%	99.5%	98.6%	100.0%			↗
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%	1.1%	0.9%	0.8%	0.9%	0.9%	0.8%	0.7%	0.7%	0.9%	0.7%			↘
Local Reporting	S136 (Place of Safety) Assessments	Monthly	No Target	16.0	18.0	26.0	18.0	19.0	17.0	28.0	15.0	24.0	24.0			↔
Local Reporting	- Formal Admissions	Monthly	No Target	4.0	2.0	4.0	5.0	4.0	2.0	4.0	0.0	6.0	5.0			↘
Local Reporting	- Informal Admissions	Monthly	No Target	0.0	4.0	7.0	2.0	5.0	3.0	4.0	4.0	7.0	7.0			↔
Local Reporting	- Under 18 Yrs Old	Monthly	No Target	0.0	2.0	0.0	2.0	1.0	0.0	1.0	1.0	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%	95.1%	95.1%	94.2%	97.1%	94.1%	93.7%	95.7%	95.3%	95.8%	95.1%			↘
NHSI	AMH Community	Monthly	90%	96.6%	96.0%	95.5%	98.4%	95.4%	95.1%	95.7%	95.4%	95.9%	95.1%			↘
NHSI	Neuro and Old Age Psychiatry	Monthly	90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	92.9%	71.4%	83.3%	85.7%			↗
NHSI	Number of people seen for crisis assessment within 4 hours of referral	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			↔
NHSI	The proportion of those on Care Programme Approach (CPA) for at least 12mnths having formal review within 12mnths ***COMPLETED***	Monthly	95%	94.1%	92.4%	92.1%	92.0%	91.8%	91.4%	91.2%	89.4%	98.3%	95.8%			↘

	Metric	Frequency	Target	April	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Trend Rate
NHSI	AMH Community	Monthly	95%	94.3%	92.4%	92.2%	92.1%	91.9%	91.5%	91.4%	89.8%	98.7%	95.6%			↘
NHSI	LD	Monthly	95%	95.7%	95.7%	100.0%	100.0%	100.0%	100.0%	96.0%	83.3%	83.3%	92.3%			↗
NHSI	Neuro and Old Age Psychiatry	Monthly	95%	100.0%	100.0%	76.9%	72.7%	72.7%	63.6%	50.0%	50.0%	75.0%	76.9%			↗
NHSI	C&YP	Monthly	95%								100.0%	100.0%	100.0%			↔
NHSI	Mental health delayed transfers of care (target NHSI) (M9-5.7%, M10-5.4%, M11-5.2%, M12-4.9%)	Monthly	5.4%	6.2%	11.4%	10.3%	10.4%	9.7%	6.1%	5.6%	7.2%	6.6%	9.0%			↗
NHSI	AMH IP	Monthly	7.5%	7.0%	8.4%	5.4%	8.6%	8.0%	7.7%	6.0%	9.0%	9.2%	12.1%			↗
NHSI	LD	Monthly	7.5%	16.7%	10.8%	0.0%	0.0%	0.0%	4.2%	0.0%	11.5%	15.6%	26.5%			↗
NHSI	Neuro and Old Age Psychiatry	Monthly	7.5%	5.3%	17.8%	21.1%	16.9%	16.2%	11.4%	15.7%	10.5%	8.8%	13.7%			↗
Trust Measure	Early Intervention Services Total Caseload	Monthly	149	182.0	184.0	196.0	193.0	187.0	201.0	199.0	191.0	180.0	188.0			↗
NHSI Domain - Effective																
National Operational	The proportion of those on Care Programme Approach(CPA) receiving follow-up contact within 7 days of discharge	Monthly	95%	97.5%	96.8%	96.9%	100.0%	96.2%	97.4%	100.0%	92.3%	97.5%	95.8%			↘
Local Quality	Readmission rate (28 days). Percentage of patients readmitted within 28 days of discharge.	Monthly	7.5%	2.9%	2.4%	6.0%	2.5%	3.7%	8.3%	4.4%	1.6%	7.6%	7.6%			↔
Local Quality	Adult IP	Monthly	7.5%	10.1%	10.0%	9.4%	3.7%	5.1%	9.8%	5.9%	1.1%	10.3%	11.3%			↗
Local Quality	OA IP	Monthly	7.5%	0.0%	5.3%	0.0%	0.0%	0.0%	3.3%	0.0%	4.3%	0.0%	0.0%			↔
Local Quality	Neuro Rehab	Monthly	7.5%	0.0%	0.0%	0.0%	0.0%	0.0%	8.3%	0.0%	0.0%	0.0%	0.0%			↔
Local Quality	LD	Monthly	7.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			↔
Local Quality	MH Rehab	Monthly	7.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			↔
Local Quality	All Service Users to have a care plan in line with their needs % on CPA with a Care Plan	Monthly	95%	98.1%	97.5%	96.9%	97.5%	97.6%	97.2%	97.9%	98.2%	96.0%	96.1%			↗
Local Quality	AMH Community	Monthly	95%	98.6%	98.2%	97.9%	98.1%	97.6%	97.4%	98.2%	98.3%	96.4%	96.5%			↗
Local Quality	Substance Misuse	Monthly	95%													
Local Quality	LD	Monthly	95%	100.0%	94.2%	96.1%	100.0%	100.0%	100.0%	98.2%	98.2%	98.2%	98.2%			↔
Local Quality	Neuro and Old Age Psychiatry	Monthly	95%	69.2%	70.6%	50.0%	69.2%	81.8%	73.3%	70.8%	71.4%	71.8%	73.0%			↗
Local Quality	C&YP	Monthly	95%	100.0%	100.0%	100.0%	100.0%	83.3%	69.2%	100.0%	90.9%	100.0%	76.9%			↘
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%	N/A	N/A	0.0%	N/A	N/A	0.0%	N/A	N/A	2.0%	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	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Local Quality	IAPT: Local Work & Social Adjustment Scale (W&SAS) – more than 75% of Service Users showing improvement against Work & Social Adjustment Scale (W&SAS) after treatment.	Monthly	75%						0.0%	0.0%	0.0%	0.0%	0.0%			↔
Local Quality	IAPT: Local. Service Users are supported to access appropriate benefits and financial advice (75% of those identified as requiring support)	Quarterly	75%	N/A	N/A		N/A	N/A	0.0%	N/A	N/A	0.0%	N/A			↑↑↑↑↑↑
Local Quality	IAPT : Local. Service Users who are referred to employment support services (90% of suitable referrals)	Quarterly	90%	N/A	N/A		N/A	N/A	100.0%	N/A	N/A	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%	N/A	N/A	N/A	N/A	N/A	82.0%	N/A	N/A	N/A	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 appropoaitely supervised)	Quarterly	No Target	N/A	N/A	100.0%	N/A	N/A	100.0%	N/A	N/A	100.0%	N/A			
NHSI	% of clients in settled accommodation	Monthly	No Target	93.2%	93.3%	94.0%	92.8%	91.2%	86.6%	90.4%	85.7%	89.3%	89.3%			↔
NHSI Domain - Caring																
National Operational	Mixed Sex Accommodation Breach	Monthly	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			↔
NHSI	Staff FFT Percentage Recommended – Care	Quarterly	61.5%	N/A	N/A	69.1%	N/A	N/A	82.0%	N/A	N/A	N/A	N/A			
NHSI	Inpatient Scores from Friends and Family Test – % positive	Monthly	No Target	87.0%	70.0%	94.0%	82.0%	92.0%	87.0%	90.0%	94.0%	78.0%	94.0%			↗

	Metric	Frequency	Target	April	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Trend Rate
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	0.0	0.0	0.0	0.0	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%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	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%	N/A	N/A	100%	N/A	N/A	100.0%	N/A	N/A	100.0%	N/A			
Local Quality	Preventing Category 3 and 4 Avoidable Pressure Ulcer	Monthly	0	0.0	0.0	0.0	0.0	0.00	0.0	0.0	0.0	0.0	0.0			⇔
Local Quality	MRSA Screening (% of patients screened on admission)	Monthly	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			⇔
National Reporting	Cases of C Diff	Monthly	No Target	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			⇔
National Reporting	Cases of MRSA	Monthly	No Target	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			⇔
National Reporting	Never Events	Monthly	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			⇔
National Reporting	Number of Reported Serious Incidents	Monthly	No Target	3.0	4.0	4.0	7.0	9.0	9.0	2.0	3.0	9.0	6.0			↘
National Reporting	Total Incidents	Monthly	No Target	380.0	372.0	366.0	437.0	319.0	338.0	411.0	454.0	382.0	375.0			↘
National Reporting	Incidents leading to Moderate/Severe harm/death	Monthly	No Target	11.0	13.0	8.0	14.0	18.0	17.0	8.0	20.0	24.0	26.0			↗
Local Reporting	Cases of MSSA	Monthly	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			⇔
Local Reporting	Cases of E Coli	Monthly	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			⇔
Local Reporting	Medication Errors Total	Monthly	No Target	13.0	9.0	9.0	16.0	8.0	7.0	14.0	14.0	5.0	15.0			↗
Local Reporting	Medication Errors leading to Moderate/Severe harm/death	Monthly	No Target	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			⇔
Local Reporting	Mental health Absconds/AWOL – rate	Monthly	No Target	2.0	3.0	2.0	13.0	6.0	7.0	6.0	5.0	3.0	6.0			↗
Local Reporting	Safety Thermometer - Percentage Harm Free Care	Monthly	No Target	95%	95%	98%	96%	98%	100%	96%	98%	100%	0.9			↘
Local Reporting	Safety Thermometer - Percentage New Harm	Monthly	No Target	5.1%	1.7%	0.0%	2.0%	2.4%	0.0%	4.1%	2.0%	0.0%	0.0			↗
Local Reporting	Preventing Future Deaths Regulation 28	Monthly	No Target	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			⇔
Local Reporting	Proportion of patients who had recorded incidents of physical assault to them	Monthly	No Target	12.0	7.0	15.0	23.0	11.0	22.0	13.0	20.0	12.0	15.0			↗
Local Reporting	Proportion of patients who had recorded incidents of physical assault to them leading to Moderate/Severe harm/death	Monthly	No Target	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.00	0.0			⇔
Local Reporting	Suspected Suicides	Monthly	No Target	2.0	4.0	1.0	3.0	0.0	0.0	0.0	0.0	0.0	0.0			⇔
Local Reporting	Inpatient	Monthly	No Target	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			⇔
Local Reporting	Inpatient on home leave	Monthly	No Target	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			⇔
Local Reporting	Community Patient (in receipt)	Monthly	No Target	2.0	4.0	1.0	3.0	0.0	0.0	0.0	0.0	0.0	1.0			↗
Local Reporting	Community patient (in receipt) within 3 months of discharge from service	Monthly	No Target	0.0	0.0	0.0	0.0	0.0	0.0	0.0	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	0.0	0.0	0.0	0.0	0.0	0.0	0.0			⇔
Local Reporting	Unexpected Deaths	Monthly	No Target	3.0	4.0	1.0	7.0	5.0	3.0	2.0	3.0	3.0	4.0			↗
Local Reporting	Inpatient	Monthly	No Target	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			⇔
Local Reporting	Inpatient on home leave	Monthly	No Target	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			⇔
Local Reporting	Community Patient (in receipt)	Monthly	No Target	3.0	4.0	1.0	7.0	5.0	3.0	3.0	3.0	3.0	4.0			↗
Local Reporting	Community patient (in receipt) within 3 months of discharge from service	Monthly	No Target	0.0	0.0	0.0	0.0	0.0	0.0	0.0	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	0.0	0.0	0.0	0.0	0.0	0.0	0.0			⇔
Local Reporting	Use of Restraint: Number of patient restraints-prone	Monthly	No Target	3.0	1.0	5.0	5.0	0.0	3.0	0.0	1.0	0.0	2.0			↗
Local Reporting	Slips Trips & Falls	Monthly	No Target	59.0	36.0	34.0	30.0	51.0	29.0	32.0	33.0	33.0	55.0			↗
Local Reporting	Slips Trips & Falls leading to Moderate/Severe harm/death	Monthly	No Target	0.0	1.0	1.0	1.0	1.0	0.0	1.0	2.0	1.0	4.0			↗
Local Reporting	Self Harm Events: Inpatient	Monthly	No Target	64.0	61.0	80.0	98.0	57.0	51.0	120.0	167.0	94.0	71.0			↘
Local Reporting	Self Harm Events: Community	Monthly	No Target	3.0	8.0	9.0	12.0	9.0	13.0	7.0	14.0	9.0	15.0			↗
Local Reporting	Self-Harm Events leading to Moderate/Severe harm/death:Inpatient	Monthly	No Target	4.0	1.0	2.0	8.0	1.0	1.0	1.0	2.0	3.0	3.0			⇔
Local Reporting	Self-Harm Events leading to Moderate/Severe harm/death: Community	Monthly	No Target	2.0	3.0	2.0	6.0	5.0	5.0	1.0	5.0	3.0	4.0			↗
Local Reporting	DNA Rate Analysis by Directorate	Monthly	8.5%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.1%			↗

	Metric	Frequency	Target	April	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Trend Rate
Local Reporting	AMH IP	Monthly	6.8%	7.0%	6.0%	6.0%	8.0%	6.0%	6.0%	6.0%	6.0%	6.0%	1.1%			↘
Local Reporting	AMH Community	Monthly	8.3%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	6.1%			↘
Local Reporting	LD	Monthly	4.5%	2.0%	2.0%	2.0%	3.0%	2.0%	2.0%	2.0%	2.0%	3.0%	2.4%			↘
Local Reporting	NOAP	Monthly	5.9%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	5.0%	5.0%	5.0%	6.5%			↗
Local Reporting	C&YP	Monthly	8%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.9%			↗
Local Reporting	Average Length of Stay: North Staffs CCG	Monthly	No Target	27.1	31.5	36.3	24.9	26.9	28.4	23.9	51.1	42.1	29.5			↘
Local Reporting	Adult IP	Monthly	No Target	27.6	24.1	18.4	45.1	34.1	31.2	16.9	84.3	52.9	14.9			↘
Local Reporting	CYP	Monthly	No Target	5.1	44.3	4.3	10.9	14.6	11.4	5.6	10.2	22.1	0.0			↘
Local Reporting	NOAP	Monthly	No Target	50.8	38.3	43.1	33.7	62.4	47.9	68.3	113.5	65.3	73.8			↗
Local Reporting	Substance Misuse	Monthly	No Target	8.7	9.3	10.8	9.7	10.3	9.8	11.5	10.4	12.7	8.3			↘
Local Reporting	LD	Monthly	No Target	0.0	0.0	752.0	0.0	0.0	245.1	225.0	0.0	0.0	371.5			↗
Local Reporting	Average Length of Stay: Stoke CCG	Monthly	No Target	25.1	30.0	37.6	25.7	29.2	26.3	27.7	28.4	29.9	59.5			↗
Local Reporting	Adult IP	Monthly	No Target	27.0	23.0	39.6	27.4	46.0	26.6	32.5	34.7	36.2	82.0			↗
Local Reporting	CYP	Monthly	No Target	9.1	10.0	10.0	4.3	5.7	8.2	7.1	3.5	36.6	47.9			↗
Local Reporting	NOAP	Monthly	No Target	56.2	55.2	59.0	79.5	67.3	54.2	68.5	63.8	84.4	54.8			↘
Local Reporting	Substance Misuse	Monthly	No Target	9.5	11.3	11.2	7.9	9.7	9.0	9.3	15.0	6.0	7.9			↗
Local Reporting	LD	Monthly	No Target	0.0	760.0	704.0	0.0	0.0	560.3	32.0	0.0	0.0	2.7			↗
NHSI	Never Events Incidence Rate	Monthly	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			↔
NHSI	Proportion of reported patient safety incidents that are harmful	Monthly	2.97%	3.6%	2.7%	1.5%	3.4%	4.0%	0.0%	0.8%	0.5%	1.6%	1.7%			↗
NHSI	CAS alerts outstanding	Monthly	0	0	0	0	0	0	0	0	0	0	0			↔
NHSI	Safety Thermometer - Percentage of Harm Free Care	Monthly	95%	94.9%	94.8%	98.1%	96.1%	97.6%	100.0%	95.9%	98.0%	100.0%	94.1%			↘
NHSI	Safety Thermometer - Percentage of new harms	Monthly	No Target	5.1%	1.7%	0.0%	2.0%	2.4%	0%	4.1%	2.0%	0.0%	3.9%			↗
NHSI	Admissions to adult facilities of patients who are under 16 years of age	Monthly	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	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%	100.0%	100.0%	100.0%	100.0%	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%	100.0%	99.9%	99.9%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%			↔
National Quality	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users	Monthly	90%	95.0%	95.0%	95.0%	95.0%	95.0%	96.0%	96.0%	Published Feb 2017					↔
NHSI	Agency Spend (of total paybill) (M9-2.9%, M10-2.8%, M11-2.7%, M12-2.6%)	Monthly	2.8%	5.2%	6.0%	6.1%	4.8%	6.0%	6.4%	7.7%	7.4%	8.4%	7.0%			↘
NHSI	Nursing Agency Spend	Quarterly	£270k	N/A	N/A	309k	N/A	N/A	267K	N/A	N/A	186K	N/A			
NHSI	Locum Agency Spend	Quarterly	£225k	N/A	N/A	350k	N/A	N/A	361k	N/A	N/A	222K	N/A			
NHSI	Total Agency Spend	Quarterly	£687k	N/A	N/A	855k	N/A	N/A	940K	N/A	N/A	1,167K	N/A			
NHSI	Sickness Absence Percentage: Days lost	Monthly	5.1%	5.3%	5.4%	4.9%	5.1%	2.9%	2.7%	2.8%	4.3%	4.5%	3.3%			↘
NHSI	Corporate	Monthly	5.1%	4.1%	4.5%	3.4%	3.1%	2.1%	2.1%	2.2%	1.9%	1.9%	0.7%			↘
NHSI	AMH Community	Monthly	5.1%	5.9%	6.4%	5.5%	6.4%	3.6%	3.6%	3.1%	4.6%	5.1%	3.7%			↘
NHSI	AMH IP	Monthly	5.1%	7.4%	9.2%	8.8%	8.6%	3.4%	3.0%	3.2%	5.0%	4.9%	3.5%			↘
NHSI	C&YP	Monthly	5.1%	4.3%	2.9%	4.3%	2.7%	2.3%	1.7%	2.3%	5.1%	3.2%	1.9%			↘
NHSI	LD	Monthly	5.1%	4.1%	4.5%	4.9%	4.1%	3.8%	1.9%	2.1%	3.3%	3.3%	3.9%			↗
NHSI	Neuro and Old Age Psychiatry	Monthly	5.1%	4.8%	4.0%	3.1%	4.7%	2.3%	2.7%	3.6%	4.8%	6.8%	4.7%			↘
NHSI	Substance Misuse	Monthly	5.1%	6.6%	5.3%	4.9%	4.4%	2.6%	1.7%	1.9%	5.6%	5.5%	5.6%			↗
NHSI	Staff Turnover (FTE)	Monthly	No Target	0.7	0.7	0.8	1.1	1.5	1.9	0.6	0.9	1.4	1.2			↘
NHSI	Corporate	Monthly	No Target	0.0	0.5	0.4	0.9	4.4	3.2	0.2	1.7	0.7	1.4			↗
NHSI	AMH Community	Monthly	No Target	1.6	0.8	1.3	1.3	1.0	1.7	0.7	0.5	0.7	0.9			↗
NHSI	AMH IP	Monthly	No Target	0.0	0.4	0.7	1.4	0.6	0.7	0.7	0.7	0.6	1.0			↗
NHSI	C&YP	Monthly	No Target	0.0	0.0	1.5	0.7	0.7	1.4	0.0	1.6	0.0	3.0			↗
NHSI	LD	Monthly	No Target	0.0	0.0	1.0	1.0	0.0	1.0	0.0	1.1	2.2	1.7			↘
NHSI	Neuro and Old Age Psychiatry	Monthly	No Target	0.0	2.0	0.3	1.6	0.8	2.4	1.0	0.9	0.8	0.4			↘
NHSI	Substance Misuse	Monthly	No Target	0.2	0.0	0.0	0.0	3.3	3.1	1.8	0.0	0.0	1.8			↗
NHSI	MH FFT response rate	Monthly	No Target	38.0	20.0	16.0	28.0	17.7	23.0	20.0	22.0	12.0	45.0			↗
NHSI	Staff FFT response rate	Quarterly	No Target	N/A	N/A	72.0%	N/A	N/A	97.0%	N/A	N/A	N/A	N/A			
NHSI	Staff FFT Percentage Recommended – Work	Quarterly	No Target	N/A	N/A	46.0%	N/A	N/A	63.0%	N/A	N/A	N/A	N/A			
NHSI	Overall safe staffing fill rate	Monthly	No Target	99.0%	97.0%	93.3%	92.6%	94.8%	95.1%	95.8%	103.3%	105.3%	104.2%			↘
Local Reporting	Percentage compliance with data completeness identifiers for patients on CPA: In "employment" SHA measure >10% is performing	Monthly	10%	12.8%	12.2%	12.0%	12.0%	11.6%	11.0%	11.2%	10.8%	11.8%	11.9%			↗
Local Reporting	Percentage compliance with data completeness identifiers for patients on CPA; In "settled accommodation" - Monitor measure	Monthly	No Target	93.2%	93.3%	94.0%	92.8%	91.2%	86.6%	87.1%	85.7%	86.6%	86.7%			↗

	Metric	Frequency	Target	April	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Trend Rate
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	95.1%	95.1%	95.5%	98.4%	95.4%	95.1%	95.5%	95.6%	95.9%	95.5%			↘
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%	95.5%	100.0%	100.0%	97.3%	100.0%	100.0%	94.1%	90.1%	89.7%			↘
Other Indicators																
Local Quality	IAPT : number people referred for psychological therapies (Target tbc)	Monthly	0	462.0	443.0	471.0	444.0	431.0	442.0	434.0	496.0	332.0	458.0			↗
Local Quality	IAPT : Balance of Service Users mapped against the local population in terms of : Age	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	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%	100.0%	93.0%	100.0%	100.0%	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%	100.0%	100.0%	100.0%	100.0%	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%	100.0%	100.0%	100.0%	100.0%	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%	1.31%	1.22%	1.37%	1.27%	1.30%	1.24%	1.32%	1.37%	1.05%	1.3%			↗
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	369.0	343.0	385.0	359.0	366.0	349.0	372.0	385.0	296.0	358.0			↗
Local Quality	IAPT: The number of people who have completed treatment during the reporting quarter broken down by age	Monthly	No Target	219.0	178.0	209.0	192.0	216.0	190.0	211.0	220.0	172.0	168.0			↘
Local Quality	IAPT: The number of people who have completed treatment during the reporting quarter broken down by sex	Monthly	No Target	219.0	178.0	209.0	192.0	216.0	190.0	211.0	220.0	172.0	168.0			↘
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	116.0	95.0	124.0	104.0	114.0	110.0	123.0	139.0	103.0	107.0			↗
Local Quality	IAPT : The number of people who have completed treatment not at clinical caseness at treatment commencement	Monthly	No Target	15.0	9.0	6.0	12.0	12.0	6.0	10.0	6.0	9.0	7.0			↘
Local Quality	IAPT : The number of people moving off sick pay or ill-health related benefit	Monthly	No Target	44.0	22.0	25.0	23.0	30.0	26.0	24.0	26.0	20.0	28.0			↗
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	204.0	169.0	203.0	180.0	204.0	184.0	201.0	214.0	163.0	161.0			↘
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%	56.9%	56.2%	61.1%	57.8%	55.9%	59.8%	61.2%	65.0%	63.2%	66.5%			↗
Local Reporting	Bed Occupancy (Including Home Leave)	Monthly	No Target	92.0%	92.0%	93.0%	88.0%	97.0%	95.0%	99.0%	96.0%	93.2%	94.4%			↗
Local Reporting	AMH IP	Monthly	No Target	106.0%	103.0%	100.0%	100.0%	104.0%	103.0%	107.0%	102.0%	95.9%	93.7%			↘
Local Reporting	Substance Misuse	Monthly	No Target	86.0%	91.0%	92.0%	90.0%	83.0%	90.0%	91.0%	83.0%	76.6%	86.6%			↗
Local Reporting	LD	Monthly	No Target	64.0%	104.0%	90.0%	84.0%	80.0%	92.0%	80.0%	97.0%	100.0%	91.4%			↘
Local Reporting	Neuro	Monthly	No Target	99.0%	95.0%	99.0%	98.0%	99.0%	96.0%	109.0%	105.0%	96.1%	104.1%			↗
Local Reporting	Old Age Psychiatry	Monthly	No Target	94.0%	87.0%	82.0%	71.0%	93.0%	98.0%	100.0%	99.0%	97.0%	99.0%			↗
Local Reporting	C&YP	Monthly	No Target	63.0%	60.0%	69.0%	70.0%	79.0%	61.0%	60.0%	62.0%	51.0%	104.2%			↗
Local Reporting	Bed Occupancy (Excluding Home Leave)	Monthly	No Target	86.0%	85.0%	88.0%	84.0%	92.0%	89.0%	94.0%	93.0%	92.7%	90.8%			↘
Local Reporting	AMH IP	Monthly	No Target	98.0%	96.0%	97.0%	99.0%	102.0%	101.0%	101.0%	100.0%	92.0%	90.0%			↘
Local Reporting	Substance Misuse	Monthly	No Target	85.0%	87.0%	84.0%	86.0%	79.0%	73.0%	86.0%	79.0%	75.5%	84.4%			↗
Local Reporting	LD	Monthly	No Target	60.0%	103.0%	89.0%	84.0%	80.0%	92.0%	78.0%	96.0%	95.7%	91.4%			↘
Local Reporting	Neuro	Monthly	No Target	98.0%	89.0%	96.0%	88.0%	89.0%	70.0%	105.0%	98.0%	89.5%	101.9%			↗
Local Reporting	Old Age Psychiatry	Monthly	No Target	90.0%	82.0%	79.0%	69.0%	93.0%	94.0%	99.0%	98.0%	96.0%	96.0%			↔
Local Reporting	C&YP	Monthly	No Target	47.0%	42.0%	69.0%	70.0%	79.0%	61.0%	66.0%	62.0%	51.1%	77.7%			↗
Trust Measure	North Staffs Wellbeing Service (IAPT) - % of people treated within 6 weeks of referral	Monthly	75%	95.0%	97.0%	97.0%	95.0%	97.0%	95.0%	96.0%	99.0%	94.0%	96.0%			↗
Trust Measure	North Staffs Wellbeing Service (IAPT) - % of people treated within 18 weeks of referral	Monthly	95%	100.0%	99.0%	100.0%	96.0%	99.0%	99.0%	100.0%	99.0%	99.0%	100.0%			↗
Trust Measure	CAMHS (Excl. ASD) - Referral to Assessment within 18 weeks	Monthly	92%	77.6%	82.6%	74.6%	81.8%	77.7%	79.5%	82.8%	84.8%	93.2%	97.9%			↗
Trust Measure	CAMHS ASD - Referral to Assessment within 18 weeks (number) (Target M9 - 150, M10 - 125, M11 - 90, M12 - 45)	Monthly	125	N/A	N/A	N/A	N/A	N/A	N/A	230.0	217.0	166.0	154.0			↘
Trust Measure	CAMHS - Referral to Assessment within 4 weeks (M9 - 68%, M10-75%, M11 - 82%, M12 - 90%)	Monthly	75%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Trust Measure	CAMHS - Referral to Treatment (or 2nd contact) within 14 weeks of assessment (Target: M9 - 68%, M10 - 75%, M11-82%, M12-90%)	Monthly	75%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

	Metric	Frequency	Target	April	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Trend Rate
Trust Measure	CAMHS - Referral to Treatment (or 2nd contact) within 18 weeks (Target: M9-68%, M10-75%, M11-82%, M12-90%)	Monthly	75%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

Enclosure 10

REPORT TO Trust Board

Date of Meeting:	9 March 2017
Title of Report:	Raising Our Service Excellence (ROSE) Update
Presented by:	Tom Thornber, Director of Strategy and Development
Author of Report:	Ben Boyd, Associate Director of Transformation/EPR Programme Manager
Purpose / Intent of Report:	Assurance
Executive Summary:	A joint Stocktake review of ROSE project planning with NHS Digital, CSC and 3 NHS Trusts was held in January 2017, feedback was positive and the action plan from this is on track. The Executive Team have held 2 deep dive sessions with all Clinical Directorates reporting on their state of readiness. Of the 11 work-streams within the project; 6 are progressing, 4 are experiencing some manageable difficulties but 1 has required Executive escalation to resolve. Escalation was required to progress the integration work with UHNM on managing results from investigations (e.g. Pathology) in the EPR. A defect in the E prescribing system has been found which unresolved would mean staff could not reliably administer Depot injections in the community. Subsequently, the Trust will limit role out of E prescribing to inpatient wards in May with full system roll out to follow. CSC have committed to remedy the prescribing system issue by November 2017. The project is forecast to underspend by £100k, most of which is agency staff
Seen at SLT or **Exec** Meeting & date	SLT / EXEC (and date): Seen by Exec Lead : Director of Strategy and Development 1 March 2017 Document Version number:
Committee Approval / Review	• Quality Committee ☐ • Finance and Performance Committee ☐ • Audit Committee ☐ • People and Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐
Relationship with: *Board Assurance Framework* *Strategic Objectives*	1. To provide the highest quality services ☒ 2. Create a learning culture to continually improve. ☐ 3. Encourage, inspire and implement research & innovation at all levels. ☐ 4. Maximise and use our resources intelligently and efficiently. ☒ 5. Attract and inspire the best people to work here. ☒

	6. Continually improve our partnership working. ☒ 7. To enhance service user and carer involvement.☒ **Comments:**
Risk / Legal Implications: (Add Risk Register Ref [if applicable])	Corporate risk 747
Resource Implications: Funding source:	NHS Digital funding
Equality & Diversity Implications:	None
Recommendations:	Continue plans for Lorenzo Go Live on 13th May 2017

27/05/16 13:27 Form emailed to all SLT/Execs/PAs

North Staffordshire Combined Healthcare NHS

NHS Trust

ROSE EPR Implementation

March 2017

Tom Thornber – Director of Strategy and Development

safe • personalised • accessible • recovery focused

spar

our vision
To be a **high quality** health and social care provider that continuously improves **patient experience** and deploys its **resources** intelligently and efficiently

our values
valuing people as individuals
providing high quality **innovative care**
working together for better lives
openness and **honesty**
exceeding expectations

INVESTORS IN PEOPLE

Contents

1. Executive Summary

Background

Following the Trust decision to become a "Digital by Choice" organisation we have been successful in applying for national funding to procure a new EPR via NHS Digital.

The majority of Trust services will use this new system called Lorenzo; the implementation has been named the Raising Our Service Excellence or ROSE Project to reflect that this is more of a fundamental business change rather than an IT project.

This paper details evidence to assure Trust Board that the project is being planned and delivered effectively.

Joint Stocktake

A joint Stocktake review of ROSE project planning with NHS Digital, CSC and 3 NHS Trusts was held in January 2017, feedback was positive and the action plan from this is on track.

Directorate Deep Dive

The Executive Team have held 2 deep dive sessions with all Clinical Directorates reporting on their state of readiness.

At the most recent session on the 22nd February, it was noted that Learning Disability were performing especially well, NOAP and AMH Inpatients were also working well.

For AMH Community and CYP it was agreed more support was required from corporate services and targeted directly at team level.

Project Management

Of the 11 work-streams within the project; 6 are progressing, 4 are experiencing some manageable difficulties but 1 has required Executive escalation to resolve.

Escalation was required to progress the integration work with UHNM on managing results from investigations (e.g. Pathology) in the EPR.

A defect in the E prescribing system has been found which unresolved would mean staff could not reliably administer Depot injections in the community.

Subsequently, the Trust will limit role out of E prescribing to inpatient wards in May with full system roll out to follow.

CSC have committed to remedy the prescribing system issue by November 2017, this has been escalated CEO to CEO for assurance.

The project is forecast to underspend by £100k, most of which is agency staff.

Recommendation

There are no indications of any significant issues that would prevent Trust Board giving approval to Go Live as planned on the 13th May 2017.

2. Introduction

In April 2016 the Trust submitted a final business case to NHS Digital to fund a new Electronic Patient Record [EPR] to replace CHIPS. CHIPS had been the Trust PAS system for over 21 years and had been upgraded over the last 5 years with added functions to represent a basic EPR. However, it was no longer fit for purpose without significant redevelopment and investment.

NHS Digital offered NHS Trusts funding from a central source to support them in procuring and deploying an EPR. This was a continuance from previous national programmes "Connecting for Health" and "NPFIT" but is due to end in July 2017.

The Trust was successful in applying for this resource and therefore procuring the system chosen by NHS Digital called Lorenzo which is supplied by Computer Sciences Corporation, [CSC].

The business case planned for the project to commence in June 2016 and the system to be deployed in March 2017 but delays in final approval from NHS Digital and NHS Improvement resulted in the project only commencing fully by August. Subsequently the new date to "Go Live" with Lorenzo was changed to May 2017.

Whilst the majority of Trust services will utilise the Lorenzo system, some will use other EPR systems for contractual reasons. Integration between the systems is being developed but staff have indicated that the ability to view other systems is the initial priority and is being facilitated for Go Live.

Trust EPR systems		
Directorate	**EPR**	**Exceptions**
AMH Community	Lorenzo	Healthy Minds Stoke will use IAPTUS
AMH Inpatient	Lorenzo	
CYP	Lorenzo	
LD	Lorenzo	
NOAP	Lorenzo	
Substance Misuse	HALO & Nebula	

Following from the Trusts strategy to move to a "Digital by Choice" organisation, the project to transform our services from using paper records and analogue communication systems was named "ROSE" for Raising our Service Excellence. This was a deliberate effort to describe that we intend not just to change our EPR but to take the opportunity to improve how services operate.

This paper will concentrate on providing the Board assurance on the current state of planning and readiness for the Lorenzo element of ROSE.

3. Joint Stocktake

3.1 Stocktake review January 2017

In partnership with NHS Digital a stocktake review of the ROSE project was held on the 17th January. In addition to CSC as product suppliers, senior staff from 3 other NHS Trusts using Lorenzo were invited to review their NSCHT counterparts within ROSE.

Review staff included;

- Consultant Psychiatrist and clinical lead for Lorenzo
- Executive Directors
- Programme Managers
- Product specialists

Norfolk & Suffolk NHS Foundation Trust	Mental Health provider
Walsall Healthcare NHS Trust	Community services provider
Warrington and Halton Hospitals NHS Foundation Trust	Acute Hospital provider

3.2 Outcome of the review

Feedback from the reviewers was entirely positive, confirming the project was planning well for EPR implementation. Significantly, the learning points echoed the concerns of the ROSE team and also provided useful evidence in recent negotiations with commissioners.

Highlights and headlines

- Trust approach to review open and prepared for learning, recognition of potential for complacency, and conscious approach to mitigate
- Revised process of Gateway review framed well the mutual learning and network development
- Transformation program focused on service improvement over technical deployment
- Clear program management and reporting in place
- Balance score card well developed.
- Good consideration for go live planning
- Further development of containment stage and program capacity
- Engagement with stakeholders in place with particular reference to commissioners and implications of go live.
- Board assurance process in place and NHS Digital commitment to join February board presentation.
- Communications function developed with monitoring
- Appointment of CCIO and placed at centre of clinical engagement for ROSE
- Strong clinical engagement detailed and key clinical champions in place, who are likely to be resilient and supportive during the inevitable challenges
- Benefit realisation program linked to organisation cost improvement program

3.3 Action plan

The action plan is progressing well and can be seen at Appendix 1.

4. Directorate Deep Dive

4.1 Deep Dive aims & objectives

The intention of the deep dives is to challenge and support Clinical Directors and Heads of Directorate for all clinical services in regards their preparations and readiness for implementation. The session in February was chaired by CEO and in attendance were Medical Director, Director of Operations and Director of Workforce and Leadership. Also present were the Trusts Digital Strategy Lead, Chief Information Officer, Associate Director for Performance and senior ROSE Project Staff.

4.2 Deep Dive Content

Each Directorate presented on the following items;

- Training performance
- Superusers to support training
- Smartcard allocation
- Current levels of data completeness for EPR processes
- Configuration of teams, wards & clinics in Lorenzo
- New business processes – Ereferral, Care Pathways, Business Continuity Plans, Benefits
- New electronic processes – Referral management, Caseload allocation, MDT meetings, Reporting
- Equipment – PCs/Laptops, Scanners, Projectors/Screens

4.3 Outcome from Deep Dive

All Directorates have produced a detailed action plan to monitor progress. However, highlights from each were;

Deep dive highlights	
Directorate	Highlights
LD	Excellent preparations across most items, encouraged to consider themselves as an “exemplar” within the Trust
AMH Inpatients	Good preparations across most items, more work required on Benefits plan and staff training
AMH Community	Good preparation across some items and noted difficulties due to size of staffing numbers, more support required to engage teams with New Business Processes and Staff Training
NOAP	Good preparations across most items, more work required on New Electronic Processes and staff training
CYP	Good preparation across some items and noted difficulties due to recent adoption of EPR processes, more support required to engage teams with New Business Processes and Staff Training
Substance Misuse	Implemented HALO as EPR for inpatient services on 14th February. Noted current challenges and agreed focus would be on integration. Not required at next deep dive session

5. Project Management

5.1 Workstreams

There are 11 Project Workstreams. Each is RAG rated (Red/Amber/Green) to indicate current status in regards delivery against objectives.

ROSE Project Workstreams 28th February 2017		
Workstream	Objectives	RAG
Training	Minimum 85% of staff appropriately trained in use of Lorenzo for Go Live.	
Information & Reporting	Deliver minimal disruption to internal and external reporting on transfer to new system and build foundation for improved reporting capability	
Testing Business Processes	Ensure robust testing of standard operating procedures and identify issues for remedy	
Interfacing & Integration	Develop improved interoperability between internal and external electronic systems to increase effectiveness and efficiency	
Data Migration	Transfer data from legacy systems with minimal loss of data and build foundation for improved data quality	
Engagement & Communication	Ensure the whole Trust understands ROSE and is committed to the service transformation it enables	
Configuration	Develop Lorenzo programming to meet clinical requirements of the Trust	
EPMA	Replace paper systems for prescribing and administering medications with electronic processes that improve safety, effectiveness and efficiency	
Infrastructure	Build IT systems capability to accommodate a full EPR system and provide devices to support staff to utilise the system fully	
Service Management	Develop the Trust capability to manage a full EPR system and maintain effective functioning after initial implementation	
Business Change	Work with Clinical Directorates to adopt new ways of working within the EPR and capture these in Standard Operating Procedures	

5.2 Information & Reporting

All 3 Trusts during the recent Joint Stocktake stressed that there would almost certainly be some disruption to reporting processes for at least 6 months after Go Live. This is not unique to Lorenzo and is somewhat understandable, as one of the main motivations for seeking a new EPR system is to improve data collection and reporting. Therefore, any implementation will flush out long standing and often poorly understood data management issues.

However, there is no complacency and the ROSE Project is mitigating this risk through 3 approaches;

- Commissioner engagement – The Finance Director and Director of Strategy have met with the lead CCG commissioners for our Trust and secured their understanding of the potential disruption and agreement for a level of tolerance for 6 months post Go Live.
- Additional resources – 4 contractors have now been engaged to boost the capability and capacity of our Performance and Information team. They are completing a comprehensive review of existing systems and under the direction of our Associate Director for Performance developing a plan for new Trust requirements.
- Improved reporting capability – In addition to new technical capability offered by Lorenzo we have not forgotten that data quality through staff inputting is critical to success. To this end the ROSE project has focussed on engaging staff and managers in developing improved system content through Care Pathways and in using smarter processes to capture and code activity.

5.3 Interfacing and Integration

The ROSE project has taken a much more ambitious approach to integration between internal/external systems at the outset than any other Trust currently using Lorenzo.

Whilst this fits well with the work going on across the Local Health Economy, it is dependent on the co-operation of third parties and largely therefore beyond our direct control. Areas where the Trust is working to integrate systems are;

Systems Integration	
System	Summary
Safeguard	Incident reporting and Risk Management system. Working to avoid staff duplicating entries for incident reports and the patient record.
Docman	Electronic document system used by over 60% of local GPs. Utilising an existing HUB with CCGs to send Ward Discharge Summaries electronically directly from Lorenzo.
CCube	Currently provide our RIBS electronic case note archive. Developing the ability to view RIBS archive records directly from the patients Lorenzo record.
IPortal	UHNM Laboratory & Imaging services. Currently staff can view results by logging into a separate system. By integrating staff will receive and view results directly to the patients Lorenzo record.
Liquid Logic	Stoke Local Authority care management system due for implementation in Autumn 2017. Working to avoid staff who input data across both Trust and Social Care duplicating this in both systems
Care Director	Staffordshire Local Authority care management system due for implementation in Autumn 2017. Working to avoid staff who input data across both Trust and Social Care duplicating this in both systems

Whilst it is unlikely all of these interfaces will be completed in time for Go Live in May, good progress is being made between the Trust and the other system providers.

The exception to this is currently the UHNM Laboratory & Imaging services and hence the Red RAG rating. Despite persistent attempts since November 2015 by ROSE Project staff to complete this work and a clear plan to do so in place since April 2016 with Executive to Executive agreement, a senior manager in UHNM at the end of February blocked progress. The issue has now been escalated by our CEO to UHNM's Director of IM&T and CEO, we await the outcome.

5.4 EPMA

The Electronic Prescribing and Medicines Administration application in Lorenzo is a new development within the system. Only one NHS Trust (Sheffield Teaching Hospitals FT) has to date implemented EPMA and this as recently as December 2016. None of the mental health or community providers were directly involved in the "first of type" work carried by Sheffield and CSC.

As a result the system has been designed to work within an Acute Hospital environment. Within ROSE we have recruited 3 dedicated EPMA staff (a nurse prescriber, a pharmacist and a pharmacy technician) in anticipation of the amount of work that would be required to develop the system for our requirements.

However, even with significant support from CSC they have been unable to correct fundamental system deficits in time for our Go Live in May. There are 2 specific issues we have been unable to resolve that would not have been uncovered within an Acute Hospital environment. Namely;

- Administering depot injections in community settings

The system does not allow any flexibility for administering depot injections. Staff can only administer on the precise date that the system forward plans 2, 3 or 4 weekly over a 12 week period. It does not allow for the possibility that these dates may fall at weekends or public holidays nor does it allow staff to administer the injection if the patient presents a few days late or early. We have over 600 patients being maintained in the community who receive depot injections, the current system posed a significant risk that a patient may miss their injection and result in rapid deterioration and crisis.

- Prescribing leave medication

Patient leave is a common practice for inpatient settings in Mental Health but is rarely used in Acute Trusts. The leave prescribing system in Lorenzo is onerous to complete and would result in staff spending significantly more time in performing this task

The issue of depot injections has resulted in the Digital by Choice Programme Board supporting the recommendation of our CCIO Dr Hardeep Uppal that fully implementing EPMA in May would result in an unacceptable clinical safety issue. Therefore, the prescribing system will be implemented for inpatient units only in May.

CSC have committed to resolving these system issues as soon as possible and whilst some adjustment may be applied to improve Leave prescribing it was clear a more fundamental solution was required for depot injections. They plan to resolve this no later than November 2017.

To confirm this our CEO has written to CSC CEO requesting he formally honours this.

5.5 Service Management

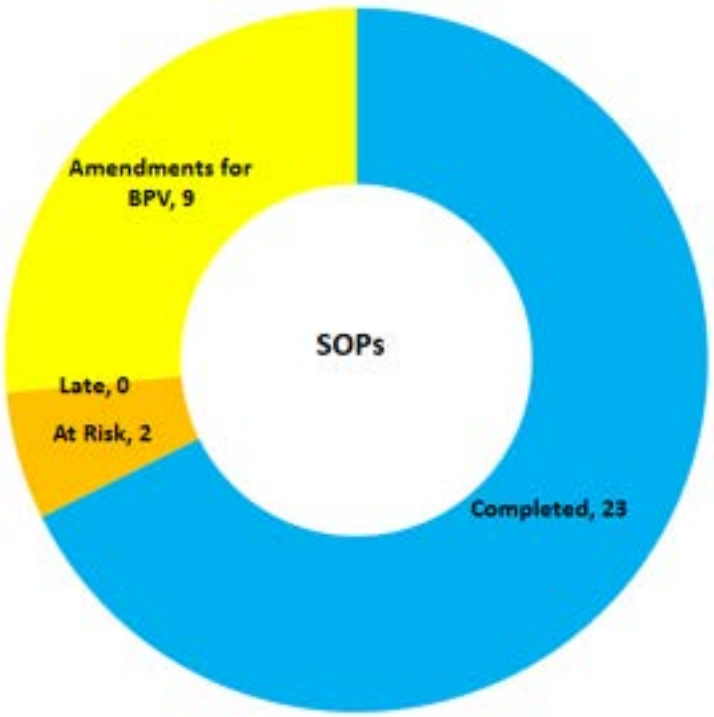
Whilst there are significant benefits to be gained by deploying a more advanced EPR such as Lorenzo there are also implications for system maintenance and support. This was captured in the benefits realisation allowing for additional costs to be incurred for regular testing of the system as quarterly updates are released year on year.

However, 12 months on it has become clear that this “disbenefit” was substantially underestimated and the benefits in paperless working did not account fully for the additional capability and capacity that will be required to fully exploit the system potential in future years.

The amber rating is therefore as a result of additional business planning that is being progressed to remedy this but as yet has not been approved by the Trust Business Development Committee.

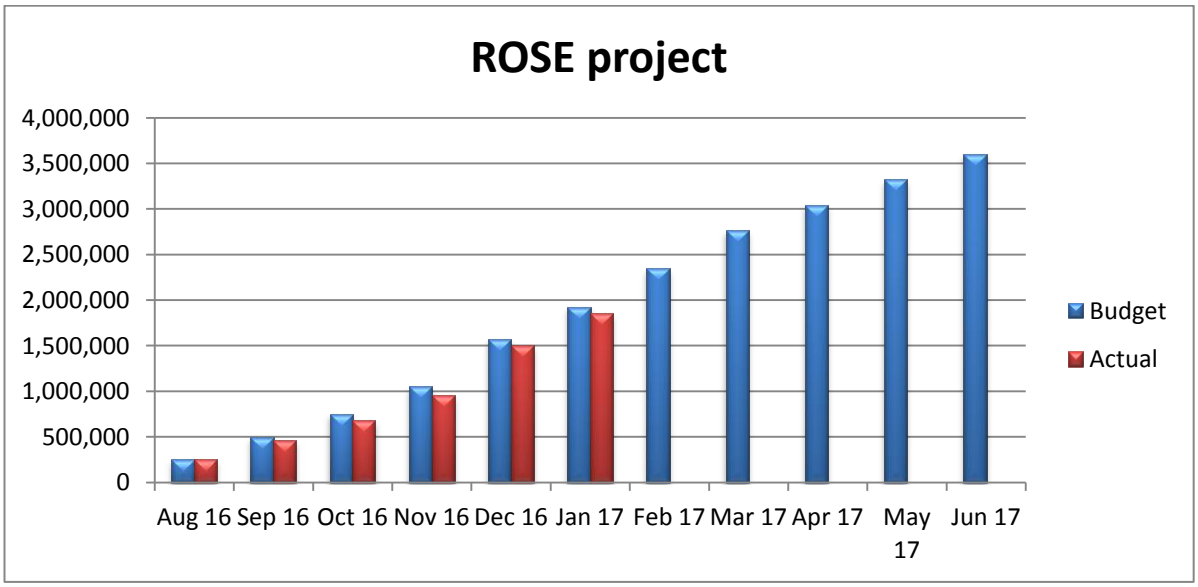
5.6 Business Change

This item has been rated as amber because the Standard Operating Procedures produced by the Business Change analysts have not been fully tested. This is due for completion at the end of March but is progressing well with the only at risk items due to EPMA difficulties described earlier.

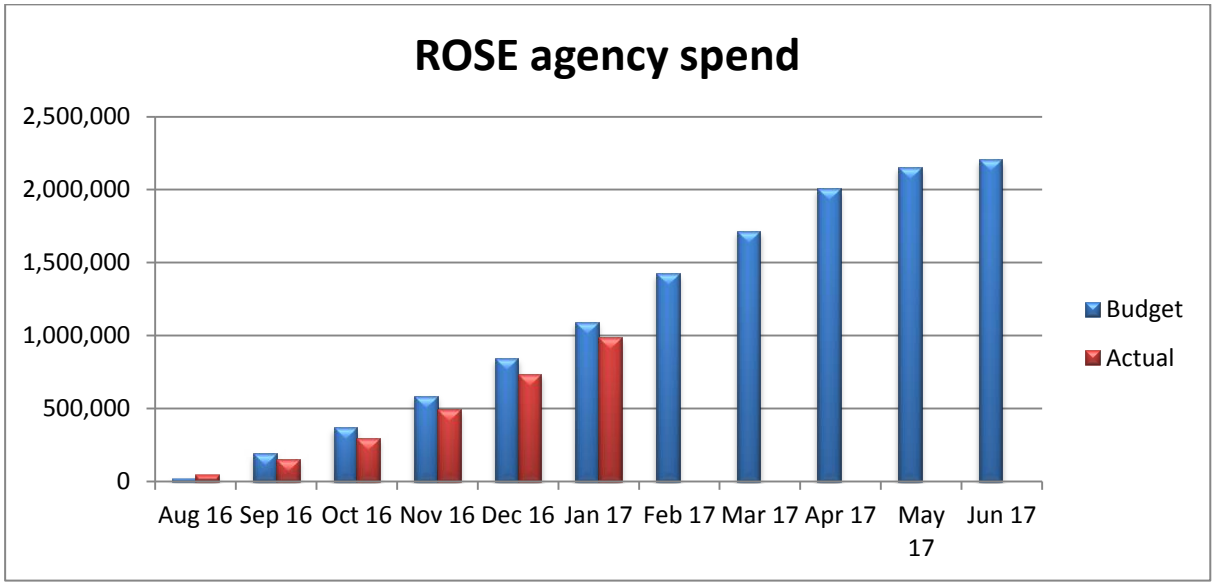


5.7 Finance

The project is currently forecast to underspend by £51k



This is predominantly a result of underspend on agency contractors.



6. Risk Register

The information and reporting risks have been expanded to reflect the learning from the Joint Stocktake where this was highlighted as an area for additional attention.

Ref	Risk	Impact	Likelihood	Gross risk	Impact	Likelihood	Residual risk
836	**(ROSE/Lorenzo) There is a risk that the Trust may fail to engage and deliver adequate reporting to meet commissioner requirements.**	4	4	16	4	3	12
831	**(ROSE/Lorenzo) There is a risk that the ROSE EPR project could fail to deliver on expected benefits due to poor planning and lack of stakeholder engagement.** Corporate Directorate Trust Risk 747	4	4	16	4	3	12
838	**ROSE/Lorenzo) There is a risk of failure to achieve the target of 85% attendance at training by May 2017 due to lack of staff Enagement.**	4	4	16	4	3	12
843	**(ROSE/Lorenzo) There is a risk that the Trust may be restricted in its ability to make significant system changes as Lorenzo is currently used by 15 other Trusts under national contract.**	4	4	16	4	3	12
902	**(ROSE/Lorenzo) There is a reputational risk to the Trust if we are unable to report performance, resulting in an adverse effect on the assurance and governance rating (NHSi segmentation)**	4	4	16	4	3	12

837	**(ROSE/Lorenzo) There is a risk of loss of patient information during data migration from CHIPS to Lorenzo which could compromise patient safety.**	4	4	16	4	3	12

7. Conclusion

At this point we do not recommend any change to the planned Go Live date of 13th May 2017.

Appendix 1

ROSE Joint Stocktake Action Plan at 28th February 2017

Activity	Outcome	Owner	By when	Criticality	Status 23rd Feb
CCIO review					
Ensure Trust documents in training environment for training.	*35 Trust documents used in training sessions.*	*Hardeep Uppal*	27th Feb	High	Completed
Review lesson plans.	*Review completed 19th Feb*	*Hardeep Uppal*	27th Feb	High	Completed
Review paper on service outages from Norfolk		*Hardeep Uppal*	7th April	High	Not due
Review capacity of CCIO in comparison with another Trust where there is combined CCIO/CSO role		*Hardeep Uppal*	13th May	Medium	Not due
CIO review					
Develop and recommend Service Management Plan to DbC Board	*Paper approved by Tom Thornber and on agenda for February Board*	*Dave Hewitt*	End of January	High	Completed
Improve relations with CSC, arrange meeting with Service Director, Head of Service & Service Management Team	*Meetings arranged 22nd Feb*	*Dave Hewitt*	End of February	Medium	Completed
Develop SOPS for service management and share with NHS Digital/ other Trusts		*Dave Hewitt*	End of April	Medium	Not due
Agree performance requirements for Service Management Group reporting		*Dave Hewitt*	End of April	Medium	Not due
Communication & Engagement review					
Assist in the Development and sign off Service Management Plan – to include super users and operational management and field experts.	*Paper approved and on agenda for February Board*	*Dawn Thompson*	End of January	High	Completed
Build into Super user sessions – requirements to cover Future state, Sop's etc.		*Dawn Thompson*	End of April	High	Not due
Hold Benefits sessions with Team Managers - BB	*All Directorates held sessions feedback at February Deep Dive*	*Ben Boyd*	End of February	High	Completed
Communications to update the Project Communications plan for immediate period and post-ROSE Day	*Assurance given at Project Board 14th Feb plan updated*	*Joe McCrea*	End of February	High	Completed

Activity	Outcome	Owner	By when	Criticality	Status 23rd Feb
Communication & Engagement review					
Arrange escalation meetings with CEO, Ops Director.	*Weekly meeting with Dir Ops & HoDs being arranged from 7th April with daily meetings for week commencing 15th May*	*Ben Boyd*	End of April	Medium	Not due
Keep in contact with Other Organisations:	*Visit to Warrington 16th Feb, Norfolk visiting Trust 21st Feb, Walsall visit 10th Mar*	*Ben Boyd*	End of February	Medium	Completed
Systems & Configuration review					
Compare Section 17 leave SOP and Test Scripts, Letters & CDC matrix with Norfolk	*Documents received and minor updates completed*	*Lesley Birkin*	End of January	Low	Completed
Test Systems issues - Letters & Team merge field	*System tested no issues*	*Lesley Birkin*	End of January	Medium	Completed
Raise awareness of Smartcard Lock box for wards and agree SAS process	*Temporary smartcards will be held by DSN who will be superusers*	*Lesley Birkin*	End of January	High	Completed
Consider the approach of Norfolk for removing wet signature. Review requirements for future state	*Wet signatures already minimal in Trust*	*Lesley Birkin*	End of February	Low	Completed
Cutover planning review					
Conclude Business Continuity Plans		*Colin Mooney*	7th April	High	Not due
Conclude floorwalker plans		*Colin Mooney*	7th April	High	Not due
N3 bandwidth – Review Before DRH Required	*CIO and HIS have re-checked bandwidth, plan to check base by base to confirm*	*Colin Mooney*	End of January	High	Completed
Complete Data Quality plan for post Go Live comparison	*Performance team have completed baseline report for Data Quality*	*Colin Mooney*	End of January	High	Completed
Ensure roles are developed for Smartcards	*16 roles identified to date*	*Colin Mooney*	7th April	High	Completed

Activity	Outcome	Owner	By when	Criticality	Status 23rd Feb
Benefits realisation review					
Complete benefit strategy document		*Ben Boyd*	7th April	Medium	Not due
Consider use of dependency mapping for forecasts	*Dependencies are being reviewed with HoDs and Finance leads*	*Ben Boyd*	End of February	Medium	Completed
Review benefits with Directorates	*All HoDs have engaged with detailed apportionment of BART*	*Ben Boyd*	End of February	Medium	Completed
Programme management review					
Incorporate "What's coming post Go Live"" into Directorate sessions planned	*Operational changes discussed at Directorate meetings with feedback at Deep dive session Feb*	*Ben Boyd*	End of January	Medium	Completed
Confirm commissioner response to Go Live paper	*Cheryl Hardisty has asked that CQUIn & NHS England reporting is prioritised, disruption for 6 months accepted for activity reports*	*Ben Boyd*	End of January	High	Completed
Review attendance at Super-user sessions planned for Jan/Feb	*Attendance excellent with over 100 superusers attending*	*Ben Boyd*	End of February	Medium	Completed

REPORT TO Trust Board

Enclosure 11

Date of Meeting:	9 March 2017
Title of Report:	People & Culture Development Committee Summary
Presented by:	Paul Draycott, Executive Director of Leadership and Workforce
Author of Report:	Rob Cragg, Deputy Director of People and Strategy
Purpose / Intent of Report:	Information and Assurance
Executive Summary:	The summary provides an overview of the People & Culture Committee meeting held on 27 February 2017
Seen at SLT or **Exec** Meeting & date	SLT / EXEC (and date): Not applicable Seen by Exec Lead : Executive Director of Leadership and Workforce Document Version number: N/A
Committee Approval / Review	• Quality Committee ☐ • Finance and Performance Committee ☐ • Audit Committee ☐ • People and Culture Development Committee ☒ • Charitable Funds Committee ☐ • Business Development Committee ☐
Relationship with: *Board Assurance Framework* *Strategic Objectives*	1. To provide the highest quality services ☒ 2. Create a learning culture to continually improve.☒ 3. Encourage, inspire and implement research at all levels.☐ 4. Maximise and use our resources intelligently and efficiently.☐ 5. Attract and inspire the best people to work here.☐ 6. Continually improve our partnership working. ☐ 7. To enhance service user and carer involvement.☐ **Comments:**
Risk / Legal Implications: (Add Risk Register Ref [if applicable])	N/A
Resource Implications: Funding source:	N/A
Equality & Diversity Implications:	N/A
Recommendations:	The Committee notes the detail of the summary for assurance purposes.

PEOPLE & CULTURE DEVELOPMENT COMMITTEE
SUMMARY TO TRUST BOARD
MONDAY 27th February 2017
9.30 – 11.30am

The meeting was chaired by Mr Sullivan.

1. POLICIES

The following Policies were agreed:

- Stress at Work
- Recognition Agreement
- New Starter's Relocation
- Resolution of Grievance and Dispute policy.

The effective partnership with staff side was acknowledged in provided constructive feedback to progress these policies.

Further negotiation and work is being undertaken and an extension of four months was agreed to

- On-Call policy
- Expenses/Subsistence manual.

An update was received that due to the current improvement and enhancements across all forms of communication media and channels, that more time four month extension was agreed for

- Media Policy
- Clinical Information Guidance

2. WORKFORCE SERVICE LINE PERFORMANCE AND INCIDENT INFORMATION

Workforce Directorate performance and incident information was received. The general areas of exception related to declines in supervision, mandatory training and PDR rates. Whilst there are competing demands at present with the ROSE training, all directorates are being tasked with their own rectification plans to reverse this decline. An update was received on the new learning management system will assist compliance in the future, as it automates reminders on personal compliance to the member of staff and manager.

3. RECTIFICATION PLANS

Linked to the previous item Rectification Plans for Supervision, Mandatory Training, Agency Spend and PDR were received by the Committee. The temporary staffing picture is skewed by ROSE and Ward 4 but at present the general temporary staffing picture is one of improvement.

4. BAF QUARTER 3 UPDATE

Performance against the BAF 2016/17 was reviewed and an update outlining progress for development of the 2017/18 BAF was received. Good progress in relation to recruitment, engagement, values and communications was highlighted.

5. BEHAVIOURS PROPOSAL

The Behaviours Framework was agreed by the Committee. The process by which the values and behaviours was detailed, as was the intended next steps was also supported. A presentation will be made to the March 2017 Board.

6. TOWARDS OUTSTANDING ENGAGEMENT

It was reported funds for the purchase of Go Engage was agreed. A timeline for implementation was discussed. The launch of the programme will occur at the Leadership Academy held on the 1st of March and it was agreed that this was timely to coincide with the release of this year's staff survey results. The Staff survey results will discussed fully at the next meeting. It was noted that the open significant changes to the 2015 survey were all positive ones.

7. HEALTH AND WELLBEING CQUIN

A detailed progress report against each of the 3 elements of the CQUIN: the flu campaign, the improved quality of food served on premises and health and well-being was received and agreed by the committee. Great progress was evident across all three sections. It is noted with regards to the nutrition aspect that Carillion, our PFI partners, have entered into a new contract from 6 February 2017 with the existing supplier to supply stock and manage the vending services, ensuring all stock within the vending machines meets the national CQUIN standards.

The health and well-being area remains the key area of focus as the criteria for gaining full CQUIN income were less clear for this element. It was noted that the trust staff survey results show an improvement in staff feeling managers are committed to this agenda.

8. FREEDOM TO SPEAK UP GUARDIAN

A summary of the work of our Freedom to Speak Up Guardian Jan Summerfield was received. Her tenure in this role is currently under review owing to increase demands on her substantive role owing to taking on the UHNM counselling contract. Kerry also mentioned that future reports to Trust Board will summarise the freedom to speak up and Dear Caroline activities together, to better portray potential patterns.

9. MANAGEMENT OF CHANGE

An update on progress made in the Substance Misuse management of change, against a backdrop of very challenge reductions in funding was received. It was further noted that despite the imposed trusts upon the trust and the management of change that the staff survey results for this team remain amongst the highest in the trust which is testimony to their management team and staff.

10. NHS PROTECT – VIOLENCE AGAINST STAFF ANNUAL FIGURES

A comprehensive report was received detailing an improving picture with regards violence against staff. Year on year improvement is now evident. Whilst the closure of Chebsy is a factor it is not the only area of improvement. More proactive planning and reporting have aided performance. There is no room for compliancy however as owing to recent acuity levels have again risen slightly in the last quarter. It was noted that the trust in the staff survey is now deemed as average in its performance in this area, as opposed to historic underperformance against peers.

11. WORKFORCE OD RISKS

Four areas of risk were reviewed all retained and remain at the same level.

12. PCD REPORTING GROUPS

Reports were received for information from Professional Leadership and Advisory Group and JNCC with no challenges or queries.

13. ANY OTHER BUSINESS

Patrick Sullivan was thanked for his service to the committee and his invaluable contribution was acknowledged. He thanked the committee for his time at chair having gained a lot of

knowledge and having enjoyed shared successes. Lorien Barber was introduced as the new chair and all wished her every success in the role.

14. DATE & TIME OF NEXT MEETING

Monday 2nd May 2017 at 9.30 am, Boardroom, Trust HQ, Lawton House, Trentham

REPORT TO TRUST BOARD

Enclosure 12

Date of Meeting:	9 March 2017
Title of Report:	Finance Report M10
Presented by:	Suzanne Robinson, Director of Finance and Performance
Author of Report:	Lisa Dodds
Purpose / Intent of Report:	Performance and monitoring
Executive Summary:	The report summarises the finance position at month 10
Seen at SLT or **Exec** Meeting & date	SLT/EXEC: Verbal report to Execs 7 Feb 2017 Seen by Exec Lead: Director of Finance and Performance Document Version number:
Committee Approval / Review	• Quality Committee ☐ • Finance and Performance Committee X • Audit Committee ☐ • People and Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐
Relationship with: *Board Assurance Framework* *Strategic Objectives*	1. To provide the highest quality services ☐ 2. Create a learning culture to continually improve.☐ 3. Encourage, inspire and implement research at all levels.☐ 4. Maximise and use our resources intelligently and efficiently. X 5. Attract and inspire the best people to work here.☐ 6. Continually improve our partnership working. ☐ 7. To enhance service user and carer involvement.☐ **Comments:**
Risk / Legal Implications: (Add Risk Register Ref [if applicable])	N/A
Resource Implications: Funding source:	N/A
Equality & Diversity Implications:	N/A
Recommendations:	Note the year to date performance of finance performance against the plan as at month 10 & approve forecast

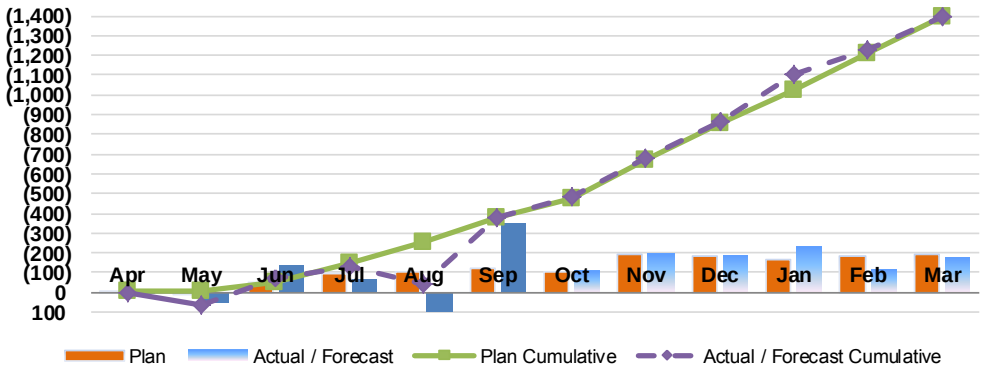
Financial Overview as at 31st January

ENCLOSURE 3

Income & Expenditure - Control Total (Surplus) / Deficit

£000	Plan	Actual	Var	%	RAG
YTD	(1,030)	(1,096)	(66)	(6)	G
FOT	(1,400)	(1,400)	0	0	G

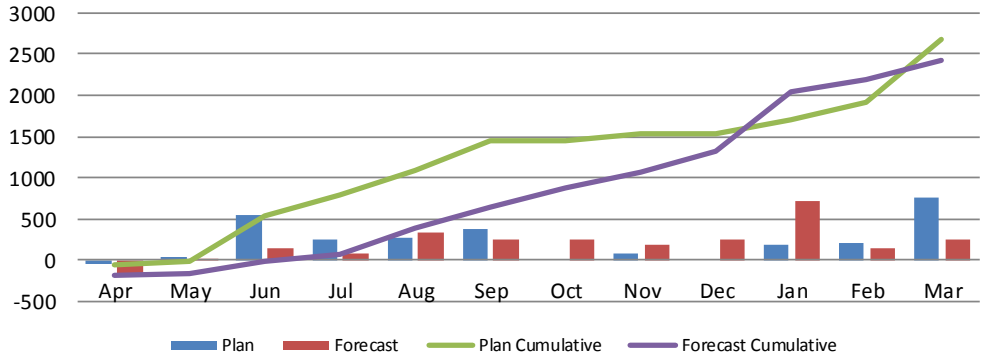
Retained (Surplus) / Deficit Run Rate 2016/17



Net Capital Expenditure

£000	Plan	Actual	Var	%	RAG
YTD	1,709	1,878	169	10	A
FOT	2,675	2,275	(400)	(15)	G

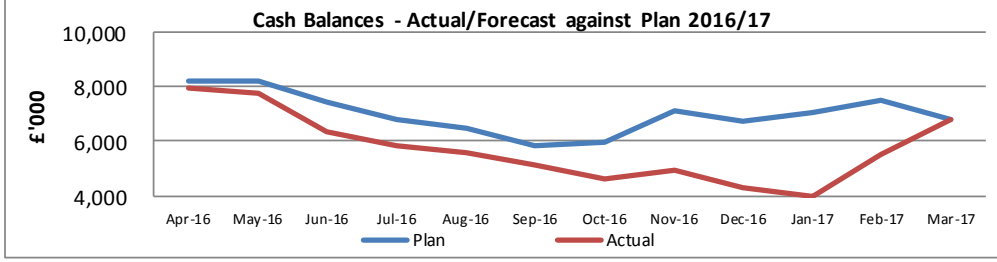
Net Capital Expenditure - Plan / Forecast 2016/17



Cash Balances

£000	Plan	Actual	Var	%	RAG
YTD	7,057	3,983	(3,074)	(77)	R
FOT	6,827	6,827	0	0	G

Cash Balances - Actual/Forecast against Plan 2016/17



Cost Improvement

£000	Plan	Actual	Var	%	RAG
Clinical	1,337	933	(404.9)	(30)	R
Corporate	614	233	(381.0)	(62)	R
Total	1,951	1,165	(786)	(40)	R

Use of Resource

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

Introduction

The Trust's original 2016/17 financial plan submission to NHS Improvement (NHSI) was a trading position of £0.343m surplus. The 'adjusted retained position' is a surplus of £0.9m (£0.343m plus IFRIC 12 adjustment of £0.557m). This is subject to the Trust delivering £2.6m worth of Cost Improvement Programmes (CIP). The Trust has since agreed with NHSI a revised control total surplus of £1.4m (£0.843m plus IFRIC 12 adjustment of £0.557m) which includes £0.5m from the Sustainability & Transformation Fund – Targeted element. As at month 10 the Trust is forecasting to achieve this revised control total.

1. Income & Expenditure (I&E) Performance

At month 10, the Trust's financial position was:

- The adjusted retained position was a planned surplus of £613k, with an actual surplus of £680k giving a favourable variance of £66k;
- The control total was a planned surplus of £1,030k, with an actual surplus of £1,096k, giving a favourable variance of £66k against plan.

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

		Month 10			Year to Date			Forecast		
Table 1: Statement of Comprehensive Income	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
Income	(80,519)	(6,993)	(6,808)	185	(66,607)	(66,802)	(196)	(80,519)	(80,902)	(383)
Pay	61,309	5,226	5,110	(116)	50,730	49,560	(1,170)	61,309	59,745	(1,564)
Non Pay	15,651	1,420	1,512	91	13,047	14,628	1,581	15,651	17,861	2,210
EBITDA (Surplus)/Deficit	**(3,559)**	**(347)**	**(186)**	**161**	**(2,829)**	**(2,614)**	**215**	**(3,559)**	**(3,296)**	**263**
Other Costs	2,659	222	(5)	(226)	2,215	1,934	(281)	2,659	2,396	(263)
Adjusted Retained Position (Surplus)/Deficit	**(900)**	**(126)**	**(191)**	**(66)**	**(613)**	**(680)**	**(66)**	**(900)**	**(900)**	**0**
Sustainability Transformation Funding	(500)	(42)	(42)	0	(417)	(417)	0	(500)	(500)	0
Control Total (Surplus)/Deficit	**(1,400)**	**(167)**	**(233)**	**(66)**	**(1,030)**	**(1,096)**	**(66)**	**(1,400)**	**(1,400)**	**0**

2. Income

The NHS Stoke-on-Trent CCG and NHS North Staffordshire CCG contracts are set on a block basis. The Trust is showing an over performance of £252k year to date across both CCG's in relation to RAID, this is non recurrent over performance in connection with the previous 24/7 service, Healthcare Facilitation and Children's services waiting list funding. At this stage the Trust is not expecting any additional income over-and-above the contract values agreed, with the exception of any further agreements in relation to other transformational schemes and income for patient related activity.

In 'Other NHS' Out of Area Treatments are showing an adverse variance of £10k as at month 10, and the Edward Myers Unit has sold fewer than their budgeted number of beds £128k. Darwin income is under performing against a plan of 15 beds by £174k year to date due to the delay in building works and delays to filling the now re-opened beds.

Other income is over performing mainly as a result of income received for 15/16 for Dyke Street carers income (£61k), ESCA drugs (£90k), dementia income (£87k), workforce (£60k).

Table 2 below shows the Trust's income by contract and other categories.

		Month 10			Year-to-Date			Forecast		
Table 2: Income	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
NHS Stoke-on-Trent CCG	(33,507)	(2,572)	(2,598)	(26)	(27,798)	(27,971)	(173)	(33,507)	(33,778)	(271)
NHS North Staffordshire CCG	(24,330)	(2,026)	(2,042)	(17)	(20,294)	(20,374)	(79)	(24,330)	(24,405)	(75)
Other NHS	(1,446)	(120)	(115)	5	(1,153)	(1,015)	138	(1,446)	(1,331)	115
Specialised Services	(2,577)	(250)	(193)	57	(2,078)	(1,904)	174	(2,577)	(2,380)	197
Stoke-on-Trent CC s75	(3,659)	(305)	(305)	0	(3,049)	(3,049)	0	(3,659)	(3,659)	0
Staffordshire CC s75	(1,062)	(88)	(88)	0	(885)	(880)	5	(1,062)	(1,056)	6
Stoke-on-Trent Public Health	(383)	(30)	15	45	(323)	(284)	39	(383)	(314)	69
Staffordshire Public Health	(613)	(51)	(51)	0	(511)	(524)	(13)	(613)	(627)	(14)
ADS/One Recovery	(2,527)	(211)	(211)	0	(2,106)	(2,106)	0	(2,527)	(2,527)	0
Other Non NHS	(77)	0	0	0	(77)	(77)	0	(77)	(77)	0
Total Clinical Income	**(70,181)**	**(5,652)**	**(5,588)**	**64**	**(58,274)**	**(58,184)**	**90**	**(70,181)**	**(70,154)**	**26**
Other Clinical Income	(10,338)	(1,341)	(1,220)	121	(8,333)	(8,619)	(286)	(10,338)	(10,748)	(410)
Total Income	**(80,519)**	**(6,993)**	**(6,808)**	**185**	**(66,607)**	**(66,802)**	**(196)**	**(80,519)**	**(80,902)**	**(383)**
Sustainability Transformation Funding	(500)	(42)	(42)	(0)	(417)	(417)	0	(500)	(500)	0
Total Income	**(81,019)**	**(7,035)**	**(6,850)**	**185**	**(67,023)**	**(67,219)**	**(196)**	**(81,019)**	**(81,402)**	**(383)**

3. Expenditure

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

		Month 10			Year to Date			Forecast		
Table 3: Expenditure	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
Medical	7,287	613	600	(13)	6,062	5,283	(779)	7,287	6,370	(917)
Nursing	27,605	2,313	2,224	(88)	22,975	22,380	(595)	27,605	26,974	(631)
Other Clinical	14,321	1,171	1,070	(101)	11,841	10,382	(1,459)	14,321	12,611	(1,710)
Non-Clinical	10,696	878	858	(20)	8,948	8,200	(748)	10,696	9,876	(820)
Non-NHS	1,875	272	358	86	1,338	3,316	1,977	1,875	4,157	2,282
Other	(476)	(21)	0	21	(434)	0	434	(476)	(243)	233
Total Pay	**61,309**	**5,226**	**5,110**	**(116)**	**50,730**	**49,560**	**(1,170)**	**61,309**	**59,745**	**(1,564)**
Drugs & Clinical Supplies	2,135	177	171	(5)	1,781	1,695	(87)	2,135	2,059	(76)
Establishment Costs	1,654	137	120	(17)	1,385	1,359	(26)	1,654	1,633	(21)
Premises Costs	1,780	150	140	(10)	1,495	1,581	86	1,780	1,912	132
Information Technology	435	53	72	19	330	437	107	435	558	123
Private Finance Initiative	3,923	327	343	16	3,269	3,410	141	3,923	4,091	168
Other	5,725	577	665	89	4,787	6,147	1,360	5,725	7,608	1,883
Total Non-Pay	**15,651**	**1,420**	**1,512**	**91**	**13,047**	**14,628**	**1,581**	**15,651**	**17,861**	**2,210**
Depreciation exc. IFRIC	1,348	112	(141)	(253)	1,123	812	(311)	1,348	927	(421)
Investment Revenue	(20)	(2)	(1)	1	(17)	(12)	5	(20)	(13)	7
Other Gains & (Losses)	0	0	0	0	0	0	0	0	0	0
LGPS	0	0	0	0	0	0	0	0	0	0
Finance Costs	1,327	111	111	0	1,106	1,106	0	1,327	1,327	0
Fixed Asset Impairment	0	0	1,173	1,173	0	1,173	1,173	0	1,173	1,173
Unwinding of Discounts	0	0	0	0	0	0	0	0	0	0
Dividends Payble on PDC	561	47	47	0	468	468	0	561	561	0
IFRIC Adjustment	(557)	(46)	(21)	25	(464)	(439)	25	(557)	(406)	151
Impairment Adjustment	0	0	(1,173)	(1,173)	0	(1,173)	(1,173)	0	(1,173)	(1,173)
Total Non-op. Costs	**2,659**	**222**	**(5)**	**(227)**	**2,215**	**1,934**	**(281)**	**2,659**	**2,396**	**(262)**
Total Expenditure	**79,619**	**6,867**	**6,617**	**(251)**	**65,993**	**66,123**	**129**	**79,619**	**80,002**	**383**

Key

Adjustments included in Control Total but excluded in the' below the line' reported position in line with accounting treatment

Impairment

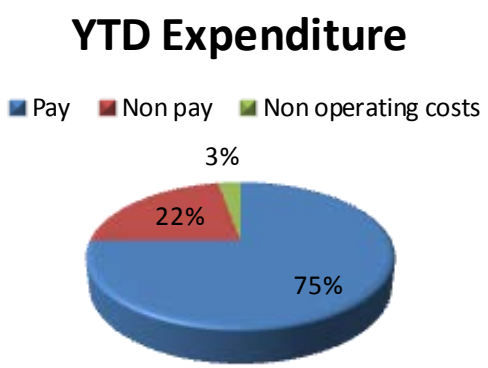
The impairment is a consequence of the revaluation of the Trust estate and is explained fully on page 5.

Pay

- There is a net underspend on pay of £1,170k year to date due to vacancies across the trust, particularly in Medical (£779k), Other Clinical (£1,459k) and Non Clinical (£748k) being backfilled with premium agency and bank.

- Agency expenditure of £3,316k year to date, with £986k being attributable to ROSE and £75k directly to the new EMI assessment unit on Ward 4. Excluding ROSE and ward 4 agency staffing, this is above the agency ceiling projected expenditure of £1,799k by £456k. This is mainly driven by Medical agency (£339k) above projection, nursing agency above projection (£98k).

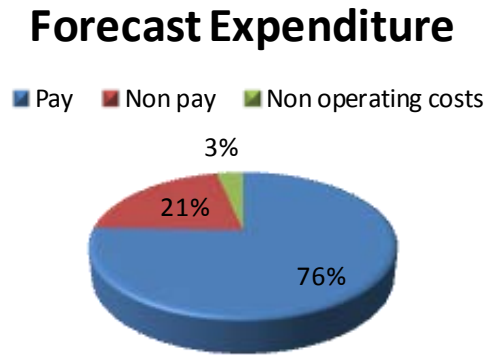
- A £434k expenditure target has been allocated to Directorates year to date, to reflect income lost due to bed reductions in Assessment and Treatment (£22k), construction works at Darwin (£208k) and disinvestment in the CHP/Propco contract (£204k), this will cease now the MOC is complete.



Non Pay

- Premises costs are overspent year to date due to minor works across clinical directorates (£86k). IT is overspend year to date due to Microsoft licences (£107k).

- 'Other' is overspending on consultancy spend and under performance of CIP party offset by profit on the sale of Bucknall.



Impairment

- During 2016/17, the 'Trust owned' properties and land have been revalued. There was a reduction in land value of £231k which was covered by the revaluation reserves. There was a reduction in the value of the buildings by £4,177k, of this £3,004k was covered by the revaluation reserve with the balance of £1,173k being impaired to the revenue position. Under the 2016/17 methodology of the Control Total calculation, this is added back to the position therefore not affecting the Trust's ability to hit the Control Total.

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	14,417	13,570	(847)	3,269	3,703	434	(1,526)	(1,543)	(17)	16,160	15,730	(430)
AMH Inpatients	5,296	5,751	455	164	347	183	0	(4)	(4)	5,460	6,094	634
Children's Services	4,932	4,939	7	601	657	56	(789)	(800)	(11)	4,744	4,796	52
Substance Misuse	2,582	2,490	(92)	655	557	(98)	(402)	(284)	119	2,835	2,763	(71)
Learning Disabilities	4,265	3,988	(277)	351	285	(67)	(46)	(43)	3	4,570	4,229	(341)
Neuro & Old Age Psychiatry	8,640	8,794	154	658	552	(107)	(781)	(813)	(32)	8,517	8,533	16
Corporate	10,599	10,029	(571)	9,564	10,462	898	(63,479)	(63,732)	(253)	(43,315)	(43,241)	74
Total	**50,730**	**49,560**	**(1,170)**	**15,263**	**16,563**	**1,300**	**(67,023)**	**(67,219)**	**(196)**	**(1,030)**	**(1,096)**	**(66)**

- AMH Community is underspent on pay. The staffing model has been reviewed in conjunction with the Meridian productivity review and CIP has been consequently transacted in month 10. Non pay is overspent due to the remaining un-transacted CIP target.

- AMH inpatient is overspent on pay mainly due to agency expenditure (£425k – Nursing £235k, Medical £173k), over and above vacancy underspend. Non pay over spends is driven by under achievement of CIP of £178k year to date.

- Learning Disabilities is underspent on pay due to vacancies, the majority of which relate to the first half of the year.

- Corporate pay is underspent due to a £266k NI rebate and Junior Doctor underspends on Workforce. Non pay is overspent due to unmet CIP and consultancy services.

5. Cost Improvement Programme

The trust target for the year is £2.6m, as reported to NHSI. This takes into account the requirement to deliver a £1.4m control surplus for 2016/17. Table 2 below shows the achievement by Directorate towards individual targets at month 10. The Trust wide CIP achievement is 60% at M10 compared to plan. Of the £1,165k achieved, 85% is recurrent.

Table 5 : CIP Delivery against Plan	Annual Target £000	YTD as at M10				FY Value Transacted at M10				Risk Adj Forecast	
		Plan £000	Actual £000	(Under) / Over Achievement £000	% Achievement	Non Recurrent £000	Recurrent £000	TOTAL £000	Variance to Annual Target £000	TOTAL £000	Variance to Annual Target £000
Clinical:											
AMH Inpatient	289	219	41	(178)	21%	0	57	57	(232)	57	(232)
AMH Community	707	514	146	(368)	28%	15	224	239	(468)	271	(436)
Children and Young persons	240	183	240	57	131%	0	288	288	48	288	48
Learning Disability	153	112	162	50	145%	20	170	190	37	190	37
Neuro and Old Age Psychiatry	410	309	344	35	111%	25	383	408	(2)	408	(2)
Total Clinical	**1,799**	**1,337**	**933**	**(405)**	**70%**	**60**	**1,121**	**1,181**	**(618)**	**1,213**	**(586)**
Corporate:											
Quality	33	23	31	8	135%	0	33	33	0	33	0
Operations	47	33	41	8	123%	0	49	49	2	49	2
CEO	71	59	0	(59)	0%	0	0	0	(71)	0	(71)
Strategy	38	32	0	(32)	0%	0	0	0	(38)	0	(38)
Finance	72	49	24	(25)	49%	0	29	29	(43)	29	(43)
MACE	49	40	0	(40)	0%	0	0	0	(49)	0	(49)
Workforce	145	104	137	33	132%	145	0	145	0	145	0
Central/Trustwide	347	273	0	(273)	0%	0	0	0	(347)	629	282
Total Corporate	**801**	**614**	**233**	**(381)**	**38%**	**145**	**111**	**256**	**(545)**	**885**	**84**
Total CIP	**2,600**	**1,951**	**1,165**	**(785)**	**60%**	**205**	**1,232**	**1,437**	**(1,163)**	**2,098**	**(502)**

- CIP for AMH Community has been transacted in M10 in relation to the Meridian work to the value of £391k recurrent FYE and £143k in year savings.
- Overachievement in Workforce and OD is due to phasing profiles of target and actual;
- The full year recurrent effect of schemes transacted is **£1,607k** or **62%** against the **£2.6m** target. The Revaluation Impact (COPR-16) will be transacted in M11 - £447k.

6. Statement of Financial Position

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

Table 6: SOFP	31/03/2015 £'000	31/03/2016 £'000	31/01/2017 £'000
Non-Current Assets			
Property, Plant & Equipment	30,863	30,726	27,488
Intangible Assets	52	17	66
Trade and Other Receivables	0	568	568
Long Term Receivables			2,139
Total Non-Current Assets	**30,915**	**31,311**	**30,261**
Current Assets			
Inventories	86	96	69
NHS Trade and Other Receivables	3,017	3,803	3,818
Non NHS Trade and Other Receivables			2,629
Cash & Cash Equivalents	6,805	7,903	3,983
Total Current Assets	**9,908**	**11,802**	**10,498**
Non-current assets held for sale	2,520	2,198	0
Total Assets	**43,343**	**45,311**	**40,760**
Current Liabilities			
NHS Trade Payables	(864)	(1,963)	(739)
Non-NHS Trade Payables	(4,374)	(4,899)	(6,006)
Non-NHS Trade Payables Capital			(120)
Borrowings	(351)	(346)	(346)
Provisions for Liabilities and charges	(1,682)	(1,298)	(784)
Total Current Liabilities	**(7,271)**	**(8,506)**	**(7,994)**
Net Current Assets / (Liabilities)	**5,157**	**5,494**	**2,504**
Total Assets less Current Liabilities	**36,072**	**36,805**	**32,766**
Non Current Liabilities			
Borrowings	(12,992)	(12,647)	(12,358)
Trade and Other Payables	(558)	0	0
Provisions for Liabilities and charges	(604)	(383)	(383)
Total Non-Current Liabilities	**(14,154)**	**(13,030)**	**(12,741)**
Total Assets Employed	**21,918**	**23,775**	**20,025**
Financed by Taxpayers' Equity			
Public Dividend Capital	7,998	7,648	7,648
Retained Earnings	814	1,800	2,632
Revaluation Reserve	13,664	13,759	9,176
Other Reserves	(558)	568	568
Total Taxpayers' Equity	**21,918**	**23,775**	**20,025**

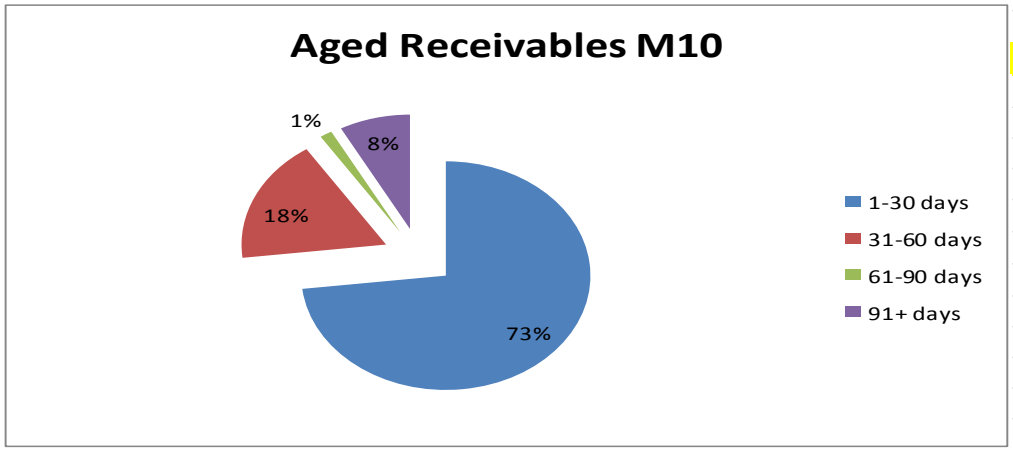
The Trust is owed £6,447k

- £3,151k is based on accruals (not yet invoiced) and relates in the main to Local Authority, ADS and prepayments.
- £3,296k in awaiting payment on invoice. (£2,411k within terms)

Of the £885k owed to the trust overdue by 31 Days or more routine credit control processes have been activated:

- £10k has been escalated to management /solicitors;
- £14k has been formally disputed through the M9 Agreement of Balances process;
- £861k 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	725	18	1	34	778
Receivables NHS	1,686	561	44	227	2,518
Payables Non NHS	773	51	9	103	936
Payables NHS	425	60	19	10	514

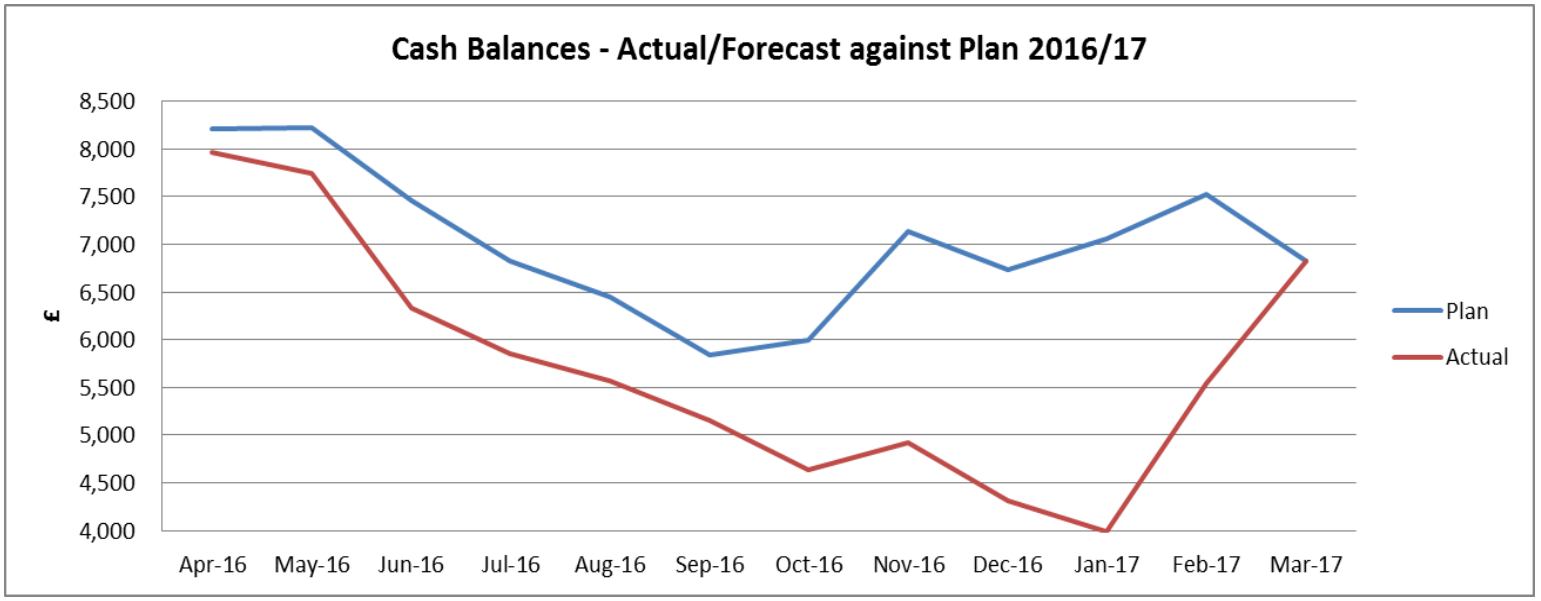


7. Cash Flow Statement

The Trust's cash position was £7.903m at 31 March 2016. The cash balance at 31st January has decreased to £3.983m due to an increase in the value of receivables.

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

Statement of Cash Flows	Apr-16 £'000	May-16 £'000	Jun-16 £'000	Jul-16 £'000	Aug-16 £'000	Sep-16 £'000	Oct-16 £'000	Nov-16 £'000	Dec-16 £'000	Jan-17 £'000	Feb-17 £'000	Mar-17 £'000	Annual £'000
Net Inflows/(Outflow) from Operating Activities	(59)	(207)	(1,304)	(218)	(82)	(130)	(245)	495	(332)	411	1,734	1,563	**1,626**
Net Inflows/(Outflow) from Investing Activities	142	24	(84)	(233)	(173)	(246)	(244)	(185)	(244)	(717)	(149)	(246)	**(2,355)**
Net Inflows/(Outflow) from Financing Activities	(29)	(29)	(29)	(29)	(29)	(29)	(29)	(29)	(28)	(29)	(29)	(29)	**(347)**
Net Increase/(Decrease)	**54**	**(212)**	**(1,417)**	**(480)**	**(284)**	**(405)**	**(518)**	**281**	**(604)**	**(335)**	**1,556**	**1,288**	**(1,076)**
Opening Cash & Cash Equivalents	**7,903**	**7,957**	**7,745**	**6,328**	**5,848**	**5,564**	**5,159**	**4,641**	**4,922**	**4,318**	**3,983**	**5,539**	
Closing Cash & Cash Equivalents	**7,957**	**7,745**	**6,328**	**5,848**	**5,564**	**5,159**	**4,641**	**4,922**	**4,318**	**3,983**	**5,539**	**6,827**	



This is an area of concern that is being closely monitored via Finance and Performance Committee where a full cash management strategy is being deployed.

8. Capital Expenditure

The Trust's permitted capital expenditure agreed within the 2016/17 plan is £2.675m. Table 8 below shows the planned capital expenditure for 2016/17 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**
Darwin Upgrade	704	723	574	(149)	704	739	35
Reduced Ligature Risks Darwin	0	0	0	0	0	0	0
A&T and Telford Unit Purchase	432	432	438	6	432	443	11
IOU beds	0		2		0	2	
Hazelhurst Unit Development	300	0	0	0	300	0	(300)
Psychiatric Intensive Care Unit	150	79	79	0	150	114	(36)
EPR	90	11	58		90	63	(27)
e-rostering	90	47	0		90	90	0
Information Technology	450	439	439	0	450	439	(11)
Enviromental Improvements	46	46	46	0	46	46	0
Equipment & Other Schemes	280	0	395	395	280	395	115
Backlog Maintenance	143				143	134	(9)
Be-Able	30				30	30	0
Go-Engage	28				28	28	0
Total Gross Capital Expenditure	**2,743**	**1,777**	**2,031**	**252**	**2,743**	**2,523**	**(220)**
Bucknall Hospital (Part)	(68)	(68)	(153)	(85)	(68)	(153)	(85)
Total Capital Receipts	**(68)**	**(68)**	**(153)**	**(85)**	**(68)**	**(153)**	**(85)**
Total Charge Against CRL	**2,675**	**1,709**	**1,878**	**167**	**2,675**	**2,370**	**(305)**

- Actual Cash proceeds for the sale of Bucknall was £153k in month 1, compared to anticipated proceeds of £68k per the Capital Plan submitted to the NHSI. The increased amount is due to planning overage improvement.

- The Hazelhurst development has been paused until the outcome of the CCG tender for A&E front of house is known.

- Work commenced on Darwin in May; the project has been delayed and with internal completion at the end of December and full completion of the project at the end of the financial year.

- The funds for A&T have been transferred in January; however there has been a delay in exchanging contracts due to NHSE disputing the legal fees.

9. Use of Resource Metrics

NHSI have introduced a Single Oversight Framework which comes into effect from 1st October. 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. **(Please note that the ratings are the reverse of the previous risk ratings with a rating of 4 indicating the most serious risk and 1 the least risk of financial failure.)**

Table 9: Use of Resource	Year to Date £'000	RAG Rating
Liquidity Ratio (days)		
Working Capital Balance	2,436	
Annual Operating Expenses	64,189	
Liquidity Ratio days	10	
Liquidity Ratio Metric	**1**	
Capital Servicing Capacity (times)		
Revenue Available for Debt Service	696	
Annual Debt Service	1,862	
Capital Servicing Capacity (times)	0.4	
Capital Servicing Capacity Metric	**4**	
I&E Margin		
Normalised Surplus/(Deficit)	1,096	
Total Income	67,219	
I&E Margin	0.02	
I&E Margin Rating	**1**	
I&E Margin Variance from Plan		
I&E Margin Variance	0.00	
I&E Margin Variance From Plan	**1**	
Agency Spend		
Providers Cap	1,799	
Agency Spend	3,316	
Agency %	84	
Agency Spend Metric	**4**	
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

Excluding the ROSE agency and ward 4, the Trust is **25%** above the providers cap at a risk rating of 3 on agency.

This would give the Trust an overall Use of Resources metric of 2.

10. 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 9, the Trust has under-performed against this target for the number of invoices, having paid 89% of the total number of invoices (95% for 2015/16), and paid 95% based on the value of invoices (97% for 2015/16). The main under performance on non-NHS invoices is in relation to timing delays on the authorisation of agency invoices. The Finance Team are investigating the issue with the Nurse Bank and the Wards. NHS invoices are seeing increases in payment time due to changes in the approval process with invoices being sent to the Directorates for approval.

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

	2015/16			2016/17 YTD		
Table 10: Better Payment Practice Code	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**
Number of Invoices						
Total Paid	441	13,114	13,555	442	12,000	12,442
Total Paid within Target	418	12,405	12,823	397	10,580	10,977
% Number of Invoices Paid	95%	95%	95%	90%	88%	88%
% Target	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**-0.2%**	**-0.4%**	**-0.4%**	**-5.2%**	**-6.8%**	**-6.8%**
Value of Invoices						
Total Value Paid (£000s)	6,477	19,136	25,613	6,255	24,016	30,271
Total Value Paid within Target (£000s)	6,429	18,393	24,822	5,806	22,913	28,719
% Value of Invoices Paid	99%	96%	97%	93%	95%	95%
% Target	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**4.3%**	**1.1%**	**1.9%**	**-2.2%**	**0.4%**	**-0.1%**

11. Recommendations

The Finance & Performance Committee is asked to:

Note

- Month 10 the trust reported a surplus of £1,096k against a plan of £1,030k surplus;
- CIP achievement in month 10 is 60% with an adverse variance of £786k from plan, with a recurrent transacted CIP of £1,607k (62%);
- The adverse cash position of the Trust as at 31st January 2017 with a balance of £3,983k;
- Capital receipts in month 10 are £2,031k compared to planned capital receipts of £1,777k; and
- Use of resource rating of 3.

Approve

- The month 10 position reported to NHSI
- The reported forecast outturn of £1.4m as per agreed Control total

Enclosure 13

REPORT TO TRUST BOARD

Date of Meeting:	9th March 2017
Title of Report:	Summary of the Finance and Performance Committee meeting held on 2nd March 2017
Presented by:	Tony Gadsby, Chair/Non-Executive Director
Author of Report:	Finance Department
Purpose / Intent of Report:	For assurance purposes
Executive Summary:	This report provides a high level summary of the key headlines from the Finance and Performance meetings held on 2nd February 2017. The full papers are available as required to members.
Seen at SLT or **Exec** Meeting & date	Chair of F&P Committee
Committee Approval / Review	• Summary of outputs from Finance and Performance Committees
Relationship with: *Board Assurance Framework* *Strategic Objectives*	• To provide the highest quality services • Create a learning culture to continually improve. • Encourage, inspire and implement research and innovation at all levels • Maximise and use our resources intelligently and efficiently • Attract and inspire the best people to work here • To continually improve our partnership working. • To enhance service user and carer involvement.
Risk / Legal Implications: (Add Risk Register Ref [if applicable])	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
Equality & Diversity Implications:	N/A
Recommendations:	• Receive for assurance purposes

Assurance Report to the Trust Board –

Thursday, 9th March 2017

Finance and Performance (F&P) Committee Report to the Trust Board – 2nd March 2017

This paper details the issues discussed at the Finance and Performance Committee meeting on 2nd March 2017. The meeting was quorate with minutes approved from the previous meeting on 2nd February 2017. Progress was reviewed and actions confirmed taken from previous meetings.

Director of Finance Update

The Committee received an update on;

- MH Investment Standard and the requirements for provider Chief Executives to counter sign a letter from CCGs confirming the investment in MH. A discussion took place regarding this. It was clarified that the Trust could only confirm the funding for the NSCHT contracted element which was actually decreasing from 17-18 to 18-19. The letter suggested an overall increase however this could not be validated by the Trust. Acknowledgement was made that the 5YFV had not been invested in in their entirety and the CCG would be working with STP to prioritise.

Finance Overview

The Committee received the financial update for month 10 (January) 2016/17.

At month 10, the Trust's retained budget plan was a surplus of £613k. The reported position was a surplus of £680k, giving a favourable variance of £66k against plan.

The YTD control total, which includes the STF funding, was a surplus of £862k against which we achieved a surplus of £863k. This includes the receipt of the STF funding to date of £375k.

The trust target for CIP for the year is £2.6m. This takes into account the requirement to deliver a £1,400k surplus for 2016/17. We have delivered £1,437k of this FYE and schemes have been identified to bridge the recurrent gap.

The Trust's cash position was £7,903k at 31st March 2016. The cash balance at 31st January 2017 has decreased to £3,983k due to an increase in the value of receivables.

The Trust's permitted capital expenditure agreed within the 2016/17 plan is £2.675m with forecast underspend of £305k against the CRL.

The Trust's overall Use of Resources (UoR) is calculated as a 3 which is largely due to the breach of the agency cap linked to the ROSE project and Ward 4.

Other Reports and Updates

The Committee received additional reports and verbal updates as follows:

- **Capital forecast**

The paper details the capital forecast. This has been reviewed at month 10 and the forecast has been revised to reflect that fact there will be some slippage. The revised forecast outturn is £2,370k giving an underspend of £305k. Committee supported this position.

- **Cost Improvement Programmes (CIP)**

At month 10, the trust is reporting achievement of £1,165k against a plan of £1,951k YTD, resulting in an underachievement of £785k. Non Recurrent achievement year to date is £205k.

The recurrent effect of schemes transacted is £1,607k or 62% against the £2.6m target. There is a further scheme £447k that will be transacted in month 11 taking the recurrent achievement over £2m.

- **Financial Recovery Plan**

The paper outline the worse, base and best case forecast outturns and the mitigations required to achieve our control total for the year. The financial gap has reduced each month as the mitigations have come to fruition. On this basis the committee supported the view to maintain the forecast to achieve the control recognising that there remains a primary risk of income expected from commissioners.

- **Agency report**

The report gave a detailed analysis of agency spend to date and the forecast outturn which is forecast a breach of the cap. The reasons for this are understood falling into the categories of core agency, ward 4 and ROSE.

- **Treasury and Cash Management Report**

The risk around the cash positon was highlighted with a detailed report on how this would be managed. There remains risk that the External Financing Limit (EFL) will not be met at 31st March 2017. This will continue to be monitored as a standing item going forward. The report outlined a clear understanding of the main creditors and the plan to recoup the cash position.

- **Budget setting**

A paper was presented to highlight the principles being applied to the 2017/18 budget setting process. This also highlighted some of the emerging costs pressures for 2017/18.

- **Performance Report**

VB updated that the performance management framework was being updated and in the future we can expect to see a new reporting of the performance data.

The PQMF report provided the committee with a summary of performance to the end of Month 10 (January 2017). Performance against NHSI metrics and key National Targets is included within the report. At Month 10 there are 3 metrics rated as Red and 1 as Amber. Only 3 of the metrics are contractual requirements and will therefore be reported to Board.

Discussion took place about the importance of the readmissions metrics and the delayed transfer of care in the context of the whole pathway. VB is leading on a pathway review with the directorate. This will incorporate benchmarking data.

The vacancy metrics requires further contextual commentary to provide the assurance for the committee. In future this be included within the report.

- **Rectification Plans**

The rectification plan for agency spend was received. This is in line with past reports and provided the necessary assurance.

- **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 top risks remain the same

- Ability to meet control total
- Delivery of CIP

The CIP risk had been downgraded for 16-17. Given the assurance the recovery plan had given it was agreed that the control total for 16-17 should also be downgraded.

.

- **The BAF**

For BAF for Q3 was received. Some metrics were highlighted that should be removed given achievement was beyond the trusts control; in particular relating to IT system development given the ROSE implementation and the capital schemes namely Hazelhurst and A&T Telford refurbishment.

- **Employees Travel Expenses Policy**

It was agreed the policy would be extended until June and then transferred to Workforce

- **One Recovery**

The paper was received and work involved acknowledged.

- **For Information**
  - Market Assessment / Tenders
  - Business Development Group Committee minutes received
  - Finance and Activity Attendance 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

REPORT TO TRUST BOARD

Date of Meeting:	9th March 2017
Title of Report:	Proposed New Trust Behaviour Framework
Presented by:	Rob Cragg
Author of Report:	Neil Clarke
Purpose / Intent of Report:	Sign off of proposed behaviour framework to support Trust Values
Executive Summary:	Engagement activity with hundreds of staff, service users and carers. Behaviours framework created using Q-Sort methodology to establish clear trends for desired behaviours. Behaviour framework created, language simplified to create increased clarity. Further changes made following feedback at Exec's and PCD.
Seen at SLT or **Exec** Meeting & date	SLT / EXEC (and date): 21.02.17 Approved by Exec Lead : Caroline Donovan Document Version number: Proposed behaviours framework report - Feb 2017 FINAL
Committee Approval / Review	• Quality Committee ☐ • Finance and Performance Committee ☐ • Audit Committee ☐ • People and Culture Development Committee ☒ • Charitable Funds Committee ☐ • Business Development Committee ☐
Relationship with: *Board Assurance Framework* *Strategic Objectives*	1. To provide the highest quality services ☒ 2. Create a learning culture to continually improve.☒ 3. Encourage, inspire and implement research & innovation at all levels.☒ 4. Maximise and use our resources intelligently and efficiently.☒ 5. Attract and inspire the best people to work here.☒ 6. Continually improve our partnership working. ☒ 7. To enhance service user and carer involvement.☒ **Comments:** By nature of Trust values and the proposed behaviour framework, the intended impact will span all strategic objectives
Risk / Legal Implications: (Add Risk Register Ref [if applicable])	N/A
Resource Implications: Funding source:	N/A

Equality & Diversity Implications:	N/A
Recommendations:	Support sign off of proposed behaviour framework

NHS
North Staffordshire
Combined Healthcare
NHS Trust

Proposed Behaviour Framework

Rob Cragg

PROUD TO CARE

spar

Our journey

- Creating Trust values – Proud to CARE
- Created behaviour statements from engagement with 100's of staff, service users and carers
- Carried our Q-Sort exercises with over 170 people – Full range/cross section (over 86hrs of engagement activity)
- Reached statistical significance
- Identified clear themes through scoring and analysis
- Create draft behaviour framework using plain English and easy to understand statements

Care

- Listening to others, considering their feelings and needs
- Respecting and being responsive towards diversity and difference
- Pulling together, helping colleagues out when their priorities are greater than your own
- Recognising your own stresses and limitations and developing ways to cope with them
- Promoting and encouraging healthy living and recovery with service users and colleagues

Approachable

- Communicating with everyone openly, clearly and appropriately
- Keeping a positive and calm manner when faced with challenging situations
- Providing and welcoming feedback to support good behaviour and challenge inappropriate behaviour
- Taking people's understanding, viewpoints and needs into account when making decisions
- Being friendly and welcoming, making eye contact, giving your name and smiling where appropriate

Responsible

- Always putting service users' first, maintaining professional integrity, confidentiality, following correct procedures, adhering to standards and adopting best practice
- Holding ourselves and others to account to prioritise our workload in delivering high quality care in a timely manner
- Developing our self-awareness by seeking feedback from others, reflecting and acting upon it
- Making the most effective use of available resources to provide best value at all times
- Take full responsibility for patients you come in contact with, providing all care appropriate to your level of training, ensuring any other needs are properly co-ordinated

Excellent

- Encouraging team problem-solving to create better outcomes and solutions
- Being flexible and responsive, changing our own practice and behaviours to ensure we continually improve
- Inspiring and recognising others, so they feel they want to strive to improve or do something different
- Welcoming and being prepared to take acceptable risk to innovate or provide safe patient-centred care
- Looking outside the trust to compare our performance, develop relationships and share learning to improve ways of working

Next steps…

- Promotional video byte – Emotive, provocative, real life scenes of staff demonstrating our behaviours
- E-learning module, linking Vision, Values, SPAR, strategic objectives (Towards Outstanding) and new appraisal documentation
- Development of team toolkit
- Embedding workshop;
  - Values-based recruitment
  - Induction
  - Appraisal/PDR
  - Training courses
  - HR policies and process
  - Reach awards

Proposed New Trust Behaviour Framework

Purpose:
To gain sign off and support for roll out of the new proposed Trust behaviour framework

Background:
Our new Trust values, "Proud to CARE" (Compassionate, Approachable, Responsible and Excellent) were created through 2 LiA waves utilising feedback through engagement with several hundred members of staff, services users and carers. Development of a Trust behaviours framework to underpin and support these values was placed on hold until after the CCQ visit in September. A behaviours framework provides a more detailed layer providing clarification of what this means to staff and how we behave and live our values.

Approach:
A scientific research based approach using Q-Sort statements was used, which turns qualitative data into quantitative data. 45 behaviours statements were created following views gathered through previous LiA Values engagement work. Exercises were carried out with nearly 180 staff and service users, equating to over 90 engagement hours. This group was reflective of band, profession, clinical/non-clinical staff and all directorates, as can be seen below:

Directorate	Staff completing exercise	No. of clinical staff
AMHC	47 Staff	37
AMHI	24 staff	23
Corporate	15 staff	0
CYP	16 staff	15
LD	20 staff	17
NOAP	27 staff	26
Sub Misuse	7 staff	7
Miscellaneous	14 staff	Unknown

Band	No.
B2	1
B3	32
B4	24
B5	28
B6	17
B7	16
B8a-d	10
Con/Doc	12
Apprentice	1
Exec/SLT	18
Misc.	3

Each behaviour is mapped by individuals against a quasi-normal distribution curve with a score assigned depending on where the individual places each behaviour statement.

This heavily involved process of engagement has already helped to create an interest and awareness in the upcoming behaviour framework, gaining buy-in.

Trends
Regular interim analysis has taken place throughout the exercise to gauge variance in results and to identify any possible trends. The first interim analysis found a set of behaviours that seemed to score higher and as more exercises have been completed and further interim analysis taken place, the scores for these behaviours have further strengthened, simply broadened the gap with other lesser preferred behaviours. It is clear we have reached statistical significance and asking more staff will simply further strengthen the existing popular behaviours identified.

Creating the behaviour framework:
A final analysis was carried out and 6 behaviours per value were selected for the behaviours framework, which were further condensed to 5 behaviours per value. A process of reviewing, merging and simplifying language took place to ensure the proposed behaviour framework is clear, using plain English so it is easy to understand by all. The key themes and strongest scoring behaviours have all been included.

The proposed behaviour framework can be seen in appendix 1.

Next steps:
Following sign-off and launch of the new trust behaviours framework, a number of embedding activities will take place, including;

- Roll out of communications strategy, including; In-house produced 60 second video bytes hosted on the Trust You-Tube channel and built into e-learning packages to demonstrate clear alignment and positioning with Trust vision, strategic objectives and quality priorities, posters (In CQC celebration style), creation of Values and Behaviours strand within the new proposed 'Towards Outstanding' brand along with dedicated twitter profile **@Combined People**.
- Creating a manager/team toolkit – Structure to hold team discussions about what this means to them, examples of good practice to educate and hold others to account.
- Building a behaviours section into the PDR/Appraisal process, and including a section specifically on values/behaviours within the new appraisal training
- Including a section into corporate induction for new staff entering the Trust, explaining the importance of values and behaviours to how we do things here at NSCHT
- Reviewing HR policies to ensure values and behaviours are aligned and referenced
- Staff recognition 'REACH' awards category dedicated to staff living our values ad being recognised for such
- Including values-based interviewing into our recruitment process

Conclusion:
The proposed behaviour framework has been created following an in-depth and fully inclusive process and will provide a solid base to enact positive changes in culture and performance towards our new vision, "To be outstanding; in all we do and how we do it"

Recommendation:
To support the sign off and promotion of the new Trust behaviours framework

END OF REPORT

Appendix 1: Proposed behaviour framework:

Care

- Listening to others, considering their feelings and needs
- Respecting and being responsive towards diversity and difference
- Pulling together, helping colleagues out when their priorities are greater than your own
- Recognising your own stresses and limitations and developing ways to cope with them
- Promoting and encouraging healthy living and recovery with service users and colleagues

Approachable

- Communicating with everyone openly, clearly and appropriately
- Keeping a positive and calm manner when faced with challenging situations
- Providing and welcoming feedback to support good behaviour and challenge inappropriate behaviour
- Taking people's understanding, viewpoints and needs into account when making decisions
- Being friendly and welcoming, making eye contact, giving your name and smiling where appropriate

Responsible

- Always putting service users' first, maintaining professional integrity, confidentiality, following correct procedures, adhering to standards and adopting best practice
- Holding ourselves and others to account to prioritise our workload in delivering high quality care in a timely manner
- Developing our self-awareness by seeking feedback from others, reflecting and acting upon it
- Making the most effective use of available resources to provide best value at all times
- Take full responsibility for patients you come in contact with, providing all care appropriate to your level of training, ensuring any other needs are properly co-ordinated

Excellent

- Encouraging team problem-solving to create better outcomes and solutions
- Being flexible and responsive, changing our own practice and behaviours to ensure we continually improve
- Inspiring and recognising others, so they feel they want to strive to improve or do something different
- Welcoming and being prepared to take acceptable risk to innovate or provide safe patient-centred care
- Looking outside the trust to compare our performance, develop relationships and share learning to improve ways of working