North Staffordshire Combined Healthcare NHS
NHS Trust

MEETING OF THE TRUST BOARD

TO BE HELD IN PUBLIC
ON THURSDAY, 11 MAY 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 – 6 April 2017** *To APPROVE the minutes of the meeting held on 6 April 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.	**REACH RECOGNITION AWARD ON EXCELLENCE** *To PRESENT the ;* • *REACH Recognition Individual Award – Stephanie Zahorodnyj, Team Leader, County CMHT, NOAP Directorate* To be introduced by the Chief Executive and presented by the Chair	Verbal

11.	**ASSURANCE REPORT FROM THE QUALITY COMMITTEE** *To RECEIVE the Quality Committee Assurance report from the meeting held 27 April 2017 from Mr P Sullivan, Chair/Non-Executive Director*	Assurance Enclosure 5
13.	**NURSE STAFFING MONTHLY REPORT - March 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
14.	**SERIOUS INCIDENT Q4 REPORT** *To RECEIVE a report in respect of Si Quarter 4 Report from Dr B Adeyemo, Medical Director*	Assurance Enclosure 7
15.	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 12** *To RECEIVE the Month 12 Performance Report from Miss S Robinson, Director of Finance and Performance*	Assurance Enclosure 8
16.	**RAISING OUR SERVICE EXCELLENCE (ROSE) 'GO LIVE'** *To RECEIVE an update for Raising Our Service Excellence (ROSE) to 'Go Live' from Mr G Thomas, Digital Strategic Advisor to be in attendance for this item.*	Approval Enclosure 9
17.	**BOARD ASSURANCE FRAMEWORK Q4 2016/17** **BOARD ASSURANCE FRAMEWORK 2017/18** *To RECEIVE the Board Assurance Framework Q4 2016/17 and Board Assurance Framework 2017/18 update from Mrs L Wrench, Associate Director of Governance*	Assurance Enclosure 10 Enclosure 11
18.	**SECOND CITIZENS' JURY TO EXAMINE MENTAL HEALTH SERVICE PROVISION (NSCHT AND SOT CCG)** *To RECEIVE the Second Citizens' Jury to examine Mental Health Service Provision from Ms M Nelligan, Executive Director of Nursing & Quality*	Assurance Enclosure 12
	TO ENHANCE SERVICE USER AND CARER INVOLVMENT	
19.	**SERVICE USER AND CARER COUNCIL** *To RECEIVE an update from, Ms W Dutton, Vice Chair of the Service User and Carer Council*	Assurance Enclosure 13
	CREATE A LEARNING CULTURE TO CONTINUALLY IMPROVE	
20.	**ASSURANCE REPORT FROM THE PEOPLE AND CULTURE DEVELOPMENT COMMITTEE** *To RECEIVE the People and Culture Development Committee Assurance Reports from the meetings held on 2 May 2017 from Miss L Barber, Chair/Non-Executive Director*	Assurance Enclosure 14
	ENCOURAGE, INSPIRE AND IMPLEMENT RESEARCH AND INNOVATION AT ALL LEVELS	

21.	*Not applicable*	
	MAXIMISE AND USE OUR RESOURCES INTELLIGENTLY AND EFFICIENTLY	
22.	**FINANCE REPORT – MONTH 12 (2016/17)** *To RECEIVE for discussion the Month 12 financial position from Miss S Robinson, Director of Finance and Performance*	Assurance Enclosure 15
23.	**ASSURANCE REPORT FROM THE FINANCE & PERFORMANCE COMMITTEE** *To RECEIVE the Finance & Performance Committee Assurance report from the meeting held 4 May 2017 from Mr T Gadsby, Chair/Non-Executive Director*	Assurance Enclosure 16
24.	**ANNUAL ACCOUNTS ASSURANCE** *To RECEIVE verbal assurance in respect of the Annual Accounts from the presentation held on 25 April 2017 from Miss S Robinson, Director of Finance and Performance*	Verbal
25.	**TRUST SELF CERTIFICATION – CONDITION G6** *To RECEIVE and SIGN OFF the Trust Self Certification – Condition G6 from Mrs L Wrench , Associate Director of Governance*	Approval Enclosure 17
	ATTRACT AND INSPIRE THE BEST PEOPLE TO WORK HERE	
26.	**REGISTER OF BOARD MEMBERS - DECLARATIONS OF INTEREST** *To RECEIVE the Register of Board Members – Declarations of Interest from Mrs L Wrench, Associate Director of Governance*	Note Enclosure 18
	CONTINUALLY IMPROVE OUR PARTNERSHIP WORKING	
27.	*To RECEIVE a verbal update on progress from Mr A Hughes, Joint Director Strategy and Development (NSCHT/GP Federation)*	Verbal
	DATE AND TIME OF THE NEXT MEETING	
28.	*The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday, 8 June 2017 at 10:00am.*	
29.	**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, 6 April 2017 At 10:00am in the Boardroom, Trust Headquarters, Lawton House Bellringer Road, Trentham, Stoke on Trent, ST4 8HH

Present:

Chairman:

Mr D Rogers
Chairman

Directors:

Mrs C Donovan
Chief Executive

Dr B Adeyemo
Medical Director

Mr P Sullivan
Non-Executive Director

Mr A Rogers
Director of Operations

Mr T Gadsby
Non-Executive Director

Mr P Draycott
Executive Director of Leadership &Workforce

Mrs B Johnson
Non-Executive Director

Mr A Hughes
Joint Director of Strategy and Development

Ms M Nelligan
Executive Director of Nursing and Quality

Dr K Tattum
GP Associate Director

Ms J Walley
Non-Executive Director

Miss L Barber
Non-Executive Director

Miss S Robinson
Director of Finance

In attendance:

Mrs L Wrench
Associate Director of Governance

Mrs J Scotcher
Executive PA

REACH Award - :Growthpoint
Phil Roberts
Matt Allen
Tracey Mace
Geoff Yardley

Mr G Thomas
Digital Strategic Lead

Staff Retirements
Wynford Johnstone
Liz Wilkes

Members of the public:
Mrs H Johnson, North Staffs Voice

Dr H Uppal
Clinical Chief Information Officer

REACH Award - Special Team Award - Older People's Community Teams
Lisa Sharrock
Liz kay
Jane Peake
Naomi McShannon
Katie Chatfield
Linda Simcock

Mark Ball
Anna Dunn
Wendy Thorley
Libby Amison
Julie Fearns
Daryl Gwynett
Jill Cook
Karen Stone
Carly Stafford

Karen Senior
Rachel Birks
Karen Kennedy
Abby Jones
Carol Heath
Jane Aaron
Chris Landon
Sarah Wright

The meeting commenced at 10:00am.

655/2017	**Apologies for Absence** Apologies were received Ms Harvey, UNISON, Mr McCrea, Associate Director of Communications and Ms Dutton, Service User and Carer Council.	**Action**

	The Chair welcomed Mr Hughes, who has recently been appointed as Joint Head of Strategy and Development, NSCHT and GP Federation.	
656/2017	**Declaration of Interest relating to agenda items** There were no declarations of interest relating to agenda items.	
657/2017	**Declarations of interest relating to any other business** There were no declarations of interest relating to any other business.	
658//2017	**Minutes of the Open Agenda – 9 March 2017** The minutes of the open session of the meeting held on 9 March 2017 were approved. Ms Walley commented that in respect of 621/2017 this should read '*Ms Walley thanked Mrs McCoy and asked that the Board would follow-up on this engagement and report back to the next meeting*' as opposed to '*promised*'.	
659/2017	**Matters arising** The Board reviewed the action monitoring schedule and agreed the following:- 4***46/16 - 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. ***This matter is in respect of a reduction in funding for our substance misuse services. Progress was noted at the last Board with a meeting with the Trust and the Police commissioner, Mr Ellis. Since then the Trust has also written to all Clinical Commissioning Groups for the second time, within the locality to request that they consider whether there is any additional CCG funding that could be made available to further mitigate the impact of cuts.*** ***Mr Rogers noted there is some measure of positivity with funding of £58k community detox posts*** ***Mrs Donovan noted that South East Staffordshire and Seisdon Peninsula CCG have set up a Quality Assurance process in order to monitor the impacts of the cuts and this will be fed back to the NHS England and the Care Quality commission.***	

	Ms Walley commented that this is helping to gain momentum and that the Trust needs to get greater collaboration and build on this small amount. ***583/17 Safe 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 next Trust Board – This is due to come to the April Board meeting –***This is due at the May Trust Board – remove from schedule*** ***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 reported in the next quarterly report – remove from schedule.*** ***621/17 Questions from the public -*** A discussion took place and it was agreed that Mrs McMahon, Head of Directorate, CAMHS, would meet with Mrs M after the Trust Board. Ms Walley thanked Mrs M and asked that the Board would follow-up on this engagement and report back to the next meeting. ***At the last Trust Board a commitment was made to deal with the services available to young people. Mr Rogers confirmed that Mrs McMahon is formulating a Transformation plan in respect of the issues raised and this will be presented to the May Trust Board.*** ***Specifically, in respect of Mrs M, a member of the public, we have now met with twice and she has attended the Open Space event and which was very positive. On today's agenda – remove from schedule*** ***Safe Staffing - January 2017 -*** Ms Dutton noted that the recent Recruitment events have not been as well attended this time. Mr McCrea to review and compare to previous events. ***Mr Draycott confirmed that a review has taken place and there are some lessons learnt which will be taken into account for the next Recruitment Campaign – remove from schedule.*** ***Service User and Carer Council*** - A further Open Space Event is due to take place on 29 March 2017 at Port Vale Football Club and all Board members will be invited. Some discussion held regarding the capacity of this venue and whether for future events, the Trust looks to book a larger venue. – ***This will be picked up in later***	

	dialogue and was extremely positive – remove from schedule. ***Values and Behaviours Framework*** - Board members welcomed and approved the Behaviours Framework. Mrs H Johnson requested that NSUG be involved as this had not been communicated previously. Mr Cragg to pick up with Mr Clarke. ***Mr Draycott confirmed the Trust has now signed off the framework and was launched at the Leadership Academy. The Trust will be enhancing Service User engagement and Mrs H Johnson will be supporting – remove from schedule*** ***Any other business*** - Mrs H Johnson highlighted the excellent work of the Patient Experience Team with service users and staff, helping them to understand their processes. She suggested that it may be beneficial to standardise this as mandatory for staff. Ms Sylvester noted that there has been real progress, consistency and stability within the team. The customer care training has been built into the Trust Induction days and further discussions regarding mandatory training will need to take place. However, she would take this on board as a suggestion and take forward. ***Mr Draycott confirmed the customer care training is being reviewed in line with the Towards Outstanding programme. - remove from schedule.***	
660/2017	**Chair's Report** The Chair noted that the NHS national position remains difficult in terms of funding. Additional funding has been issued recently by the Government, however this is limited. The Chair also updated regarding the Staffordshire Transformation Plan in that it has been frustrating due to the delayed start and lack of transparency. However, there has now been a development with the leadership with Mr Pearson, Chair of SSOTP and the Trust will have his support going forward. The Chair reported positively on an event held on 16 March 2017 at Keele University, whereby a national charity; Caldwell Children and the Autism community unveiled exclusive information of the charity's ground breaking project to provide a new £15million centre for diagnosis, support and research for children and families affected by Autism and other neurodevelopmental conditions.	

	He informed members that the '*Next Steps on the Five Year Forward View'* by the NHS England has recently been published which is encouraging in terms of mental health. ***Received***	
661/2017	**Chief Executive's Report** Mrs Donovan, Chief Executive, presented this report which provides an update on the activities undertaken since the last meeting in March 2017 and draws the Board's attention to any other issues of significance or interest. **NHS Staff Survey results** The results of the 2016 annual NHS Staff Survey have been published and confirm the journey we are making Towards Outstanding. This is on today's agenda: **Flu team** The team were shortlisted for Team of the Year at 2017 Flu Fighter Awards in recognition of our hugely successful flu campaign which led Combined to become the highest performing mental health trust in the country with a total of 79.7% of frontline staff being vaccinated between September-December 2016. The team were highly commended. **Developing our Patient Safety Culture** The Trust Board came together recently for an important learning and discussion session on how we can build an even stronger patient safety culture with the mentorship from Advancing Quality Alliance (AQUA). **Mr Hughes – Joint Director of Strategy and Development** Mr Hughes has been appointed by the Trust and North Staffordshire GP Federation as Joint Director of Strategy and Development. **Feel Good Friday Initiative and Leading with Compassion Scheme shortlisted at HPMA Awards** Our Feel Good Friday health and wellbeing initiative has been chosen as a finalist in the Social Partnership Forum Award for partnership working between employers and trade unions. Feel Good Friday was set up in October 2016 to enable staff to receive information and advice on a range of things aimed at enhancing health and wellbeing. The other nomination comes in the Academy Wales Award for Excellence in Organisational Development for the Leading with Compassion scheme where staff, patients and carers are able to recognise someone who they believe has demonstrated compassion.	

Long Service Awards
The Trust held a Long Service Awards event on 17 March 2017. A tea party was held to celebrate and thank each member of staff whose loyal service both to the Trust and the NHS in general is a real source of inspiration.

New Beginnings open morning
The independent New Beginnings group will be holding their latest open morning on Thursday 4 May 2017. The event takes place from 9.15-11.15am in the Edward Myers Unit on the Harplands Hospital.

Shoppers urged to use their vote to support One Recovery
The One Recovery Drug and Alcohol support service has been selected by the Leek branch of Waitrose as one of three good causes it will be supporting in April.

Nutrition and Hydration week celebrated by staff and teams
Our staff and teams held events to promote the important messages of Nutrition and Hydration Week during 13-19 March 2017.

New Health and Wellbeing portal launched on Trust's staff intranet
A new Health and Wellbeing portal has been added to the Trust's staff intranet, bringing together a host of health and wellbeing-related topics and websites. These include cycling, Pilates sessions taking place at Lawton House, the monthly Feel Good Friday events at Harplands Hospital, the Harplands walk and list of health and wellbeing apps. In addition, the portal also includes information about our Staff Counselling and Support service.

Leadership in the Medical profession
Our Medical Director, Dr Buki Adeyemo has been invited to be a key speaker for the British Medical Journal's 2017 Leaders in Healthcare Conference in Liverpool later this year. It is further proof of our growing reputation for being a Trust that is providing great leadership across our staff and senior team.

Staffordshire and Stoke-on-Trent Sustainability and Transformation Plan (STP)
More than 70 leaders, staff and influencers across Staffordshire and Stoke-on-Trent came together for the Accelerated Design Event at Stoke City Football City's Bet365 Stadium on 23 March 2017. The purpose was to review how we work together, but also the climate within which we operate and how our structures and decision-making culture can hinder us from achieving everything we need and want to do.

	NHS Mandate for 2017-18 published On 20 March, the Government published its mandate for the NHS for 2017-18. The mandate confirms the seven high level objectives for the NHS **Five year Forward View** On 31 March, NHS England (NHSE) published 'Next Steps on the Five Year Forward View'. ***Received***	
662/2017	**Questions from the public** No questions were received.	
663/2017	**Staff Retirements** Mrs Donovan recognised those staff who are retiring this month as follows, **Liz Wilkes – Assistant Technical Officer – Pharmacy Department** Liz joined the Trust as an Associate Technical Officer in the Pharmacy Department in 2005. Initially her job was working at different dispensaries in Leek, Bucknall and Bradwell. She was then promoted to become a Senior Associate Technical Officer and was based at Harplands Hospital. Liz has always, in the true spirit of the NHS, been willing to go beyond what can reasonably be expected from her. She is often the first to volunteer to stay behind after work hours in order to complete unfinished tasks. Liz is always willing to contribute to weekly team meetings and has come up with a number of suggestions over the years which have now become normal practice. She is a very diligent and extremely conscientious worker who is always willing to take on more. We wish Liz all the best for her retirement. **Wynford Johnstone (EMT Maintenance Fitter)** Wyn joined the Trust in January 2005. His "can do" attitude and friendly outlook has held him in good stead with the workforce ever since. His work has been varied including fabrication where needed, maintenance of medical appliances, beds, wheelchairs and his valued contribution to the On-Call System.	

	Initially, starting at Bucknall Hospital, Wyn has moved around the city as the workforce has relocated over the years. His colleagues regard him as a true team player and thank him for all his hard work and efforts over the last 12 years. Other staff retiring unable to attend: • Clare Halsey – Psychological Services Lead, Children and Young People • Janice Allen – Planning Manager, Estates Directorate • Nicholas Dutton – Cognitive Behavioural Therapist • Jeanette Raisada – Staff Nurse – Assessment and Treatment • Susan Atkin – Support Service Assistant – Ashcombe Centre ***Received***	
664/2017	**Recognising Excellence and Achievement in Combined Healthcare (REACH)** **Special Team Award - Older People's Community Teams** Whilst we are immensely proud to have received an overall 'Good' rating from our recent CQC inspection, we wish to formally recognise the achievement of our Older Peoples' Community Teams who excelled in being rated 'Outstanding'. This really makes these services our exemplar to which we are so very proud. This reflects not only the high clinical standards within these teams, but also the incredible values of the team members who consistently go 'above and beyond' for our patients. Anyone who has had the pleasure of working with the community team will agree that they offer a truly holistic view of a person – which includes the wellbeing of carers and their families. The service is both patient centred and innovative, embracing technology, prevention and the development of new models of working through place-based care. Being at the forefront of these developments, our team members quickly identified it is not only place-based care that is important but relationship-based practice. Where practitioners value engagement with patients and our partners this reflects in the positive outcomes for patients. The team intend to build on this in the coming months with further innovation across the local health economy.	

	The Older People's Community Teams have a vision now to move beyond 'Outstanding'. The Board recognised this commitment and achievement and formally and thanked the teams for the hard work and passion shown through their practice.	
665/2017	**Recognising Excellence and Achievement in Combined Healthcare (REACH) – Growthpoint – Adult Mental Health Community Directorate** Set up in 1998 to help people with mental health needs back into the community and/or employment, Growthpoint has excelled in its innovative approach to providing support to people in their recovery through amongst other things horticultural therapy. This has helped to reduce relapse for users of the service and has supported many into training and employment. The Growthpoint team provides a safe work environment, with every service user receiving support in working towards their own personalised recovery plan. Information, advice and guidance are also provided to enable clients to access other opportunities to enhance their skills. For example 6 service users have completed a Level 2 qualification in Horticulture and Plumbing in the last 12 months and they also provide continued support to three people who are now self-employed and no longer in receipt of benefits. The service offers 10 service users employment at any time on an annual rotational scheme. A modern apprentice scheme is also planned in the near future. It also offers placements to Keele medical students. The value that best represents Growthpoint is Excellent as the dedicated team of enthusiastic staff and volunteers continue to provide a unique and highly effective service that is quite rightly seen as one of the jewels in Combined Healthcare's crown. Geoff Yardley delivered a presentation in respect of Growthpoint. The Board congratulated the Growthpoint team on their award and the excellent work they do. Ms Walley thanked the team and asked on what the scope is for obtaining further contracts and partnerships with local companies?	

	Geoff stated this is more possible with the apprenticeship schemes (not necessarily 18 year olds) but is also about having the capacity to do the amount of work involved. Growthpoint have previously worked with a young man who was a service user and this had worked very well. He also recalled another patient story who had his own landscape gardening company and had been referred into Growthpoint as a service user. The team had supported him and helped him through this period; however due to funding they could not retain his role. It was noted Growthpoint would benefit from sponsorship. Mrs Donovan commented on the opportunities for obtaining further contracts; however there is a need for us to provide the necessary skills. She further commented that there is new national focus within the Five Year Forward view in respect of the employment of Service Users. The Trust needs to improve its numbers in this area and this is definitely an area to invest funding. Ms Nelligan commended the Growthpoint team and they provide a fantastic service, 'a hidden gem'. She further noted that the Trust is in the process of developing a Recovery Academy to help bring more volunteers through this route. Mr Sullivan asked the Growthpoint team what could the Board do to help and support their work? Geoff noted that IT connections are difficult on the allotment and that there are regulations to adhere to, when you do not own the land. Previously, the team have purchased their own laptop and dongle. It was agreed to support Growthpoint with their IT issues going forward.	**Mr Rogers**
666/2017	**Safe Staffing Monthly report – February 2017** Ms Nelligan, Executive Director of Nursing and Quality presented the assurance report. This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during the data collection period (1 – 28 February 2017) in line with the National Quality Board. The performance relating to fill rate (actual numbers of staff deployed vs numbers planned) during February 2017 was 84% for registered staff and 107% for care staff on day shifts and 87% and 102% 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. It has been a challenging month and although the Trust recruited with newly qualified Keele University students in October 2016, Ward 4 has now reopened and has impacted on staffing levels. In addition, there are further Band 5 vacancies across Wards1, 2 and 3. Mr Sullivan queried why ward 5 was not inspected by the CQC? Mrs Wrench noted that Ward 5 was not inspected as it was classed as a specialist service and not under a core service. Other areas that were not included in the CQC inspection, were Parent and Baby Unit and the Criminal Justice Team. Mrs H Johnson commented that North Staffs Voice for Mental Health representatives visit Ward 5 regularly to help highlight any issues and that it is a very good ward. Mrs Donovan gave assurance that the Trust has commissioned an external review with the Parent and Baby Unit and this was received at the Quality Committee on 28 February 2017. The Action Plan will be received at the next meeting on 27 April 2017. Furthermore, Ward managers and members of the multi-disciplinary team have clinically supported day shifts to ensure safe patient care. Also in terms patient safety, staff encouraged to report any potential incidents/risks. The Six month Safe staffing report for the period July – December 2016 will be submitted to the next Trust Board in May 2017. Mr Rogers noted that discussions are being held with the commissioners in respect of Ward 4, originally opened as a dual care ward but now as an assessment unit. Mrs H Johnson commented that staff choosing not to take breaks is concerning and may have an impact on patient care. Ms Nelligan commented that this is a concern and has been discussed at the Safe Staffing Group, as previously mentioned tighter controls are being put into place and e-rostering will also be of benefit. ***Received***	

667/2017	**Performance and Quality Management Framework Report (PQMF) Month 11** Miss Robinson, Director of Finance, presented this report. The report provides the Board with a more detailed level of summary of performance to the end of Month 11. At Month 11 there are 2 metrics rated as Red and 1 as Amber. The following performance highlights should be noted; • 100% of patients have been assessed within 12 weeks of referral to the Memory Service Assessment • 78.6% of S136 assessments are carried out within 3 hours (where clinically appropriate) (Target M11 – 70%) • The readmission rate within 28 days of discharge has significantly reduced to 3.8% • 100% of complaints are responded to within agreed timescales • 100% of patients referred to IAPT service are treated within 6 weeks of referral In Month 11 there are 2 metrics rated as Red and 1 as Amber; all other indicators are within expected tolerances. Exceptions were noted as follows: ***Delayed Transfers of Care (DTOC) –*** increased to 11.6% at M11. Mr A Rogers assured members that these are reviewed on a daily basis by the directorate, some of these are outside of our control. The Trust is using a new process 'Red' to 'Green' and we have been recognised as the first mental health Trust to develop this and NHS Improvement have recognised this model and want us to showcase. ***Agency –*** reduced 6.9% ***Care Programme Approach (CPA)*** – reduced in respect of 4 patients, follow-ups are being dealt with. Mr Sullivan queried what has happened regarding IR35? Mr Draycott noted that in respect of IR35, this has now been reversed, in that someone who has a substantive post can now also work as part of an agency. The new guidance goes live today. ***Received***	
668/2017	**Raising our Service Excellence** Mr Thomas, Digital Strategic Lead and Dr Hardeep Uppal, Clinical Chief Information Officer, was in attendance for this item only to present the ROSE update for Lorenzo 'Go Live' on 13 May 2017.	

	The Board noted that a joint Stocktake review of the 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 3 deep dive sessions with all Clinical Directorates reporting on their state of readiness. Of the 11 work-streams within the project; 6 are progressing, 3 are experiencing some manageable difficulties but 2 have 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 prescribe for patients going on leave from hospital. Ms Walley queried what the mitigations were for the E-prescribing and has there been an escalation to resolve it? Dr Adeyemo confirmed that initially the Trust will be undertaking a pilot in a small area to help iron out the issues. Subsequently, the Trust will limit role out of E prescribing to 1 inpatient ward in May with full system roll out to follow. The project is forecast to be delivered on budget and the Trust is minimising all risks. All is on track as it should be and the pace of decision making is getting faster and in line with our governance framework. Board members were assured that the training sessions and numbers attending are positive. Dr Tattum noted from his GP previous experience, issues have occurred and the Trust needs to be cautious. Mr Thomas assured members that the Trust has worked with other organisations who have been through the same process and this has enabled us to learn lessons. Mr Thomas urged that the Trust carry out a Business Contingency exercise led by our Emergency Planning lead. It was agreed to take this forward.	**Mr Hughes/ Miss Robinson**

	Miss Barber queried what would cause a delay or suspension to 'Go live'? Mr Thomas stated that it was difficult to know now, but if the Trust has a robust contingency plan than this is assurance. Mr Gadsby noted the £89,0000 underspend and was this likely to continue or will there be further agency costs? Miss Robinson confirmed that the project is still forecasting to come in on budget. A Benefits realisation process will be fed through to the Finance and Performance Committee and this will help give Non-Execs further assurance. Dr Uppal, Clinical chief Information Officer, further commented that a 'dress rehearsal' would take place on 7, 8 and 9 April 2017 (over the weekend). Staff have volunteered to come and assist. This will give the Trust a good understanding and reassurance for the implementation of ROSE. Mrs B Johnson queried whether such matters such as discharge notes to GPs would be delayed and this is a concern? Dr Uppal stated that this would continue in the main as it stands now. The issue will be if some GPs have not signed up to the software and therefore it is a local health issue rather than a Trust issue. However, the Trust will continue to work with GPs to ensure discharge summaries are sent in a timely manner. ***Received***	
	Board Assurance Framework Update Mrs Wrench, Associate Director Governance, presented an update in respect of the Board Assurance Framework 2017/18. This is a first glance for Board members to review and provides the controls and assurances to mitigate risk to the delivery of the Strategic objectives. This will be presented to the next cycle of committees for discussion and will then be submitted to the Trust Board in May 2017. Any comments to be forwarded to Mrs Wrench. The framework has been enhanced to give source of assurance. ***Received***	

669/2017	**Service User and Carer Council** Ms H Johnson, North Staffs Voice, gave a verbal update on behalf of Ms Dutton to inform the Board of the work of the Council. The Open Space event took place on 29 March 2017. This was an opportunity to engage with service users and carers, discuss our Quality priorities as part of the Quality Strategy approved in August 2016. Participants all had voting buttons, to vote what they thought our priorities should be and this worked extremely well. The next steps would be to complete a formal report to Quality committee. This will be going forward to align with the Board Assurance Framework and this will be a commitment on an annual basis. The event was also an opportunity for the Council to have an engagement session with service users and carers as a wider group. All ideas will be discussed at the next Service User Carer Council meeting and a report will be generated to come here. Mrs H Johnson remarked that the event was a very good day and there was good representation of service users and carers. The Service User Carer Council will be able to review any trends or themes from the day. Some themes were highlighted ; • The transition for young people around learning disabilities and the move to adulthood. Waiting times in CAMHS • More CPNs having more contact time with service users • Standards in terms of when service users contact our community teams and the response to our telephone calls ***Received***	**Ms Nelligan**
670/2017	**Research and Development** The Trust is working with Manchester University in respect of research and development of MCPs. This will help the Trust work 'Towards Outstanding'. A Workshop will be scheduled with Keele University and prevention in primary care.	

	The Trust has appointed Dr Chris Link as the Research and Development Director, he will be playing a key part in revising the Research Strategy and collaborating with our partners.	
671/2017	**Summary paper on understanding 'Developing People – Improving Care'** Mr Draycott, Executive Director of Leadership and Workforce, presented the Developing People, Improving Care report. The document provides a vision for improvement and leadership in the NHS. This vision co-ordinated by NHSI recognises the changing demands on health and care services, which are creating different development needs among staff in NHS-funded services across England. The NHS regulators and governing bodies through this vision want to equip and encourage staff to deliver continuous improvement in local health and care systems and gain pride from their work. This vision is for team leaders at every level of the NHS to develop improvement and leadership capabilities among their staff and themselves. This will help protect and improve services for patients in the short term and for the next 20 years. The framework has been co-developed by the Care Quality Commission, Department of Health, Health Education England, Local Government Association, NHS Clinical Commissioners, NHS Confederation, NHS England, NHS Improvement, NHS Leadership Academy, NHS Providers, NICE, Public Health England and Skills for Care. The Board noted the contents, in particular the purpose and the Trust's mapping of our current leadership, talent and improvement approaches against the 5 conditions. The Board supported review of this process via the People and Culture Development Committee in 6 months time. ***Received***	
672/2017	**Monthly Finance Reporting Suite – Month 11** Miss Robinson, Director of Finance, presented this report which contains the financial position at Month 11. At Month 11, the Trust Board is asked to note: • Month 11 the Trust reported a surplus of £1,248k against a plan of £1,216 surplus	

	• CIP achievement in month 11 is 77% with an adverse variance of £521k from plan, with a recurrent transacted CIP of £2,063k (79%) • The adverse cash position of the Trust as at 28 February 2017 with a balance of £2,999k • Capital receipts in Month 11 are £2,141k compared to planned capital receipts of £1,977k • Use of resource rating at 3 The Trust's cash position is significantly behind plan. This has been escalated to the Finance and Performance Committee in terms of the management of actions that have been put in place to recover this. Miss Robinson was able to confirm that cash balances had been met which would formally be reported in the Month 12 report. Mr D Rogers noted the good progress made in respect of the Capital Plan and this is very impressive and a credit to all. The Board approved the Month 11 position and the reported forecast outturn of £1.4m as per agreed Control total. ***Approved***	
673/2017	**Finance and Performance Committee Assurance Report – 30 March 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 30 March 2017 Cash was discussed and the fact that the position had significantly improved since Month 11 position. The committee recognised the progress made in the last month and all credit due to Miss Robinson and the Finance team. The CIP YTD was discussed and recognised the outturn would be £500k less than the plan. The recurrent impact of CIP achievement was positive reviewed and accepted by the Committee as a good achievement. ***Received***	

674/2017	**Audit Committee Assurance Report – 30 March 2017** Mrs B Johnson, Chair/Non-Executive Director, presented the Audit Committee Assurance Report from the meeting on 30 March 2017. The Audit Committee received assurance with; ***Quality Account Project Plan***– Assured that the process is on track. ***Progress Report – Internal Audit -*** 8 Audit Reports finalised, 23 actions in progress (however not due yet). ***Business conduct policy*** – Approved. ***Gifts hospitality, sponsorship register*** – No queries or concerns. ***Draft Annual Governance Statement*** – Approved. ***Internal Audit Progress report*** –– Medical Revalidation has now made progress. ***Internal audit plan 2017/18*** – Received and approved. ***Local Counter fraud Progress Report and Work plan – 2017/18*** – Received. ***Review Draft Internal Audit report and opinion*** – Received and no concerns. ***Going Concern –*** Received. ***SFIs and Scheme of Delegation –*** Approved and ratified. ***Phishing Exercise*** – Received and noted that exercises will take place over the year. ***Received***	
675/2017	**Charitable Funds Committee Assurance Report –21 March 2017** Miss Robinson, Director of Finance and Performance, presented the Charitable Funds Committee Assurance Report from the meeting on 21 March 2017. The Charitable Funds Committee received assurance with; The committee received and agreed; • Review of Charity annual accounts closedown timetable • Review of funder holder balances • Charity Strategy and future arrangements – it was agreed to develop a fundraising strategy and infrastructure. However, this will also require agreement with SSOTP and a formal response is due by 31 May 2017. • SSOTP will confirm by 31 May 2017, if they wish to be part of this direction of travel.	

	Miss Robinson noted that a Task and Finish Group would be set up. Mr Gadsby noted that the challenges are when the funds are ring-fenced, however the course of action to have a Strategy was the right one. ***Received and awaiting SSOTP response***	
676/2017	**Staff Survey Results** Mr Draycott, Executive Director of Leadership and Workforce, presented this report in respect of the Trust's Staff Survey Results. The paper highlights some our positive results and areas for improvement, concluding with an action plan to further enhance our results in 2017. • Over 20% of the surveys 27 indicators demonstrate significant improvement, with non in significant decline • Comparing like for like figures with 2015 we see that over 70% of indicators have an improved score in 2016 • Above average scores posted against comparator NHS organisations in approximately a third of areas • Strongest areas of performance are in reporting of errors and near misses, plus percentage of staff experiencing harassment, bullying, discrimination or abuse at work ***Received***	
677/2017	**EU National Workforce Report** Mr Draycott, Executive Director of Leadership and Workforce, presented the EU National Workforce Report to advise the Trust Board of the current EU workforce (exc UK) profile in order to highlight the potential risks of the UKs decision to leave the EU. 1% (14 staff) of the Trusts current workforce is classed as EU Nationals. 50% of the individuals are employed as Clinical Psychologists (7 staff)) and 21% are employed as Medical Doctors (3 staff). Ireland and Romania have the highest number of employed EU nationals with 35% (5 staff) and 21% (3 staff). Further updates regarding the impact of leaving the EU on the Trust's workforce will be provided to the Trust Board and People Culture development Committee once the national direction has been given.	

	In the meantime the demand and capacity of the Trusts workforce supply will continue to be monitored and reviewed as part of the Trusts active workforce plan. ***Received***	
678/2017	**Any other business** Mr Hughes introduced himself to the Board. His joint appointment is a demonstration of the partnership being developed between the GP Federation and our Trust, as part of a wider strategy to transform and develop integrated and partnership working between providers, primary care, community and hospital services throughout North Staffordshire and Stoke-on-Trent. There will be a shared agenda and new developments to work together with the Clinical Partnership Board. There are 82 practices across North Staffordshire and Stoke-on-Trent. A GP Federation Board meeting was held last week and this was perceived as an entrepreneurial meeting. The Trust can add value with the infrastructure and governance. . The Alliance Board is due to be held on 12 April 2017.	
679/2017	**Date and time of next meeting** The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday, 11 May 2017 at 10:00am, in the Boardroom, Lawton House, Trust HQ.	
680/2017	*** 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 12.40pm

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	11-May-17	See minutes for update - remain on schedule
06-Apr-17	666/2017	**Safe Staffing Monthly report – February 2017 -**The Six month Safe staffing report for the period July – December 2016 will be submitted to the next Trust Board in May 2017.	Ms M Nelligan	11-May-17	
06-Apr-17	668/2017	**ROSE Update** - Mr Thomas urged that the Trust carry out a Business Contingency exercise led by our Emergency Planning lead. It was agreed to take this forward.	Mr Hughes	11-May-17	

North Staffordshire Combined Healthcare NHS Trust

REPORT TO Trust Board

Date of Meeting:	Thursday 11 May 2017
Title of Report:	Chief Executive's Report to the Trust Board
Presented by:	Mrs Caroline Donovan
Author of Report: Name: Date: Email:	Caroline Donovan, Chief Executive Caroline Donovan Thursday 11 May 2017 caroline.donovan@northstaffs.nhs.uk
Committee Approval/Received prior to Trust Board:	
Purpose / Intent of Report:	For information
Executive Summary:	This report updates the Board on activities undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Quality Strategy • Digital Strategy • Governance Strategy • Innovation Strategy • Workforce Strategy • Financial Strategy
Relationship with Annual Objectives:	n/a
Risk / Legal Implications:	n/a
Resource Implications:	n/a
Equality and Diversity Implications:	n/a
Relationship with the Board Assurance Framework	1. Provide the highest quality services 2. Create a learning culture to continually improve 3. Encourage, inspire and implement research and innovation at all levels 4. Maximise and use our resources intelligently and efficiently 5. Attract and inspire the best people to work here 6. Continually improve our partnership working 7. Enhance service user and carer involvement
Recommendations:	To receive this report for information

Chief Executive's Report to the Trust Board
11 May 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. LAUNCH OF NEW BEHAVIOURS FRAMEWORK

Following extensive engagement with staff, service users and carers through a Listening into Action (LiA) project team, we launched our new Trust values of Proud to CARE – Compassionate, Approachable, Responsible, Excellent. To support these values we have created a behaviour framework that highlights how we should behave as staff. The framework was developed through a further wave of engagement ensuring the behaviours include the thoughts and views of staff about what is important to our future success as a Trust. It highlights how we should behave and can be used to educate and encourage staff to behave in a particular way, and hold people to account. We have aligned our behaviour framework with our values as below:

Compassionate

- 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, ensuring any other needs are properly coordinated.

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, search out best practice, develop relationships and share learning to improve ways of working.

The full details of the new framework are available at
www.combined.nhs.uk/news/latest-news/launch-of-our-behaviours-framework/

2. STRIVING TOWARDS OUTSTANDING LEVELS OF STAFF ENGAGEMENT

We are delighted to have launched 'Go Engage - Towards Outstanding Engagement' – a dedicated programme for improving staff engagement and culture. This programme will provide teams the opportunity to better understand their current internal culture, whilst also equipping them with new tools to be able to improve things for the better.

The first 10 pioneering teams will commence their six-month staff engagement journey journeys in June. The programme encompasses a wide range of staff engagement tools, including listening events, team building and back to the floor. Staff are able to highlight the issues within their team, and make their own choices about how they can improve or sustain staff engagement. Participants on the programme will reflect both the skill and professional mix within that team.

3. RAISING OUR SERVICE EXCELLENCE (ROSE)

Following months of hard work and preparation, our go live for our new electronic patient record (EPR) system ROSE takes place on 13 May. Teams are being supported as we migrate to the new system over the go-live weekend, while staff have been busy completing their e-learning and attending face-to-face training sessions to ensure they are fully prepared for what promises to be an exciting new chapter in our journey Towards Outstanding.

A successful dress rehearsal took place earlier this month, using the new system and volunteers from frontline staff. We have held the final Deep Dive with each Head of Directorate and received their assurance that everything is ready for a successful launch.

Whilst we are confident that everything has been done to ensure a successful launch, we are not complacent. We have contingency arrangements in place to ensure that we can revert to alternative arrangements should there be any problems on launch day.

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.

4. WARD 4 HARPLANDS

Over the past few years Ward 4 has been recommissioned on short term arrangements to provide support to the local health economy at times of winter pressure. Initially, this was as a shared care service with University Hospitals of North Midlands NHS Trust (UHNM), and latterly as a nursing assessment service.

We are delighted that the ward has now been permanently commissioned as a shared care service with UHNM from June 2017 and will provide 15 beds for patients with dementia and physical health needs. This follows on from the extremely positive external inspections that took place when the ward previously offered shared care with recognition of the holistic and person centred support provided to older people in our locality.

The ward is working through a transition programme at present and we are in the process of recruiting to the ward through our Discover Your Future recruitment campaign (more information about this is below). The ward environment will be truly unique as it will be supported by both physical and mental health staff and have strong links to external partners.

5. STRONG YEAR-END FINANCIAL PERFORMANCE ACHIEVED ONCE AGAIN BY THE TRUST

The Trust ended 2016/17 with a £1.45m surplus against a planned surplus of £1.4m – the 18th consecutive year we have demonstrated strong financial performance. As a result, the Trust received a further £600,000 of sustainability and transformation funding, which is earned by trusts that operate within their agreed financial limits. Our staff deserve a big thank you for helping us to achieve this position in spite of the extremely challenging financial climate.

6. DISCOVER YOUR FUTURE RECRUITMENT CAMPAIGN

Following the success of our Discover Your Future campaign last year, we are holding another series of one-stop recruitment events over the summer. The events are for registered nurses mental health (RNMHs), registered nurses learning disability (RNLDs) and registered nurses adults (RNAs) and will take place at Harplands Hospital, starting on Tuesday 23 May and Wednesday 24 May. Those applying will have the opportunity to apply for available posts on the day, be interviewed by a panel and potentially leave with a job offer. For more information, visit www.discoveryourfuture.co.uk.

7. CELEBRATING AND NURTURING NURSING EXCELLENCE CONFERENCE

Following the success of last year's Nursing at its Best @ Combined conference, we will be marking International Nurses Day on Friday 12 May with another Trust event – Celebrating & Nurturing Nursing Excellence. This year's conference takes will once again feature a range of presentations and workshops, with the keynote speech being delivered by award-winning mental health nurse Julie Sheen. Other presentations will be given by dementia care campaigner Tommy Whitelaw, as well as from our Head of Nursing & Professional Practice Julie-Anne Murray. The afternoon will be a 'supercharge safari' in which attendees will be able to discover more and discuss with colleagues about a series of themes exploring how we can further nurture nursing excellence. The event will conclude with both our Mentor of the Year and Preceptor of the Year awards being presented.

8. OPEN DAY FOR PSYCHOLOGICAL SERVICES

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

9. RELIGION AND MENTAL HEALTH MEETING

We were delighted to hold a Religion and Mental Health event where we welcomed representatives of the Sikh community and a representative from Sanctus, a charity supporting asylum seekers and refugees as they go through their assessment process for right to remain. It was a really good event, at which informal discussions were held around mental health and our services. Discussion topics included how we could reach out more effectively to our local communities to provide services that met people's needs and expectations and inspire them to be part of the next generation of healthcare workers; and what barriers there were to people accessing services and having positive, person-centred experiences. We look forward to nurturing these budding relationships and further improving accessibility and person-centred care for all our patients and service users.

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

The Staffordshire STP has now been identified as the most financially challenged health economy in the country, with significant deficits reported by both Staffordshire and Stoke-on-Trent Partnership NHS Trust (SSOTP) and University Hospitals of North Midlands NHS Trust (UHNM). Across the county health services are £120m in deficit and urgent work is underway to try to find solutions to this recurrent problem.

Within this context, we can only continue to celebrate our success in delivering our financial control total – and massive thanks and congratulations to everyone for your part in it.

Within Northern Staffordshire we continue to define and plan for a multispecialty community provider (MCP) with North Staffordshire GP Federation, SSOTP, Stoke-on-Trent City Council, Staffordshire County Council and the voluntary sector. We

have had two meetings of our Alliance Board and, internally, are now giving real focus to plans to align our services with the MCP approach and localities.

The Chief Executives of NHS Improvement (Jim Mackey) and of NHS England (Simon Stevens) have written to all NHS trusts flagging up the publication of a NHS Five Year Forward View Delivery Plan.

The letter sets out "the steps we will take to help you", including:

- Initiating a formal appointment process for STP leaders.
- Giving STP leaders the right to make recommendations to about local organisational governance, as well as other actions to overcome the inertia or organisational vetoes that are preventing improvements.
- Giving the strongest STPs greater control over NHS England staff, together with CCG and trust resources, to enhance their implementation capability.
- Providing a relatively small amount of centrally held transformation funding to areas with strong plans and partnerships to help them make faster progress. This funding will help create exemplars for elective and emergency care, and get the most advanced accountable care systems off the ground. We will also provide some additional central funding to support the formation of primary care hubs or networks across the country. STP leaders will oversee this transformation funding.
- Setting out the small number of governance models we see emerging across the country and providing hands-on support for implementing these locally.
- Providing a small amount of one-off funding on a pro rata basis to STPs as a contribution to operating costs and to help you assemble your teams quickly.
- Ensuring each area has developed a credible implementation plan now that the contracting round is nearly complete. This plan will need to show how areas will manage activity and achieve the efficiencies in organisations' contracts. Implementation plans will also need to reconcile these contracts with STPs where this has not been done already.

11. SERVICE TRANSFORMATION EVENT

One of the roles I play in our local Sustainability and Transformation Plan (STP) is to lead the Organisational Development workstream. Earlier this month, I chaired a Service Transformation Showcase which gave all of the partners across the STP the chance to celebrate and share the service improvement activities that currently exist within the Staffordshire health economy.

It also gave us a chance to discuss how service improvement can be embedded across our area, and how system leadership can help make it happen.

There were a host of presentations and ideas and it shows what great practice we have going on across Staffordshire.

12. DIRECTOR OF OPERATIONS

Our Director of Operations, Andy Rogers, will be leaving the Trust at the end of May to take up a new opportunity as Chief Operating Officer at Camden and Islington NHS Foundation Trust. This is a great opportunity for Andy and we are delighted to see him continue to progress his career leading NHS mental health services. Since joining the Trust in July 2013, Andy has been responsible for leading operational service delivery across clinical directorates. As such, he has made a significant contribution to our journey of improvement culminating in our recent

'Good' rating from the Care Quality Commission (CQC). Andy has been a highly committed director who will be greatly missed by his colleagues. He is wished every success in this new and exciting opportunity.

Following Andy's announcement, we advertised for an internal secondment for six months and I am delighted to announce that Dr Nasreen Fazal-Short, our Director of Psychology and Clinical Director for Adult Mental Health Inpatients, has been successful in securing the post. Nasreen has a great track record of leading transformation and service delivery. She has supported the great work of our improving access to psychological therapies (IAPT) services and was recognised by the CQC in respect of the leadership she has brought to our adult inpatient wards.

We have started the recruitment of the Clinical Director replacement to enable a smooth transition for the Director of Operations and I am sure you will join me in wishing Nasreen success in her new role.

We will be advertising nationally for the Director of Operations post towards the end of the year.

NATIONAL UPDATE

13. GENERAL ELECTION 2017 – TRUSTS NOW IN 'PURDAH' PERIOD

Following the announcement that a General Election is to take place on Thursday 8 June, we are now in a 'purdah' period. Purdah is the pre-election period immediately before elections when specific restrictions are put in place. As an NHS trust, we are not allowed to take part in any activity that would be considered politically controversial or influential, which could compete for public attention or be identified with a party, candidate or campaign group. The purdah period is due to continue until the day after the election on Friday 9 June subject to a new government being formed.

Encl. 5

REPORT TO: Trust Board

Date of Meeting:	11 May 2017
Title of Report:	Summary of the Quality Committee meeting held on 27 April 2017
Presented by:	Patrick Sullivan Non-Executive Director and Chair of Quality Committee
Author of Report:	Sandra Storey Associate Director MACE sandraj.storey@northstaffs.nhs.uk 3 May 2017
Purpose / Intent of Report:	For approval (policies) and information and assurance in terms of work of committee
Executive Summary:	This report provides a high level summary of the key headlines from the Quality Committee meeting held on the 27 April 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 and Nursing Directors and 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 highlighted in the report.

Key points from the Quality Committee meeting held on 27 April 2017 for the Trust Board meeting on 11 May 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 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:

- 7.07 - Records Management Policy
- 4.42 - R&D Commercial Research
- 1.44 - Dual Diagnosis – Review on-going extend until 31 August 2017.

3 Quality Impact Assessment of Cost Improvement Schemes (CIP)

The Committee received a verbal update following the position paper received at its last meeting. It was noted that there were no issues to report by exception. There is continuous monitoring in place for those schemes approved with key performance indicators in place that monitors closely for any negative impact on quality of service. Members were advised that there are dates in place to review new 2017/18 schemes as they come through. The Committee will receive a further report that provides a position statement for April and May 2017 at its next meeting.

4 Nurse Staffing Performance monthly report – February and March 2017

The Committee received the safer staffing performance report on a shift by shift basis for February and March 2017. Delivery of Registered Nurse staffing levels is a key requirement to ensuring that the Trust complies with National Quality Board standards. During February the Trust achieved staffing levels of 84% for registered staff and 107% for care staff on day shifts and 87% and 102% for nights respectively. Where 100% fill rate was not achieved, the Quality Committee were assured that safety was maintained on in-patient wards by use of additional hours, cross cover and Ward Manager supporting clinical duties.

For March 2017, the Trust achieved 80% for registered staff and 103% for care staff on day shifts and 84% and 107% nights respectively. With support of additional hours, cross cover and Ward Manager supporting clinical duties

It was noted that this remains an area that can be challenging and is therefore being closely monitored. There were particular challenges in March 2017, as there were vacancies across Acute Adult Mental Health wards in particular, in addition the opening of Ward 4 had contributed to this.

The Committee heard that while recruitment to some of the registered nurse posts has had limited success recently, alternate strategies are being progressed. The six-monthly safer staffing review was discussed and disseminated to the Committee.

5 Performance & Quality Management Framework Month 11 2016/17

Committee members discussed performance by exception and the rectification plans in place, particularly in respect to delayed transfers of care, clinical supervision, complaint response times and statutory and mandatory training. It was noted that rectification plans will be received at other committees such as the People and Culture Development Committee in respect to compliance with statutory and mandatory training but important to be aware of this at the Quality Committee to monitor any negative impact on quality of service provision.

6 Reports received for Information and Assurance

6a Director of Quality Report

The Committee received the Director of Quality Report under the SPAR qualities priorities with notable items as follows:

Safe:

- **Community and Mental Health Trusts are next on list for Carter productivity review.** The review will look to understand how community and mental health organisations operate and what work is currently being done to improve productivity and efficiency. Key findings from this national review will be reported end of 2017 and will be considered by the Committee.

Personalised:

- **Deprivation of Liberty (DOL) on discharge and Care Treatment Orders (CTO).** The Court of Appeal has given judgement in two cases external to the Trust which relate to conditions being imposed upon discharge or CTO, which unintentionally deprived persons of their liberty. The learning and developments following these cases has been disseminated.

Accessible:

- **Law Commission report and the draft Mental Capacity (Amendment) Bill 2017.** In March 2017 the Law Commission published a report proposing reforms to the Mental Capacity Act and DOL Safeguards. The report recommends the repeal of DOLS and the introduction of the Liberty Protection Scheme (LPS). The scheme is intended to be less onerous but also aims to improve the protection of human rights. A response is now awaited from the Government.

Recovery focused:

- **Obesity in secure Mental Health Units: implications for commissioners and providers.** Public Health England published a Working Together document to address obesity in Adult Mental Health Units, calling on Commissioners and providers to work together to address Food policies. This is an area already being given attention by the Trust, and the report to the Quality Committee described the range of initiatives and work being undertaken.

6b Learning from Patient Experience February and March 2017 Commissioners have noted their acceptance of these reports as part of their contract monitoring arrangements detailing Falls, medication incidents, violence and aggression incidents, complaints, compliments and safeguarding.

6c **Clinical Effectiveness Report** - reporting on outputs of Committee sub-groups. Of note was the work of the Clinical Effectiveness Group and the progress with the Rapid Tranquilisation Policy and monitoring and establishment of a Physical Health Group.

6d **Adult Community Survey Results and Action Plan 2016/17** - progress being closely monitored by the Directorate and led by the Director of Operations.

7 Board Assurance Framework Q4 2016/17 and Q1 2017/18

The Committee received this report detailing the progress made with objectives at Q4 2016/17. Members also reviewed the proposed objectives for 2017/18 and those that fall under the remit of the Committee.

8 Infection, Prevention and Control Group Terms of Reference

The Committee considered and approved the revised Terms of Reference.

9 Quality Account 2016/17 first draft

The Committee received the first draft of the Quality Account for initial review and comment. Members were assured that the project plan is on target to ensure completion of the report by the publication deadline of 30 June 2017. The Committee has delegated authority on behalf of the Trust Board to approve the final report on their behalf.

10 Directorate Performance Reports

Members discussed in detail the performance of each directorate, including Patient experience in respect to incidents, complaints and compliments, identified risks and mitigation plans in place. The committee also received an update report on quality standards for the care of older people living with frailty, assessment and co-ordination of care.

11 Risk to Quality of Services M11 2016/17

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 assurance about the actions being taken.

12 CCG, Trust and Healthwatch Joint Visits

The Committee received a paper detailing the purpose of the visits, process and governance arrangements. There has been a clinical visits programme in operation and since November 2016 these have taken place jointly with the CCG Lead Nurse for Quality, the Trust's Quality Assurance and Improvement Manager and representatives from Healthwatch. These visits have proved successful and will continue in 2017/18. The CCGs and Healthwatch are clear that these are not inspection visits as that is the role of the Care Quality Commission. However, the Trust has welcomed these visits as they are seen as a vital way of gaining feedback about the quality of services and building stronger relationships to further promote service improvements. A presentation from the CCG will take place at the next meeting.

13 Unannounced Assurance Visits

In September 2016, the Trust introduced a programme of unannounced assurance visits. The programme is led by the Director of Nursing & Quality and each visit is led by an Executive Director, a Non-Executive Director, a service user/carer, Peer Manager, and a member of the Trust's governance team supporting the visit. These inspections of the in-patient teams are in line with the CQC's Key Lines of Enquiry and 15 steps challenge. The report provided an overview of the inspection process, key themes of the 7 visits and going forward there will be a detailed quarterly report to the Committee detailing findings and any actions.

14 NCISH Scorecard Project

The National Confidential Inquiry into Suicide and Homicide by people with mental illness - scorecard project is a development that helps to benchmark data to support quality improvement. The Committee reviewed the current scorecard for the Trust and how it compares with other organisation. NCISH has also completed a 20 year review of Mental Health Services and the report set out a number of key features for safer mental health care for consideration.

15 Serious Incident Report Q4 2016/17

The Committee received an update on the number and type of serious incidents reported against each Directorate. Fewer deaths were reported in comparison to Q4 2015/16 and from an initial review of the incidents, no service or care delivery issues were identified. The report also included compliance with Duty of Candour and Mortality Surveillance for Q4 2016/17.

16 SI Thematic Review Action Plan

A Thematic Review was undertaken by the Adult Community Directorate in respect of a number of unexplained deaths from April – December 2016. The aim of the review was to identify any emerging themes which would need to be addressed in addition to any learning already identified in the serious incident reviews previously undertaken.

It was noted that although there were some key findings, these were not with any causative concern, but were felt to be areas of improvement which would support the Directorate and Trust's continuing journey towards outstanding. An overarching action plan has replaced the individual action plans in place. The Committee will take oversight of this action plan.

17 Learning from Deaths – National Quality Board – March 2017

A national framework document entitled Learning from Deaths was published by the National Quality Board setting out expectations for NHS Trusts on how they learn from patients deaths. This was in response to the Care Quality Commission publishing its review: Learning, Candour and Accountability. The report to the Committee included reference to the Trust's arrangements and while the majority of fundamental requirements are in place, proposals were included to strengthen existing practice and implement new requirements which will be set out in the revised policy.

18 Parent and Bay Day Unit Review and Action Plan

The report intended to review the service model, skill mix interface with Adult Mental Health Services and primary care, performance and clinical outcomes. It found a number of strengths, notably experienced and dedicated staff, as well as a need to raise awareness of the service, increase referral rate with possible expansion to provide a Community Outreach Service. While a bid for national and regional funding for expansion was unsuccessful, it is anticipated that a further bid opportunity will become available later in the year. In the meantime work is in place to address the other findings.

19 Letter to CEO post Quality Surveillance Group

The Committee received the summary letter following the Quality Surveillance Group meeting held in February 2017. NHS England uses a Surveillance Rating as part of its quality assurance process and rated the organisation in this correspondence as Green, Regular Surveillance, no specific concerns. It noted that following the CQC inspection, complaints were identified as a concern and training has been instigated; there have been significant improvements reported.

20 CQC Quality Assurance report – April 2017

The Committee received a position statement and progress report on work undertaken since the last CQC inspection. It was noted that the Trust continues to maintain momentum with the required improvements and systems in place to ensure that assurance against these improvements remains robust.

21 Mid-year Review of Committee Effectiveness

Discussion took place around the timing of the review session proposed for facilitation by NHS Elect, which had been delayed due to their availability. It was agreed that the Committee should proceed with making refinements to further enhance the effectiveness of the meeting.

From the next meeting a new Directorate dashboard will be introduced. By focusing on individual dashboards, it was agreed that this will offer more in-depth reporting and consistency of feedback from Directorates. Directorates will deliver this information by way of a presentation which will allow more participation by the wider group and targeted drilldown. A patient story will also introduced from next meeting and a Service User & Carer Council representative will be invited to join the Committee.

The Terms of Reference will be reviewed alongside the Terms of Reference for the Senior Leadership Team. Reports to the Committee will be further streamlined to avoid any unnecessary duplication, as well as making clear those reports that provide assurance and those being provided for information purposes. To further enhance effectiveness, more information will be circulated outside of the meeting to ensure that the time in meeting is used more productively.

22 Next meeting:
Thursday 22 June 2017 2pm

On behalf of the Committee Chair, Mr Patrick Sullivan, Non-Executive Director

Sandra Storey
Associate Director of Medical and Clinical Effectiveness
02 May 2017

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: Trust Board

Enclosure 6

Date of Meeting:	11 May 2017
Title of Report:	Safer Staffing Monthly Report for March 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 March 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 March 2017 was 80% for registered staff and 103% for care staff on day shifts and 84% and 107% respectively on night shifts. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover and Ward Manager supporting clinical duties.

	The position reflects that Ward Managers are effectively deploying additional staff to meet increasing patient needs as necessary.
Seen at SLT or **Exec** Meeting & date	SLT/EXEC: See 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 March 2017 following the reporting of the planned and actual hours of both Registered Nurses (RN) and Health Care Support Workers (Care Staff) to Unify. Appendix 1 also details the establishment hours in comparison to planned and actual hours.

2 BACKGROUND

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

In addition to the monthly reporting requirements the Executive Director of Nursing & Quality is required to review ward staffing on a 6 monthly basis and report the outcome of the review to the Trust Board of Directors. The next 6 month review covering the period July 2016 - December 2016 is currently being finalised and will be reported to SLT in April 2017 and then to Board of Directors.

3 TRUST PERFORMANCE MONTH 12

During March 2017 the Trust achieved staffing levels of 80% for registered staff and 103% for care staff on day shifts and 84% and 107% respectively on night shifts. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by 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.

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.

4 Issues impacting on fill rates

Ward Managers report the reason for unfilled shifts on a shift by shift basis. Themes and mitigating actions are summarised in Appendix 2, however the key themes are the opening of Ward 4 and recruitment to vacancies.

4.1 Impact on Patient Safety

A summary from Ward Managers of issues, patient safety, patient experience, staff experience and mitigating actions is set out below.

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

Ward	Incident
A&T	Three occasions where staffing levels were reduced leading to reprioritisation of workload for the shift.

Ward	Incident
Ward 5	Two occasions where ward staffing was short by 2 members of staff for the shift, therefore it was challenging for remaining staff to safely care for service users.
Edward Myers	One occasion where a member of staff was moved to another ward to support staffing shortages. One further incident when bank member of staff booked for IOU failed to report for duty. No capacity for staff from other wards to support therefore IOU closed to new admissions, IOU bed already occupied was supported by ward staff.

4.2 Impact on Patient Experience

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

4.3 Impact on Staff Experience

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

- 49 staff breaks were cancelled (equivalent to approximately 1% of breaks)
- 10 staff breaks were shortened (equivalent to approximately 0.2% of breaks)
- 181 hrs of ward cross cover (nursing staff were reallocated to cover shortfall within other clinical areas)

4.4 Mitigating Actions

Ward Managers and members of the multi-disciplinary team have clinically supported day shifts to ensure safe patient care. Skill mix has been altered to backfill shortfalls. A total of 257 Registered Nurse shifts were covered by Healthcare Support Workers where Registered Nurse temporary staffing was unavailable. A total of 12 Healthcare Support Worker shifts were covered by Registered Nurse staff where Healthcare Support Worker temporary staffing was unavailable. Additionally, as outlined in section 4.3, staff breaks have been shortened (time is given in lieu) or not taken and wards have cross covered to support safe staffing levels.

5. SUMMARY

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

Appendix 1 March 2017 Safer Staffing

March	DAY						NIGHT						DAY		NIGHT					
Ward name	Registered nurses			Care staff			Registered nurses			Care staff			Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Safe staffing was maintained by:	Vacancies	Bed occupancy	Movement	Provisional sickness data
	Establishment Hours	Clinically required Hours	Total monthly actual hours	Establishment Hours	Clinically required	Total monthly actual hours	Establishment Hours	Clinically required	Total monthly actual hours	Establishment Hours	Clinically required	Total monthly actual staff hours									
Ward 1	1563	1563	782	1395	1395	1849	665	665	418	665	997	1223	50%	133%	63%	123%	Nursing staff working additional hours and altering skill mix.	2 B5 3B3	91%	↓	6.80%
Ward 2	1463	1463	1201	1395	1395	1508	665	665	429	665	665	922	82%	108%	65%	139%	Nursing staff working additional hours and altering skill mix.	4.6 B5 1B3 2B2	99%	↑	15.69%
Ward 3	1568	1568	1277	1395	1395	1569	665	665	375	665	665	954	81%	112%	56%	144%	Altering skill mix, cancelling non direct care activity and support from the MDT.	3.8 B5 1.6 B2	91%	↑	3.29%
Ward 5	1103	1568	935	930	1395	1662	290	290	309	871	871	851	60%	119%	106%	98%	Altering skill mix, cross cover was also provided to other wards.	0	100%	↓	0.00%
Ward 6	1103	1283	1050	1860	1860	1853	291	291	291	872	1004	947	82%	100%	100%	94%	Altering skill mix.	0	90%	↓	0.00%
Ward 7	1013	953	843	1395	1395	1411	290	290	290	582	581	581	88%	101%	100%	100%	Nursing staff working additional hours and altering skill mix.	1 B5	93%	↓	0.00%
A&T	1588	1386	1282	1395	1861	1640	333	333	355	1000	1709	1666	92%	88%	106%	97%	Altering skill mix and reprioritsing activties.	2 B5	96%	↑	5.26%
Edward Myers	1136	1151	1101	930	930	890	291	291	294	581	581	582	96%	96%	101%	100%	*	1 B3	94%	↑	5.88%
Darwin Centre	1098	1176	1140	1395	1022	1001	333	333	333	660	693	693	97%	98%	100%	100%	*	1 B5	96%	↑	0.00%
Summers View	1005	1005	811	930	930	802	332	332	332	665	665	665	81%	86%	100%	100%	Support from the MDT.	0.8 B5 1 B3	98%	↑	4.92%
Florence House	563	563	542	930	930	819	332	332	332	332	332	332	96%	88%	100%	100%	Support from the MDT.	0	100%		5.72%
Trust total	**13199**	**13677**	**10964**	**13950**	**14508**	**15004**	**4488**	**4488**	**3759**	**7558**	**8763**	**9417**	**80%**	**103%**	**84%**	**107%**					

Appendix 2 - March 2017 Staffing Issues

- Ward 4 opened temporarily in November 2016, to support the local health economy, has impacted on staffing levels since then. There are two reasons for this; firstly, the use of temporary staffing to staff the majority of Ward 4 shifts has resulted in other wards having difficulty in sourcing temporary staff when needed. Secondly, Wards 5, 6 and 7 released 1 WTE Registered Nurse each to provide Ward 4 with stable Registered Nurse leadership, additionally the acting Ward 4 Manager was seconded from Ward 7. This has led to the depletion of Registered Nurses on existing wards. Ward 4 was initially commissioned until the end of March 2017 but has recently been commissioned to open permanently as a shared care ward. Therefore there will be a transition period whilst staffing, equipment, processes and procedures etc. are put in place to safely open the ward as shared care.

  Across the wards there has also been staff turnover and further vacancies have arisen since October 2016. These have been difficult to fill and despite several adverts there are currently 15.2 WTE Registered Nurse vacancies reported across in-patient wards. This is in line with the national picture where nursing shortages are being experienced across sectors. To pro-actively attract new Nurses to the Trust, 22 Student Nurses, due to qualify in Oct 2017, have been offered posts. Monthly one-stop shops are also planned alongside a rolling recruitment campaign. From a long term perspective the Director of Nursing and Head of Nursing are meeting with UHNM with regards to pre-registration nursing and Nursing Associate apprenticeships which will help us to 'grow our own' nurses over coming years.

- The highest Registered Nurse vacancies are across the Acute Adult Mental Health wards with Wards 1, 2 and 3 currently having B5 vacancies of 2, 4.6 and 3.8 WTE respectively; these posts have been advertised externally, however only 2 B5 positions have been appointed to. The two 'one stop shop' recruitment events that took place in March 2017 had limited success. Return to practice (RTP) nurses were also be encouraged to apply with a view to attracting experienced nurses back to the profession however there were no RTP applicants.

- There is a further potential staffing issue due to Ward 4 opening permanently as a shared care ward. There will need to be a mixture of Mental Health and Adult Registered Nurses to support the ward and recruiting nurses for a whole ward will be challenging in the current climate. Furthermore the acting Ward Manager and 2 substantive Staff Nurses, currently allocated to Ward 4, have secured other posts within the Trust. Whilst there is a degree of flexibility with start dates due to posts being internal, these cannot be held indefinitely.

- The Ward 5 Registered Nurse fill rate on days was 60% during March 2017. The previous 2 six monthly safe staffing reviews have recommended that Ward 5 require additional 4.26 Registered Nurses, additionally Ward 5 have 1 Registered Nurse seconded to Ward 4 and 1 Registered Nurse seconded to RAID. These factors are impacting on the Registered Nurse fill rate.

In terms of day shifts, the ward is attempting to staff to the uplift in staffing recommended in the safer staffing, that is 3 Registered Nurses on the early shift and 3 on the late shift.

- Currently the ward establishment will only allow for staffing of 2 Registered Nurses on the early and late shifts therefore, as a maximum, they can only achieve 72% fill rate within their current establishment. The impact of Ward 4 and RAID secondments and the difficulty of sourcing temporary staff due to the needs of Ward 4 have resulted in even the 72% fill rate not being achieved. This situation has been raised with the Modern Matron (MM) and Head of Directorate (HoD) who are reviewing this operationally and agency Registered Nurse cover has been agreed to backfill the Registered Nurse seconded to Ward 4.

- The Ward 1 Registered Nurse fill rate on days was 50% during March. During March 2017 the ward have 2 Registered Nurses on long term sick, 2 Registered Nurse vacancies and one Registered Nurse was on secondment. Additionally there were 2 Registered Nurses on short term sick, a combination of annual leave and training also contributed to the fill rate. Skill mix was altered to increase Healthcare Support Worker numbers during March bringing the overall day shift fill rate to 88%. This has been raised with the Modern Matron who will keep this under review; the Modern Matron will also be overseeing roster practices to ensure that resources are used effectively.

- In June 2016 the planned Registered Nurse night shift cover was increased from 1 to 2 Registered Nurses on the Acute Wards (1, 2 and 3); this has led to a temporary decreased Registered Nurse nightshift fill rate on these wards. Now that the majority of newly qualified nurses have completed preceptorship, the Ward Managers have been directed to prioritise 2 Registered Nurses being rostered on nights. It is acknowledged that vacancies impact on Registered Nurse cover however given that more Registered Nurse support is available on the day, through Ward Managers, Modern Matrons and Nurse Practitioners, night shifts are the time when Registered Nurse support needs to be strengthened.

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

North Staffordshire Combined Healthcare NHS Trust

REPORT TO Trust Board

Enclosure 7

Date of Meeting:	11 May 2017
Title of Report:	2016/17 SI Quarter 4I Report
Presented by:	Dr Buki Adeyemo. Medical Director
Author of Report:	Jackie Wilshaw. Head of Patient and Organisation Safety Team
Purpose / Intent of Report:	for information/assurance
Executive Summary:	This report provides an overview of the Serious Incidents reported during Q4 2016/17
Seen at SLT or **Exec** Meeting & date	SLT / EXEC (and date): Approved by Exec Lead : Medical Director 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])	
Resource Implications: Funding source:	
Equality & Diversity Implications:	
Recommendations:	

1 Purpose of Report

1.1 The Quality Committee will receive this report, detailing the serious incidents from 1st January to 31st March (Quarter 4) 2016/17. This report will detail the status of serious incidents currently open and illustrate comparative trend data for Q3 and Q4 2016/17.

1.2 The report details serious incidents by category reported by quarter

1.3 The report details themes, learning and change arising from serious incidents

1.4 The report details the quarterly Duty of Candour report

1.5 The report details the quarterly Mortality Surveillance report

2 Serious Incidents Q4

The table below illustrates total SI`s reported by quarter for the period January 2017 to March 2017. Following a change to the StEIS reporting system in 2015, we are only able to compare incidents reported after that date; therefore Q1 of 2015/16 is not included.

At the time of generating this report (April) for Q4, 13 SIs have been reported onto StEIS at the end of March.

	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total 15/16	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total (YTD) 16/17
Homicide by Outpatient (in receipt)		0	0	1	**1**	0	0	0	0	**0**
Slip Trip Fall		1	1	2	**4**	2	0	1	2	**5**
Pending review - unexpected/potentially avoidable death		4	7	4	**15**	0	10	7	6	**23**
Apparent/actual/suspected self-inflicted harm meeting SI criteria (non-fatal)		0	2	0	**2**	0	1	1	1	**3**
Disruptive aggressive behaviour meeting SI criteria		0	0	0	**0**	1	0	0	0	**1**
Apparent/actual/suspected self-inflicted harm meeting SI criteria (suspected suicide)		2	5	7	**14**	7	11	4	2	**24**
Unexpected/potentially avoidable injury causing harm		0	0	0		0	1	0	0	**1**
Total		7	15	14	**36**	10	23	13	11	**57**

Quarter 4 serious incident analysis is summarised below:

There have been 13 serious incidents reported in Q4. However 2 of these incidents were downgraded and the investigations completed under internal processes. It should be noted that, at the time of this report, a number of the investigations are on-going.

The main points to note are:

- There were 3 unexpected deaths in the Substance Misuse Directorate, in Q4. This is a reduction in the deaths reported when compared to previous quarters.
- There were 5 incidents reported from the Adult Community Directorate. These included a suspected suicide and a serious incident as a result of self-harm.
- In the NOAP Directorate, there were 3 serious incidents. There were 2 incidents that were related to falls and 1 suspected suicide.

  From the initial review of the incidents, no service or care delivery issues (creating a causal link between these incidents) has been identified in this quarter.

3 Themes and Trends

There are no themes or trends identified specifically for Q4.

In Q4 the number of suspected suicides has reduced, with 2 suspected suicides reported during this timeframe in comparison with 4 suspected suicides reported in Q3.

4 Learning from Serious Incidents (SIs)

Recommendations for learning from Q3 and Q4 SIs include the following:

- CHMTs should clearly identify the referral routes into services. In particular, those people who are referred back in to services within 12 months will have their level of assessment identified and implemented following a MDT discussion.
- Improved communication between wards and departments at RSUH. Wards have been reminded to include the duty doctor in conversations when necessary, this is in relation to the return transfer of people admitted to RSUH, to ensure that the best care can be provided upon transfer back to our care.
- Improved documentation regarding the use of 'as required' medication (anxiolytic/antipsychotic, including rapid tranquilisation). Staff have been reminded to include the rationale for the decision to administer 'as required' medication including the non-pharmacological / defusion interventions and the effectiveness of any medication given.
- All NOAP ward staff will complete the level 2 dementia training; this will ensure that best practice is shared in relation to interventions used to ameliorate the behavioural and psychological symptoms of dementia

However it is recognised that investigations are also able to highlight areas of good practice:-

This includes:-

- Effective communication between teams.
- Appropriate use of family involvement in patient support.
- Patient involvement in risk assessment and care planning.
- Feedback from families which identified there appreciation of the care and support given to the patient.

The Suicide Prevention Strategy was approved by the Board in January and a work programme is in development. We are also working with partners in the development of a Stoke-on-Trent and Staffordshire wide prevention plan.

We continue to develop our learning from all incidents, the Learning Lessons bulletin and learning events are produced monthly in order to keep pace with new learning and to ensure timely sharing across the Trust. The workshop events have been very well received with good attendance and positive feedback from staff.

5. Duty of Candour (Q4)

All incidents that have met the criteria for the statutory Duty of Candour (DoC) requirements have been progressed in line with the Trust`s policy and national guidance.

The next of kin of people whose deaths meet the SI criteria receive a condolence/DoC letter and a face to face visit is offered. Outside of the SI process the Patient and Organisational Safety Team (P+OS) Team highlight possible cases with teams and monitor this process.

The weekly Incident Review Group examines all moderate and above incidents with regards to the Duty of Candour requirements. There is an established process to ensure that incidents are graded accurately and supported by an education programme.
The Duty of Candour incidents are set out below:-

	January 2017 – March 2017			
	Jan	**Feb**	**Mar**	**Tot**
Original Patient Safety Incident - moderate and above	41	32	44	117
Downgraded following review and do not meet the requirements for DoC.	33	30	39	102
Final Moderate and above total	8	2	5 +5 possible - returned to reporter	15

6 Mortality Surveillance (Q4)

There is a need to ensure that the Trust can be confident that all unexpected deaths are reported and investigated appropriately and that the information contained within its databases is accurate and informs the Trust standard of transparency and accountability.

When someone does die unexpectedly, it is important that their death is reported correctly and where necessary identified as a patient safety Incident (PSI)

It is important that the right level of review or investigation is undertaken to improve services, identify any service failure, learn from any mistakes and to provide families and stakeholders with relevant information.

The purpose of reviewing the circumstances of or investigating a death is:

- to establish if there is any learning for the Trust around the circumstances of the death and the care provided leading up to a death;
- to learn from any care and delivery problems that need to be addressed to prevent future deaths and improve services;
- to identify if there is any untoward concern in the circumstances leading up to death;
- to be in a position to provide information to HM Coroner if requested;
- to be able to work with families to understand the full circumstances and answer questions;
- to have the full detail of the events available for any subsequent complaint or legal investigation.

A Mortality Surveillance report is produced quarterly and is discussed at the Clinical Safety Improvement Group and Quality Committee. This will ensure that the Trust is sighted on all deaths as a result of natural causes, in addition to those deaths subject to Serious Incident investigation. This enables the Trust to identify gaps in service delivery/lessons learnt and identify action as appropriate. The following table identifies the Q4 number of deaths reported on CHIPS (NB March data is not available at the time of report):-

	Total number of deaths	Total number of deaths – out of service	Reported as SI	Open to services at time of death- natural causes
Jan	148	142	3	3
Feb	43	38	2 *2	3
March	Data not yet available			

Natural cause deaths (open to services at the time of death), as identified by HM Coroner, are not subject to SI investigation, however case reviews are undertaken in order to ensure that there are no gaps/omissions in service delivery.
All unnatural deaths where the person is in receipt of services were investigated through the Serious Incident process.

The vast majority of deaths are reported on CHIPS (the Trust`s clinical record) for the Neuro and Old Age Psychiatry Directorate, deaths relate to elderly people who have had some contact with the Memory service (this is a diagnostic service), in the main these deaths relate to people who have been out of service for over 12 months and deaths that do not meet the criteria for SI investigation.

7 Summary

The Board is asked to note the process in place set out in this report and to note SIs, Duty of Candour and Mortality Surveillance for Q4.

Jackie Wilshaw
Senior Nurse/Head of the Patient and Organisational Safety Team
April 2017

REPORT TO Trust Board

Enclosure 8

Date of Meeting:	11 May 2017
Title of Report:	Performance Report - Month12 2016/17
Presented by:	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 12 (March 2017). Performance against NHSI metrics and key National Targets is included within the report. At Month 12 there are 2 metrics rated as Red and 1 as Amber.
Seen at SLT or **Exec** Meeting & date	SLT / EXEC (and date): 25th May 2017 Seen by Exec Lead : DoF Document Version number: 4
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

PERFORMANCE MANAGEMENT REPORT TO TRUST BOARD

Date of meeting:	11th May 2017
Report title:	**Performance & Quality Management Framework** **Performance Report – Month 12** **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 March 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.

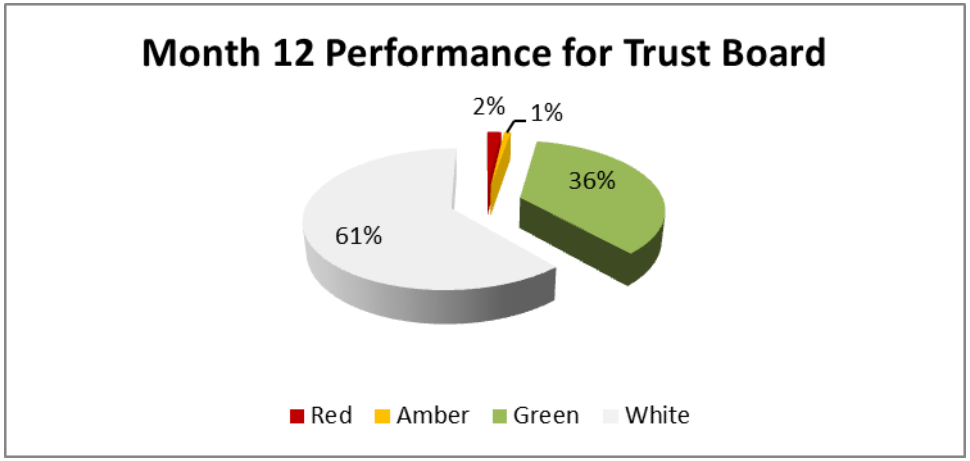
2 Executive Summary – Exception Reporting

The following performance highlights should be noted;

- 94.3% of patients Trust wide were assessed within 18 weeks of referral against a target of 92%
- 99.5% of CAMHS patients (excluding ASD) have been referred for assessment within 18 weeks
- 100% data sets submitted to SUS has an NHS number field completed
- Our DNA rate has remained consistently below target throughout the year (trust wide)
- 96.2% of service users on CPA have received a review within 12 months and 96.6% have a care plan in place
- The response rates to all categories of RAID referrals have been consistently met in Quarter 4

In Month 12 there are 3 targets related metric rated as Red and 1 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.

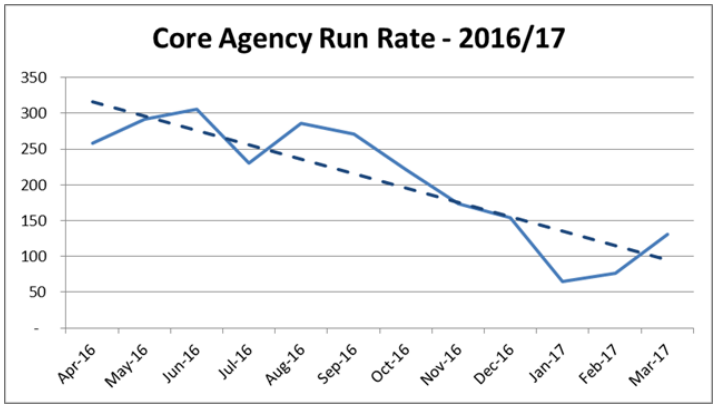
Contracted (National/Local CCG) & NHSI KPIs					
Metric	Red	Amber	Green	White	TOTAL
Exceptions – Month 10	2	2	43	67	114
Exceptions – Month 11	2	1	44	67	114
Exceptions – Month 12	3	1	39	67	110

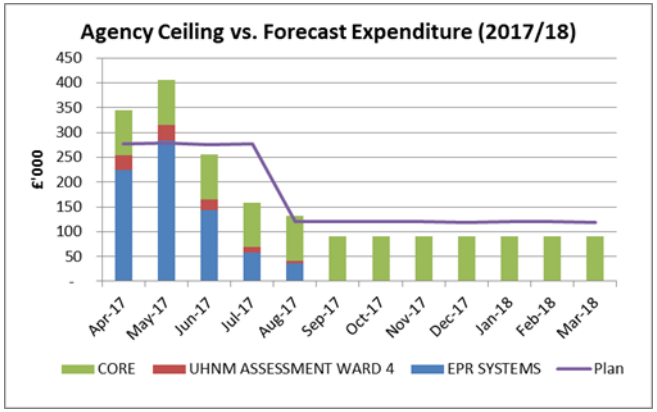


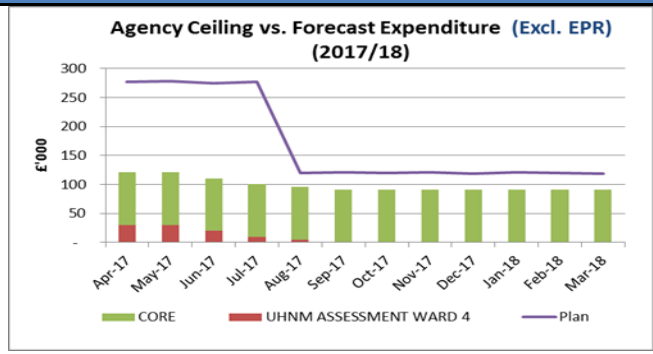
3 Rectification Plans

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. Given the high number of readmissions in the last 2 quarters and the deep dive being undertaken, the detail has been included as an exception in month despite improvement in month 11.

4 Exceptions - Month 12

KPI Classification	Metric	Exec/Op Lead	Target	M11	M12	Trend	Commentary
NHSi	**Agency Spend:**	Dir of Workforce	**M12 2.6%**	**RED 6.9%**	**RED 5.7%**	↘	5.7% at M12 from 6.9% at M11 . The Agency spend is broken down into 3 main areas as summarised below:
	Core Agency Spend			**1.6%**	**2.9%**	↗	Core Agency – 2.9% at M12 from 1.6% at M11 The run rate for agency has significantly reduced as shown by the graph below  Average monthly spend in Q1 is £285k, compared to £91k for Q4; **a 68% run rate reduction**. There is a small increase in run rate for March 17 due to Locum cover for a recent IP leaver. Interview scheduled for 21 April.

KPI Classification	Metric	Exec/Op Lead	Target	M11	M12	Trend	Commentary
							Forecast Performance 2017/18 The plan submitted for 2017/18 remains at £2.068m. The graph below summarises the Agency position for 2017/18. • EPR and Ward 4 Agency is anticipated to cease by September 2017 • The use of resources framework is anticipated to be October 2017 • Trust and national initiatives are likely to reduce core agency spend further than levels modelled 

KPI Classification	Metric	Exec/Op Lead	Target	M11	M12	Trend	Commentary
	ROSE Agency Spend			**4.8%**	**2.3%**	↘	 ROSE – 2.3% at M12 from 4.8% at M11 Agency spend on ROSE remains below the planned trajectory A detailed agency plan has previously been submitted to the Trust Board. A rectification plan has been submitted to Finance & Performance Committee and People and Cultural Development Committee. **Rectification Plan: Received at all sub-committees**
NHSI	**Delayed Transfers of Care**	Dir of Ops	**4.9%**	**RED 11.6%**	**RED 12.9%**	↗	**12.9% at M12 from 11.6% at M11** The delays relate to delays in accessing access to health and social care funding and placements and patient choice. It should be noted that the figures are volatile depending on the number of patients with long delays. At the beginning of 2016, the numbers of delays had decreased and then increased significantly over the last quarter. This has a significant impact on bed availability in the Trust and on flow across the local health economy. In view of this, there will be a deep dive of all Trust and Directorate delays in year which

KPI Classification	Metric	Exec/Op Lead	Target	M11	M12	Trend	Commentary
							will be reported back to Committee. The Trust is piloting the RED to Green approach developed by the Emergency Care Improvement Programme (ECIP), which focuses on eliminating patient time wasted in the pathway (red days) and focussing on days which are of value to the patient (green days). We are an early adopter of red to green in mental health and we believe the first Trust to do so. NHS Improvement has expressed an interest in the work. Confirm and challenge sessions are held with ward managers to ensure that delays are escalated to CCGs and Local Authorities for speedy resolution. AMH IP – 8.6% at M12 from 5.4% at M11 NOAP – 31.3% at M12 from 29.9% **A rectification plan will be required.**
Local Quality	**Readmissions:** Percentage of patients readmitted within 28 days of discharge	Dir of Ops	**7.5%**	**GREEN** **3.8%**	**RED** **8.8%**	↗	**8.8% at M12 from 3.8% at M11** Adult IP = 12.1% at M12 from 4.6% at M11 A deep dive is being undertaken analysing the emergency readmissions for Adult Inpatient services over the last 6 months. This has provided a detailed analysis of the circumstance of each emergency readmission and this will be followed up through a quality audit to understand where improvement may be required.

KPI Classification	Metric	Exec/Op Lead	Target	M11	M12	Trend	Commentary
Local Quality	**7 Day Follow Up:** Patients seen within 7 days of discharge from hospital (CPA)	Dir of Ops	**95%**	**AMBER** **92.5%**	**AMBER** **91.0%**	↘	**91.0% at M12 from 92.5% at M11** AMH IP – 95.1% at M12 from 93.9% at M11 NOAP – 33.3% at M12 from 75.0% at M11 There were four breaches of CPA 7 day follow up cases in March out of a total of 44 CPA discharges; 2 of these were Adult Community services and 2 were in NOAP. The respective directorates have been supplied on a weekly basis with the patient names of breaches to ensure when a follow up is completed, it is recorded on the system. **A rectification plan will be required.**

5 Recommendations

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

Trust Dashboard
Month: **March**

12
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%	100.0%	84.6%	↘
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%	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%	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	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%	93.8%	94.3%	↗
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%	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%	89.9%	90.6%	↗
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%	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%	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%	100.0%	98.5%	↘
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%	98.3%	99.5%	↗
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%	100.0%	100.0%	↔
Local Quality	Percentage of adults who have received secondary mental health services who were on a Care Programme Approach who have had at least one formal review in the last 12 months *CCG Measure*	Monthly	95%	95.7%	95.0%	95.1%	94.9%	94.5%	93.6%	94.6%	95.9%	95.6%	96.5%	96.3%	97.0%	↗
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%	98.0%	95.0%	↘
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%	93.0%	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%	90.0%	98.0%	↗
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%	100.0%	100.0%	↔
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%	99.0%	98.8%	↗
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%	98.8%	98.8%	↗
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%	0.7%	0.6%	↘
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	14.0	25.0	↗
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	3.0	1.0	↘
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	3.0	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	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%	93.6%	93.8%	↗
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%	93.8%	93.9%	
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%	82.8%	71.4%	
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%	100.0%	100.0%	↔

	Metric	Frequency	Target	April	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Trend Rate
NHSI	The proportion of those on Care Programme Approach (CPA) for at least 12mnths having formal review within 12mnths *NHSI*	Monthly	95%	94.1%	92.4%	92.1%	92.0%	91.8%	91.4%	91.2%	89.4%	98.3%	95.8%	95.5%	96.2%	↗
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%	95.6%	96.4%	↗
NHSI	LD	Monthly	95%	95.7%	95.7%	100.0%	100.0%	100.0%	100.0%	96.0%	83.3%	83.3%	92.3%	100.0%	100.0%	↔
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%	76.9%	66.7%	↘
NHSI	C&YP	Monthly	95%								100.0%	100.0%	100.0%	100.0%	50.0%	↘
NHSI	Mental health delayed transfers of care (target NHSI) (M9-5.7%, M10-5.4%, M11-5.2%, M12-4.9%)	Monthly	4.9%	6.2%	11.4%	10.3%	10.4%	9.7%	6.1%	5.6%	5.8%	6.6%	9.0%	11.6%	12.9%	
NHSI	AMH IP	Monthly	4.9%	7.0%	8.4%	5.4%	8.6%	8.0%	7.7%	6.0%	5.6%	9.2%	12.1%	5.4%	8.6%	
NHSI	LD	Monthly	4.9%	16.7%	10.8%	0.0%	0.0%	0.0%	4.2%	0.0%	8.0%	15.6%	26.5%	24.6%	1.1%	
NHSI	Neuro and Old Age Psychiatry	Monthly	4.9%	5.3%	17.8%	21.1%	16.9%	16.2%	11.4%	15.7%	9.5%	8.8%	13.7%	29.9%	31.3%	
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	174.0	186.0	↗
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%	92.5%	91.0%	↘
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%	9.3%	3.8%	8.8%	↗
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%	4.6%	12.1%	↗
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%	1.8%	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%	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%	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%	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%	95.8%	96.6%	↗
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%	96.4%	97.0%	↗
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%	98.2%	100.0%	↗
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%	78.9%	78.4%	↘
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%	56.3%	66.7%	↗
Local Quality	IAPT: Service User Satisfaction Local. To include questions on: • Access/referral arrangements • Treatment Options • Communication / Contact • Overall service provided (From a minimum sample of 30% of Service Users less than 15%	Monthly (questionnaire to be agreed with commissioners)	15%	N/A	N/A	0.0%	N/A	N/A	0.0%	N/A	N/A	2.0%	N/A	N/A	0.0%	
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	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%	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	N/A	0.0%	
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	N/A	100.0%	
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	N/A	76.5%	
Local Quality	IAPT: Local. The number of staff who have accessed clinical supervision Requirement is for minimum of 1 hour per week for all IAPT staff, - target % of staff in receipt of required level. (No threshold but there should be a framework in place that the Provider is working to ensure that all staff are approporaitely supervised)	Quarterly	No Target	N/A	N/A	100.0%	N/A	N/A	100.0%	N/A	N/A	100.0%	N/A	N/A	100.0%	
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%	89.3%	88.8%	↘
NHSI Domain - Caring																

	Metric	Frequency	Target	April	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Trend Rate
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	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	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%	86.0%	85.0%	
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	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	N/A	100.0%	
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	N/A	100.0%	
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	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%	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	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	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	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	2.0	4.0	↗
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	390.0	405.0	↗
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	19.0	24.0	↗
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	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	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	10.0	12.0	↗
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	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	2.0	2.0	⇔
Local Reporting	Safety Thermometer - Percentage Harm Free Care	Monthly	No Target	95%	95%	98%	96%	98%	100%	96%	98%	100%	94.1%	98.0%	96.1%	↘
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%	3.9%	2.0%	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	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	15.0	13.0	↘
Local Reporting	Proportion of patients who had recorded incidents of physical assault to them leading to Moderate/Severe harm/death	Monthly	No Target	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.00	0.0	0.0	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	0.0	3.0	↗
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	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	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	0.0	0.0	⇔
Local Reporting	Community patient (in receipt) within 3 months of discharge from service	Monthly	No Target	0.0	0.0	0.0	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	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	2.0	3.0	↗
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	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	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	2.0	3.0	↗
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	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	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	2.0	3.0	↗
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	50.0	43.0	↘
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	0.0	1.0	↗
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	64.0	49.0	↘

	Metric	Frequency	Target	April	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Trend Rate
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	34.0	27.0	↘
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	1.0	5.0	↗
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	6.0	11.0	↗
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%	6.0%	6.0%	⇔
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%	6.0%	5.9%	↘
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%	7.0%	6.7%	↘
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%	2.0%	2.5%	↗
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%	5.0%	4.9%	↘
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%	8.0%	7.5%	↘
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	33.0	17.5	↘
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	34.9	8.2	↘
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	15.8	148.9	↗
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	61.6	57.9	↘
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	10.2	13.4	↗
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	349.4	3.1	↘
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	32.0	29.2	↘
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	37.8	32.7	↘
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	8.9	108.9	↗
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	65.9	52.6	↘
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	9.9	11.7	↗
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	498.7	2.4	↘
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	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%	1.6%	0.0%	↘
NHSI	CAS alerts outstanding	Monthly	0	0	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%	98.0%	96.1%	↘
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%	2.0%	0.0%	↘
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	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%	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%	99.8%	100.0%	↗
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%	92.0%	96.0%	96.0%	Published April 2017			⇔
NHSI	Agency Spend (of total paybill) (M9-2.9%, M10-2.8%, M11-2.7%, M12-2.6%)	Monthly	2.7%	5.2%	6.0%	6.1%	4.8%	6.0%	6.4%	7.7%	7.4%	8.4%	7.0%	6.9%	5.7%	↘
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%	3.4%	3.7%	↗
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%	0.8%	2.7%	↗
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%	4.0%	4.5%	↗
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%	4.2%	6.4%	↗
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%	3.9%	1.8%	↘
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%	4.9%	3.0%	↘
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%	2.8%	2.9%	↗
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%	5.6%	3.9%	↘
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	0.8	1.4	↗
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	0.9	2.1	↗
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	0.9	2.1	↗
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	1.3	0.0	↘
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	0.4	0.0	↘
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	0.0	1.8	↗
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	0.8	0.0	↘
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	1.9	5.9	↗
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	106.0	52.0	↘
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	51.0%	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	50%	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%	104.1%	105.9%	↗

	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: 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%	11.5%	10.7%	↘
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%	86.3%	84.7%	↘
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%	93.7%	93.6%	↘
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%	91.4%	98.1%	↗
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	398.0	493.0	↗
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%	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%	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%	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%	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%	1.11%	1.50%	↗
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	313.0	421.0	↗
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	171.0	227.0	↗
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	171.0	227.0	↗
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	123.0	145.0	↗
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	10.0	15.0	↗
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	19.0	21.0	↗
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: Qtr 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	162.0	211.0	↗
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%	75.9%	68.7%	↘
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%	91.8%	94.0%	↗
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%	81.8%	91.1%	↗
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%	79.8%	93.5%	↗
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%	77.4%	96.2%	↗
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%	101.0%	100.0%	↘
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%	102.4%	89.9%	↘
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%	90.2%	96.2%	↗
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%	86.4%	89.7%	↗
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%	80.4%	88.3%	↗
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%	76.8%	87.9%	↗
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%	77.4%	96.2%	↗
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%	94.8%	96.8%	↗
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%	91.7%	89.2%	↘
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%	64.0%	76.9%	↗
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%	95.0%	91.0%	↘
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%	100.0%	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%	98.4%	99.5%	↗
Trust Measure	CAMHS ASD - Referral to Assessment within 18 weeks (number) (Target M9 - 150, M10 - 125, M11 - 90, M12 - 45)	Monthly	90	N/A	N/A	N/A	N/A	N/A	N/A	230.0	217.0	166.0	154.0	139.0	108.0	↘

REPORT TO Trust Board

Enclosure 9

Date of Meeting:	11th May 2017
Title of Report:	ROSE Update
Presented by:	Gwyn Thomas, Digital Strategic Lead
Author of Report:	Ben Boyd, Associate Director of Transformation
Purpose / Intent of Report:	Assurance and approval
Executive Summary:	Lorenzo Go Live scheduled to commence from 13th May with all Trust services established by 15th May All necessary documents have been completed and final approval provided by Trust Completed documents as described will be submiited for final approval by NHS Digital on 11th May.
Seen at SLT or **Exec** Meeting & date	SLT / EXEC (and date): Seen by Exec Lead : 03/05/2017 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])	Corporate risk 747
Resource Implications: Funding source:	NHS Digital funding

Equality & Diversity Implications:	None
Recommendations:	Continue plans for Lorenzo Go Live commencing 13th May 2017

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

Trust Board Report 03/05/2017

Sign Off Document	Trust approval	Description
Chief Executive SRO Letter	Caroline Donovan SRO, Dave Rogers Chair	Final approval for Trust to proceed
Final Validation Report	Caroline Donovan SRO, Dave Hewitt CIO	Document to confirm system has been appropriately tested and configured to satisfaction of Trust/NHS Digital/DXC
Clinical Safety Report	Dr Hardeep Uppal CCIO	Report to NHS Digital describing approach to managing risks and clinical safety, identifies hazards and provides a statement from Clinical Lead that it is safe to proceed
Signed SDRC 5	Caroline Donovan SRO	5 stage checklist compiled by supplier DXC to confirm organisational readiness for infrastructure, training, configuration and governance
Security Model	Dr Buki Adeyemo	Confirmation from Caldicott Guardian that Smartcards and Clinical Roles have been set up appropriately

North Staffordshire Combined Healthcare NHS

NHS Trust

LORENZO
CLINICAL SAFETY CASE REPORT

Dr HARDEEP UPPAL

CHIEF CLINICAL INFORMATION OFFICER
AND CLINICAL SAFETY OFFICER

May 2017

PROUD TO CARE

spar

Towards Outstanding

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1. Version control

Version	Amendments	Date	Owner
1	First draft	10/4/2017	H. Uppal
2	Updated various sections	12/4/2017	H. Uppal
3	Updated all sections	18/4/2017	H. Uppal
4	Updated various sections, added section on deployment units, dxc risks, updated training and summary statement	25/4/2017	H. Uppal
5	Updated various sections	01/05/2017	H. Uppal
6	Edited following NHS Digital comments and added 2 further medium clinical risk issues from DXC	03/05/2017	H. Uppal

2. Introduction

This report summarises the current position on clinical safety with regards the intended deployment of Lorenzo version 2.11 Hotfix 1 on 13th May 2017 at North Staffordshire Combined NHS Trust [The Trust]. Lorenzo will replace the current processes of recording patient information in the Trust that are a combination of an electronic system (CHIPS) and paper.

This report is based upon regular reviews of the risks and hazards and the progress against these. The Digital Programme Board, chaired by our Chief Executive, provides the overall leadership for the project and regularly reviews the project's progress against the risks.

This report summarises the progress on clinical safety up to 1st May 2017. The report has been approved by the Trust (on 24th April 2017) and is due for NHS Digital sign-off on 5th May 2017, followed by Clinical Authority To Release. Our proposed Go Live date is 13th May 2017.

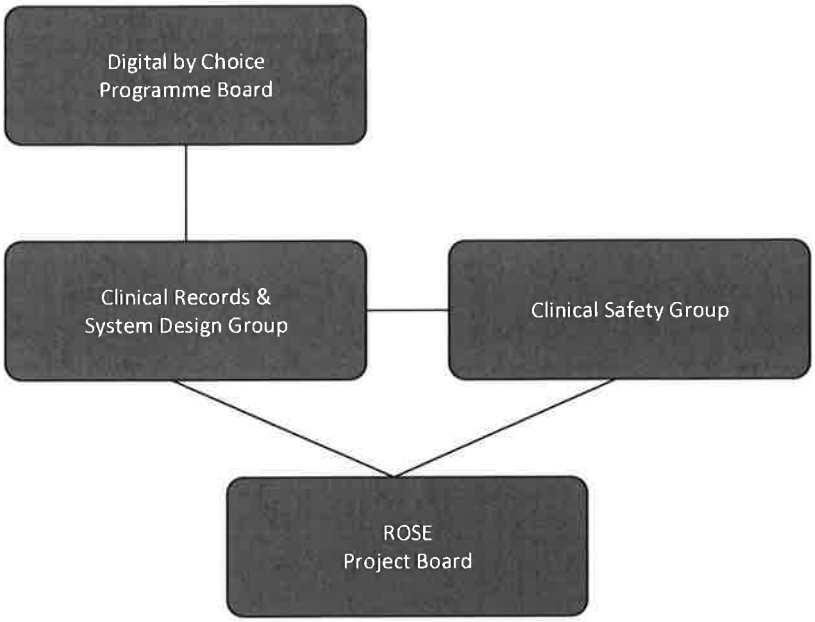
The Trust will deploy Lorenzo across 5 directorates (Adult Mental Health Community, Adult Mental Health Inpatients, Learning Disabilities, Neuropsychiatry and Older Adults and Child and Adolescent Mental Health Services). All directorates are intending to use the deployment units highlighted below from the Go Live date on 13th May 2017. The EPR project within the Trust is called ROSE (Raising Our Service Excellence).

3. Clinical Risk Management System

The EPR Project is overseen by a special committee of the Trust, Digital by Choice Programme Board, chaired by the CEO, with attendance from CCIO, Medical Director, Director of Nursing & Quality, Operations Director, Director of Finance, Workforce & Leadership Director and CIO.

At these monthly meetings a report is received on Risk Management from the Clinical Records & System Design Group [CRSDG]. The CRSDG meets monthly and is chaired by the Medical Director, or CCIO in their absence, and membership includes senior clinical representation from all 6 Directorates, Deputy Director of Nursing and senior corporate staff. This group meets monthly and has responsibility for reviewing the Risk Register, managing clinical and business risks and providing assurance that issues are being managed, or escalated as appropriate, within the directorates.

The Clinical Safety Group is a sub-group of CRSDG and is chaired by the CCIO/CSO with representation from the Organisational Safety Team, Governance Team, Project Management Office and ROSE Project Team. This group is responsible for preparing the Risk Register for review and ensuring that actions against the various risks are being undertaken and risks are appropriately mitigated. New risks are added at this group.



The CCIO underwent clinical safety training provided by NHS Digital and this provided the background with which he oversees any issues that arise from the project to verify whether they are clinical safety issues or not. Other members of the clinical safety group have also had clinical safety training.

4. Deployment Units

Deployment Unit	Phase 1	Not taking
Care Management	√	
Mental Health CM	√	
Emergency Care	√	
Clinical Documentation	√	
Requests and Results	√	
TTO (Outpatient Prescribing)	√	
Static Care Plans	√	
Day Care*		√
Advanced Bed Management*		√
Maternity*		√
In Patient Prescribing and Medicines Administration (IPPMA)	√	

All the highlighted deployment units will go live on 13th May 2017. The main modules that the Trust will use are care management and clinical documentation. These are core functionality used by all other Trusts on the RPA contract. The main issues with them are around performance and fixes are proposed to improve performance over the next 6 months. The Trust has not identified any clinical risks associated with these deployment units.

Mental Health Law is used by one other Trust presently and we have tested this function within the Trust. We have a small mental health team that are highly engaged and excited about using this new software that will massively improve our data quality. It will significantly reduce the clinical risks that have existed

around patients being detained incorrectly on the wrong paperwork and incorrect paperwork being completed whilst detained.

Emergency care is only due to be rolled out within our Place of Safety initially and it will be mainly used to monitor time to assessment. This function will be further explored post Go Live dependent upon the local health economy.

The Trust will only be using the Results part of Requests and Results due to ongoing issues with the local acute hospital. For Go Live we will only have imaging results in the system. There is no clinical risk here as results are already accessible through another system. We are simply trying to improve the quality of the patient record and have all the information in one place. Testing has not revealed any clinical risks.

Static Care plans are being used to deliver a new function of care plan pathways. This will allow us to guide clinicians to what they need to complete for a person with certain difficulties e.g. psychosis. This process will be used more for monitoring and reporting. This will be an improvement on the current process which is a mixture of paper and databases. There are no clinical risks that have been identified with this process. It will instead improve the care delivered by the different directorates and enhance the consistency of support and documentation.

TTO and IPPMA are combined to form the EPMA module. This is covered in detail below. In summary, other than for TTO and IPPMA, there have been no significant clinical risks identified with the Lorenzo deployment.

5. Risk Management

The hazard log is managed using the below matrix as below and is updated at least monthly;

Likelihood						
	Very High	3	4	4	5	5
	High	2	3	3	4	5
	Medium	2	2	3	3	4
	Low	1	2	2	3	4
	Very Low	1	1	2	2	3
		Minor	Significant	Considerable	Major	Catastrophic
		Consequence				

Each risk has a gross rating, a target rating and a residual rating after mitigating actions. The likelihood and consequence ratings are combined to give an overall rating for risk. All risks with a residual rating of 12 are reviewed by CRSDG and their management reported to Digital by Choice Board. The Clinical Safety Group manages all risks rated 12 or below. A hazard log is attached to this report summarising all the relevant clinical risks both high level and project level.

6. High level Risks

The highest risk within the project at present is EPMA (830 on risk register). This is discussed in detail later in the report (see Sections 9 and 10).

Our high level clinical risks are:

- Risk to patient safety if sufficient staff are not trained. (838 on risk register).
- Risk to patient safety if the data migration is not accurate. (837 on risk register).
- Risk to patient safety if there is inappropriate access of a patient's record. (828 on risk register).

Training and data migration are covered in more detail in Sections 6 and 7. Our business risks are not covered in this document as they relate to business processes and are not related to clinical safety.

7. Testing

There have been various levels of testing of the system starting with trial loads 1 and 2, then Business Process Validation (BPV) and finally Dress Rehearsal.

Business process validation began on 13th February; this was driven by scripts based upon the business processes from each directorate. Around 130 staff (approximately 10% of Trust staff) were involved in this process and an issue management process captured all issues arising. Feedback from BPV is in the table below. This shows that there was a high correlation between the test scripts and business processes.

Question	Excellent	Good	Good/Below	Below	Poor	Total
How would you rate the overall organisation of the session you attended	**98%**					
	75	52	0	3	0	130
How well did the test scenarios reflect real-life	**91%**					
	49	69	0	11	0	129
How easy to follow did you find the scripts	**93%**					
	42	77	1	8	0	128
How well do you believe the new system and processes will satisfy the needs of the business in your every day enviornment	**85%**					
	33	73	3	15	1	124
What is your overall impression of the look, feel and usability of the Lorenzo system	**84%**					
	39	63	3	17	4	122

Throughout the testing processes, no clinical safety issues have been identified other than with electronic prescribing (EPMA). There have been issues with business processes, as expected, and the expected risks around data migration and data quality within the current system (CHIPS). These are being managed by the project team and there are no expected issues around this for Go Live.

At Dress Rehearsal on 7th -10th April there were around 5 million records transferred across from the legacy system. There were some minor data quality issues but no clinical safety issues arose as part of the migration. There were no other clinical safety issues raised during Dress Rehearsal. The expected impact for patients around the data migration is minimal. If there are any significant clinical safety issues, as defined by the command centre at cutover, that could lead to patient harm, CHIPS will still be available to return to.

8. Training

Training has taken the form of elearning for all staff including those staff that will not need face to face training. The level of engagement from the Trust has been excellent and the current percentage of staff trained is 85% as at 1st May and therefore presents no clinical risk for the go-live. NHS Digital require 80%

trained for Go Live. Within the Trust, we have set a goal of 85% trained in each Directorate as a minimum and our training team will be providing bespoke training to specific specialist teams to aid their use of the system in addition to the face to face training and elearning. Given the high percentage of staff trained, there is expected to be minimal harm to patients from using Lorenzo.

9. EPMA

A number of potential clinical safety issues have been identified regarding Electronic Prescribing and Medicines Administration. These are covered in the attached hazard log.

A meeting was held on 23rd March 2017, where the EPMA team, DXC and CCIO met to discuss and evaluate the open issues to see how these could be mitigated. There was a discussion regarding the deployment of EPMA due to the ongoing issues. It was agreed that a recommendation would be made to the Trust Board that the deployment be limited to one ward. This ward is a learning disability assessment and treatment ward. It has up to 6 patients who are generally admitted for at least 3 months. The ward is on the main hospital site for the Trust and therefore easily accessible for pharmacy and the EPMA team, who are also located on the same site, to rapidly address issues. It was agreed that deploying in this fashion would mitigate clinical safety issues through using the system in a controlled and limited deployment until the appropriate fixes are delivered. This recommendation has been discussed at Digital Programme Board and Trust Board (6th April 2017) and has been agreed at both as a safe method for deployment.

In summary, the key clinical issues with EPMA are around issues with the leave prescription (a unique feature for mental health trusts), issues with the discharge prescription (which is currently being looked at by DXC) and issues with depot prescribing due to an inability to administer 2 weeks either side as is current practice (a change request has been raised). Other issues are currently being fixed or raised within the user group for further support to lead to change requests being raised. The impact on patients will be minimal based upon the limited deployment.

10.EPMA Issues from Other Trusts

NHS Digital asked the Trust, in early April 2017, to evaluate a number of issues that had been raised by other Trusts, these are in the table below.

Trust	CSC QCID	Summary
Warrington and Haltor	189079	LOR5101 - RWW - Stepped / Variable Drug eg Prednisolone causes Drug Sections in
South Warwickshire Fo	194694	SWFT_RJC_Outpatient Prescribing Misleading appearance of quantity prescribed in
Ipswich Hospital NHS T	198140	Issue with unlocking after 5 minutes inpatient prescription, allows to concurrent users to prescribe a same medication on a s
Sheffield Teaching Hos	199070	02/02 14:36 - LOR5101 - RHQ - Changing dose discrepancies on Discharge summary
Hull and East Yorkshire	199303	HEY - IPPMA - BPV - 524 - Stepped variable reducing dose by dose as a duration displaying out of order in the drug chart
Hull and East Yorkshire	200238	HEY - IPPMA - 524 - Duel entry with no warning prior to user 1 being in for 5 minutes 524.
North Staffordshire Co	200627	RLY_828: When prescribing naseptin for a patient who has a recorded severe allergy of peanuts, no warning appears, even though t

The above issues were discussed with the CCIO and it was felt, after consideration, that none of them would present any further risk to the Trust Deployment of EPMA (due to fixes already having been delivered or the nature of the Trust's deployment). All of the above were reviewed in a meeting with DXC on 6th April 2017 and the only issue which was in doubt was 2000627. Due to the nature of this issue, training will be provided to staff to make them aware that Lorenzo does not automatically check against

non-drug allergies. Also, the following statement has been issued by DXC regarding 200238 "200238 is down as resolved awaiting customer confirmation and they are tracking the change request for 198140."

11.DXC Medium Clinical Risk Issues

NHS Digital asked the Trust to review the open medium clinical risk issues prior to Go Live. The issues, with comments, are in the table below.

CSC QCID	Release/DU	Summary	Build	Remedy Date	Comments
188789	DU: Care Management	LOR5101 - RHQ - Messages not being added to LAA table for sending to downstream systems	2.11.0.2 Provisional	17/11/2015	We will monitor this post go live. Not a clinical safety issue at present.
189079	DU: TTO & Outpatient Prescribing	LOR5101 - RWW - Stepped / Variable Drug eg Prednisolone Causes Drug Sections in Discharge Summary to fail	Pending TF Requirement	13/01/2016	PAN issued 25th January 2016 – This has never been replicated and continues to be monitored. We will be typing medications into the discharge summary at present.
193118	DU: Care Management	LOR5101 - RTX - Clinical note data loss (physio)	Pending TF Requirement	23/05/2016	We will monitor this when we are live. No issues of clinical note data loss have been reported in BPV or Dress rehearsal.
193671	DU: Care Management	Parent LOR5101 - RTX - Letters to GP following A&E attendance are missing from the system	Pending TF Requirement	16/02/2016	Not applicable as we do not have an A&E.
193672	DU: Care Management	LOR5101 - RWA - HEY_PROD_you investigate how an Encounter ID can exist on two different patients	Pending TF Requirement	25/05/2016	We are using NHS number as identifier so this is not relevant.
193925	DU: Requests & Results	R&R VisitID + Patient confusion	Pending TF Requirem	22/07/2016	This is not relevant to us given we will receive results from an

			ent		external trust using NHS number as the identifier.
194694	DU: TTO & Outpatient Prescribing	Outpatient Prescribing Misleading appearance of quantity prescribed in prescription.	2.12.0.0 Candidate	17/08/2016	PAN distributed August 2016 This CR will deliver a permanent fix which is currently being mitigated by a script.
194771		As a developer, I need to provide an API to provide the count of finalised forms and latest forms finalised date/time so that retrospective form indicators can be calculated for the patient.			PAN issued 15th July 2016. A DCS has been prepared and run for this item as a temporary fix and is already in deployment. As there is a fix in deployment, this is not a clinical risk for our deployment.
195877	DU: Clinical Documentation	LOR5101 - RWA - Incorrect patients details in footer of clinical note	Pending TF Requirement	06/10/2016	Not noted by us in BPV or DRH. We will monitor when we are live.
198034	DU: Care Management	TCN - LOR5101 - RWW - Relog of HD1064836 - Linking referrals causing Maternity information to disappear.	Pending TF Requirement	19/12/2016	We will monitor for similar issues when we are live (we do not have maternity and do not link referrals).
198140	DU: Inpatient Prescribing (including Medication Administration)	Issue with unlocking after 5 minutes inpatient prescription, allows to concurrent users to prescribe a same medication on a s	Tactical Fix In Progress	03/01/2017	Only one prescriber on our initial ward. We are not planning to deploy wider until this and several other issues are resolved.
199303	DU: Inpatient Prescribing (including Medication Administration)	HEY - IPPMA - BPV - 524 - Stepped variable reducing dose by dose as a duration displaying out of order in the drug chart		08/02/2017	We are aware of this issue as well as other issues with stepped variable doses. We will monitor post go live.
200647	DU: TTO &	LOR5101 - RHQ -		31/03/2017	We are aware of this

	Outpatient Prescribing	Discharge summary information is missing on stepped variable.			and have taken the discharge prescription out of scope until it is fixed.
200889	DU: Care Management	Clinical note data loss when appending clinical note. Only the template has been saved.			LOR CSN 005-00 Distributed 3rd May 2017. This has not been identified within our testing processes. We will monitor post go live. The CSN contains information with regards how to prevent this happening.

At present the risks in the above table are all considered acceptable or not relevant based upon how we will be deploying Lorenzo.

12.Clinical Safety Statement

This report highlights that the Trust has engaged in clinical safety. We have achieved a high training completed figure (training continues until 5th May 2017). We have achieved the NHS Digital requirement of 80%. We have robust procedures for identifying, assessing, mitigating and monitoring risks. There have been a number of workshops that have covered various aspects of risk identification (whilst covering other processes too) and risk management, in particular around the clinical data capture forms being user friendly and reportable.

The Trust has had a successful dress rehearsal that identified few issues with data migration, due to the rigorous testing that has happened prior to dress rehearsal. Staff that attended received important insight into the difficulties they will face in the Go Live period but also the potential benefits they will gain. A valuable insight from a staff member was that no amount of training can prepare for Go Live. We are using several approaches to try to minimise the strain on staff in the Go Live period including super users who have had extra training including resolving smart card issues, extra floor walkers and a robust cutover plan with command centre.

The Trust has also conducted a number of 'deep dives' into the directorates going live with Lorenzo in order to assure and reassure that their needs are being met but also that they are meeting goals around training, clinical safety, business change, cutover planning and business continuity. There has also been a joint 'deep dive' between the Trust, DXC and NHS Digital in January that identified a number of business issues that have been addressed but no clinical safety issues.

Based upon the information provided within this report and all the ongoing preparatory work for a successful Go Live from the Trust corporate staff, clinical staff and project team, I do not have any clinical reason to advise the Trust to postpone the Go Live planned for 13th May 2017.

I am aware that the IPPMA functionality is a first of type pilot and clinical safety has not been signed off for the initial pilot in Sheffield. I believe that we are able to safely Go Live with EPMA with the inpatient prescribing part at present until fixes are delivered for leave prescribing, discharge prescribing and depot administration. As these fixes are delivered, we will update our clinical safety case, which will be reviewed by the CSG, in order to allow further roll out of EPMA. The ward we are planning to use has been identified as the ideal type of ward by Sheffield staff at the National Lorenzo User Group on 13th April 2017 to Go Live with for EPMA. Hazards for other deployment units have been considered and accepted including review of the single source of truth, PANs and CSNs.

In summary, other than for EPMA, no clinical safety risks have been identified with Lorenzo that require a significant work-around or non-beneficial change to business processes. The Trust has made a lot of effort to carefully assess clinical safety issues and rapidly mitigate them. However, EPMA continues to need a lot of development and we are keen to work with NHS Digital and DXC to achieve this.

Signature ..... H. Uppal ..... Date ..... 4/5/17 .....

Hardeep Uppal
Consultant Intellectual Disability Psychiatrist
Chief Clinical Information Officer
Clinical Safety Officer
North Staffordshire Combined NHS Trust

REPORT TO TRUST BOARD

Enclosure 10

Date of Meeting:	11th May 2017
Title of Report:	Board Assurance Framework 2016/17 Q4 update
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 4.
Seen at SLT or **Exec** Meeting & date	SLT/EXEC: Agreed by Execs w/c 24th April 2017 Date: Various Document Version number: 1
Committee Approval / Review	✓ Audit Committee ✓ Quality Committee ✓ Finance and Performance Committee ✓ People and Culture Development 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])	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 Q4 Update against the Board Assurance Framework for 2016/17 for assurance and information purposes.

North Staffordshire Combined Healthcare NHS Trust

Board Assurance Framework (BAF) 2016/2017 – Quarter 4

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

SPAR Reference	**CONTROLS**	**ASSURANCES**	**TIMESCALE**	**Progress against assurance**	**Lead Director**	**End Q4 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	Quarter 4	Deferred to 2017/18 BAF	DON			

		management						
		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 • Ward manager leadership programme prepared ward managers for the introduction of assessment and accreditation framework. • Assessment and accreditation framework developed	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	Patient safety campaign delivered as part of Safety Culture CQUIN	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 planned from 2017/18. To date visits completed for Wards 3, 6, 7 and 5.	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	• Training programme will commence in May • Care certificate competencies already in place • New Physical Health competencies for all registered nurses has been approved • Peer sessions to commence again between senior nurses and GP trainees. • New process to	MD			

				facilitate physical health checks prior to psychiatric appointment in outpatient clinics established.				
		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. 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	DON			

				median for mental health 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 53% for Q4 To improve compliance, further cascade trainers have been identified within Teams and additional training sessions planned. Clarification of 'eligible' nurses to ensure staff who do not handle medicines are excluded from count completed. E-learning for medicines calculations will commence in April in line with Trust E-learning strategy. On-going development of E-learning for medicines progressing using Script.	MD			
8. Safe		To increase the number of reported medication errors by 20% by end of Q4	20% increase for Quarter 4	Continuing improving picture shows 70% increase compared to baseline	MD			
9. Safe		To reduce the number of medication omitted	By Q4 there will be a 10% reduction	March result 5.9% which exceeds 10% reduction	MD			

		doses by 10% from the baseline of 8.38% by clinical teams	from the baseline of 8.38%					
10. Personalised		Consent to treatment to be recorded for 100% in partnership with patients	Quarter 1	Q4 update - The Consent Policy has been strengthened 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 79% compliance at end of March 17.	MD			
11. Personalised		Section 17 Leave forms to be completed for 100% in partnership with patients	Quarter 1	Included as part of the care planning checks, and compliance overseen by the Mental Health Law Governance Group. Quality Assurance Audit results March 17 demonstrates compliance.	MD			
12. Recovery		90% of appropriate staff will receive training on the Mental Health Act and Mental Capacity Act	Quarterly	Quarter 4 compliance 86%. E-learning packages available from April 2017 to improve accessibility and compliance.	MD			

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%	50% increase by Quarter 4	Q2 target 55% Q2 actual: 58.3% Q3 target 60% Q3 actual: 71% Q4 target 66% Q4 actual: 77%	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	Q4 update CQUIN requirements for Q4 submitted to commissioners; awaiting outcome.	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% Q4 actual: 92%	DO			
		IAPT target of 75% patients having	To be monitored	Q1 actual: 98.5% Q2 actual: 98.4%	DO			

		commenced treatment within 6 weeks of date of referral	Quarterly	Q3 actual: 94% Q4 actual: 100%				
		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% Q4 actual: 100%	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% Q4 actual: 94.3%	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% Q4 actual: Risk assessment 95.0% Care Plan 91.6%	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	Q4 actual 90%	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. Q4 update Core Directorate BCPs complete for AMH, NOAP and LD. Further work to complete other areas, during April/May Lorenzo requirement added in Q4. Plans produced, desktop test carried out and with Directorates for embedding in core BCP's	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** • **Clinical Audit Reports** • **Practice Improvement & Lessons**	• **Internal Audit**	• **Internal Audit Reports** • **External Visits / Inspection Reports** • **National Staff Surveys** • **Annual Audit Letter** • **External Audit**

Learnt Report • **Annual Governance Statement** • **Internal Audit Reports** •		• **Benchmarking**

	CONTROLS	ASSURANCES	TIMESCALE	GAPS AND ACTIONS	Lead Director	End Q4 RAG status	On Target RAG Status	End Year RAG Forecast
1	Strengthen integration of Mental Health with Primary Care services	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	Quarter 4	Work remains on-going: • There is agreement in place through the Associate Professor of Enterprise and Education Development at Staffs University to have a memorandum of understanding as formal recognition of collaboration. • Trust has become a member of MidTech (West Midlands Innovation	MD			

		and is successful in achieving external research funding.		Hub)R&D Team member approached to be a collaborator on RfPB bid (Research for Patient Benefit). • Received an invitation to participate in a joint project with UHNM and Human-nature CIC. (Community Interest Company). NSCHT to be lead for a RfPB (Research for Patient benefit)bid on recovery and resilience. Trust R&D Team member leading on this.				
3	Increased research activity and profile	Increase the number of research partners by 50% from baseline by Quarter 4 (n=20)	50% increase by Quarter 4	Annual target of 30 exceeded. Current number of partners is 47, Target 50%, achieved 134%.	MD			
		Increase the number of publications by 50% from baseline by Quarter 4 (n=8)	Quarter 4	Annual target of 12 for the year (3 each quarter exceeded) 17 Publications and presentations, Target 50%, achieved 110%.	MD			
		Increase the number of staff / teams engaged in research and evaluation by 50% from baseline by Quarter 4 (n=27)	50% increase by Quarter 4	Annual target of 40 exceeded Current number of teams & individuals engaged is 44, Target 50%, achieved 62%.	MD			
		Increase the number of home grown research and evaluation projects by 50% from baseline by Quarter 4 (n=14)	50% increase by Quarter 4, a total of 21 by Quarter 4	Annual target of 21 exceeded. Number of new projects initiated this year is 35. Target 50%, achieved 150%	MD			

		Increase the number of returns for student satisfaction surveys by 50% from baseline by Quarter 4	50% increase by Quarter 4	100% achieved.	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 technology to enhance quality and efficiency of service delivery • Access Programme • Autographer Programme	Quarter 4	Access Phase 1 implementation complete. Access phase 2 collaborative joint model with health care providers across North Staffordshire and Stoke-on-Trent. Continued roll out into 2017/18 – Autographer Project has secured £30K funding	DSD			

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 Q4 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 • Values Based Recruitment • Induction • Appraisal/PDR • Training Courses • HR Policies and Procedures	Quarter 4	Behaviour framework developed. 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 in 2017/18	DLW			
		Clinical Director and Clinical Leadership Development programmes are developed quarter 1 and	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	DLW			

		assurance obtained via • Clinical Director's completion of programme (Q4) • All identified Senior Clinical future talent on a rolling leadership programme (Q4)		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.				
		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	External software delays during March and April having a knock-on effect to start date. Trust is ready for implementation	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	Platform in place and programmes developed. Go live in May 2017 as deferred due to focus on ROSE 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	Improvements demonstrated	DLW			
		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%	Quarter 2	Current compliance 81%. Rectification Plans in place and managed through performance management sessions.	DLW			

		at end Quarter 2						
5	Widening Participation	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	Plan in place for April 2017 onwards	DLW			
		To develop processes, systems and relationships within the Trust, Training Providers and other stakeholders to commence apprentice recruitment to meet regional targets for 2016/17 of 22 new apprenticeships.	Quarter 4	Through preparation for the levy, it is prudent to have been made to defer some recruitment until after 1st May 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.	DLW	No RAG rating as assurance to be delivered in 2017/18		
	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	Quarter 4	An Action Plan related to the CQC inspection has been developed in Q4 to inform BAF for 17/18.	DLW			

		assessed by commissioners						
	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 Q4 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% Q4 actual: XXXXX Vacancy hold due to financial position	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	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			

		and wider leadership development.						
		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	New website is in place	DLW			
		Develop an effective online presence and increase online traffic	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	Quarter 3	Website enhanced with positive feedback. New website to launch	DLW			

		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		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.				
		Engage staff in two way communication - Increasing feedback from staff by 100% through various media. Twitter followership is increased from 442 to 900	Quarter 4	Q1 Twitter followers: 554. Q2 Twitter followers: 645 Q3 Twitter followers: 728 Q4 Twitter followers: 842	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 QIA to take place during Quarter 4	Quarter 3 Quarter 4	CIP plans in development for 2017/18. Schemes under identification. Significant work required on 17/18 CIP plans to close gap.	DO			
		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 fully delivered for 16/17 with all but £200k delivered recurrently	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. Structure in place to develop business intelligence (2017-18 objective)	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	£200k rebate on over payments made by trust as a result of energy use agreed and finalised. Trust considering a £250k further settlement in respect of pipework. Review of catering costs ongoing. Carillion have offered a £15k rebate on catering costs in return for the Trust forgoing the 2019 benchmarking opportunity. This has been turned down as external advice is that meal cost in particular given low levels of food and pay inflation in recent years and contract increasing by RPI.	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.	DO			
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 Complete in Mar 17.	DO			
		Completion of A&T Telford Purchase	Quarter 1	Purchase complete	DSD			
		Implement and ensure delivery of robust implementation plans for key estates schemes: 1. PICU (planning and commencement of	Quarter 1	Implementation plan required Contract in process of signature. Significant work required to keep on track in 17/18	DO			

		work)						
		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	This was held pending award of front of house contract that will drive how front door MH services will be delivered.	DO	**No RAG rating as delays for completion not in the control of the Trust.**		
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**		
5	Better use of the Estate	A review of the Estates function will be undertaken	Quarter 1	Q4. The planned review supported by Christie NHS Trust was completed. The report demonstrated what a good estates function looked like however an audit led review is now due for completion in	DO			

				May 2017 to understand the transformational model.				
		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	**RAG not provided as no longer seen as a priority for 2016/17**		
		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	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			

				Qtr 4 57 / 67 = 85% metrics were rated as Green				

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** • **Corporate Performance Report/ Dashboard**	• **Internal Audit**	• **Internal Audit Reports** • **External Audit Reports** • **LCFS** • **External Visits / Inspection Reports** • **Network Reviews**

• **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**		• **Healthwatch Reports**

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q4 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	DSD	No RAG rating as STP process delayed		
		Framework for business planning for clinical and corporate directorates is implemented	Quarter 1	Completed	DSD			
		Approval of 2016/17 plan and Development of 2017/18 plan	Quarter 4	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	DSD			

				development.				
		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 Birmingham 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** • **Reportable Issues Alert** • **Quality Account**		• **External Visits / Inspection Reports (e.g. CQC)** • **Independent Reviews (e.g. Ombudsman Reports)** • **National Patient Satisfaction Surveys (F&F Test)** • **Healthwatch Reports**

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q4 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.	Target 50% by Quarter 4 from Quarter 1	Q1 Inpatient: 22% Q2 Inpatient: 29% Q3 Inpatient: 54% Q4 Inpatient: 57% Target achieved	DON			
		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	RAG not available as timing of survey means 2017/18 results not yet available.		
		An increase in the number of service users employed by the Trust	Quarter 4	**Current position:** • April 2016 to date: 77 referrals actioned • Supported into Employment: 106	DLW			

				• Of those: 4 have been employed in NSCHT compared to zero in 2016/17				
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			

REPORT TO TRUST BOARD

Enclosure 11

Date of Meeting:	11th May 2017
Title of Report:	Board Assurance Framework 2017/18
Presented by:	Laurie Wrench, Associate Director of Governance
Author of Report:	Laurie Wrench, Associate Director of Governance
Purpose / Intent of Report:	Assurance
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 for 2017/18 has been further strengthened with the introduction of tiered level of assurance in line with internal audit recommendations. This year, the BAF has also been mapped to the key Trustwide risks that score 12 or above to allow a top down and bottom up approach to risk management. The inclusion of a year start RAG demonstrates where additional 'stretch' has been applied to the assurance introduced with those rated as 'amber' and 'red' posing greater challenge to delivery.
Seen at SLT or **Exec** Meeting & date	SLT/EXEC: Discussed with Execs w/c 24th April Date: Various Document Version number: 8
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 and maps to the Trustwide risks that score 12 or above.
Resource Implications:	None

Funding source:	
Equality & Diversity Implications:	None
Recommendations:	• The Board receive the 2017/18 BAF for assurance purposes.

Board Assurance Framework (BAF) 2017/2018

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

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

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

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

Objective 1:	To enhance service user and carer involvement								
SPAR PRIORITY									
Exec owner:	Director of Nursing and Quality								
Assurance Committee:	Quality Committee								
Risk appetite	Financial		Quality (Innovation)		Regulation		Reputation		

RISK: *The Trust fails to 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 (31/03/18)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
Risk Trend Arrow ⟷	4	3	12	3	3	9	2	3	6

Links to 12+ Trust Risks	**Description of linked 12+ Trust Risks**
	• **Not Linked to any Trust Wide Risk**

Internal Assurance Examples		**External Assurance Examples**
Level 1	**Level 2**	**Level 3**
• **Corporate Performance Report/ Dashboard** • **Internal Performance** • **Reportable Issues Alert** • **Quality Account** • **Internal Audit Reports** • **Practice Improvement & Lessons Learnt Report** • **Complaints and Concerns Report**	• **Internal Audit (linked to annual plan)** • **Strategy implemented** • **Plan realised**	• **National Patient Satisfaction Surveys (F & F Test)** • **Healthwatch Reports** • **Independent Reviews (e.g. Ombudsman Reports)** • **External Visits / Inspection Reports** • **CQC** • **External Audit** • **Benchmarking** • **Quality Account**

• **Incident Reports** • **SI Reports** • **Clinical Audit**		• **Annual Governance Statement**

SPAR Reference	CONTROLS to Mitigate Strategic Risk	Level of Assurance	Description of Assurance	Exec Owner	Year Start RAG	Quarter Due	Forward Plan / Progress	Q1 RAG	On Target RAG	Year End RAG
S P A R	Embed service user involvement across the Trust	2	Service user and carer engagement strategy is refreshed	DON		Q3				
		2	Ensure there is a service user and carer representation at the Mental Health STP Board	DSD		Q1				
		2	The service user friends and family test response rate is increased by XX% (to be confirmed once Q4 data available)	DON		Qrtly				
		2	The % of service users recommending the trust as a place to receive care is increased and maintained at 90% or above	DO		Qrtly				
		2	There is service user / carer representation on trust committees facilitated through the service user and carer council	DON		Q3				
		3	The Trust will achieve scores in the “best performing Trusts” category for >50% of indicators in the Community Mental Health	DO		Q4				

			Survey							
		2	Refresh of the Quality Strategy with full input from service users and carers	DON		Q1				
A	Service users and carers are engaged in the development of the STP	3	The chair of the service user and carer council is a member of the community reference groups	DLW		Q2				
A	Development of a network of peer support workers	2	A plan is developed to introduce peer support workers in line with the service user and carer engagement strategy. Ten peer support workers will be in place by the end of Q4	DON		Q4				
A	Enhanced understanding of the financial position for service users, carers and staff	1	Implement alternative presentation of the annual accounts 2016-17 for AGM	DFP		Q3				
		1	Creation of a number of finance videos explaining the Trust's finances	DLW		Q4				
R	Development of a wellbeing academy	2	Wellbeing academy is implemented to complement traditional rehabilitation approaches by providing people with education and learning experiences as a means of supporting personal and social recovery.	DON		Q3				

Objective 2:	To provide the highest quality services
SPAR PRIORITY	
Exec owner:	Director of Nursing and Quality and Medical Director
Assurance Committee:	Quality Committee

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

RISK: *The Trust fails to improve patient safety, eliminate avoidable harm and deliver high quality services, resulting in less than optimal care, reputational harm, increased scrutiny and regulatory restrictions* *Risk Trend Arrow*	**Gross Risk (no mitigation)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/18)**		
	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** • 440 – Place of Safety • 441 – PICU • 423 – Compliance with MHA/MCA

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

• **Practice Improvement & Lessons Learnt Report** • **Complaints and Concerns Report** • **Incident Reports** • **SI Reports** • **Clinical Audit**		• **External Audit** • **Benchmarking** • **Quality Account** • **Annual Governance Statement**

SPAR Reference	CONTROLS to Mitigate Strategic Risk	Level of Assurance	Description of Assurance	Exec Owner	Year Start RAG	Quarter Due	Forward Plan / Progress	Q1 RAG	On Target RAG	Year End RAG
S P A R	Every CQC core service rating is 'good' or 'outstanding'	3	CAMHS Community services are rated as 'good'	DO		Q3				
		3	Adult Community Services are rated as 'good' for the safe domain	DO		Q2				
		3	Older persons inpatient services are rated as 'good' for the safe domain	DO		Q2				
S	Improved physical health monitoring	3	The Trust is a smoke free organisation	MD		Q4				
		2	Increased staff recognition of the 'deteriorating patient' in relation to the onset of sepsis.	DON		Q4				
		3	Flu vaccination campaign is delivered achieving national targets of at least 75% frontline staff receiving the vaccination	DON		Q4				
		2	A falls reduction programme is developed and implemented resulting in a 30% decrease in the number of falls	DON		Q4				
		3	A programme of prevention and assessment	MD		Q3				

			of cardiometabolic disease is developed and implemented in older adult inpatient services aligned to the Lester Tool for adult inpatient services							
		1	100% compliance with physical health monitoring and recording post rapid tranquilisation	MD		Q1				
S P A R	Safer Staffing	2	Safer staffing is introduced for 24/7 services	DON		Q2				
		1	Vacancy rates remain below the mental health national average of XX	DO		Monthly				
		1	Sickness rates remain below the mental health national average of XX	DO		Monthly				
		1	Time to recruit rates remain below the mental health national average of XX	DLW		Monthly				
		1	Safer staffing levels do not fall below recommended thresholds	DON		Monthly				
S P A R	A quality improvement programme is established focussing on a decrease in mortality	2	Unannounced assurance visits continue to be embedded with a quarterly report to the Quality Committee and Trust Board	DON		Qrtly				
		2	Implement Productive Inpatient Wards to release time to care for patients	DON		Qq4				

		2	An inpatient assessment accreditation framework is implemented with 100% of wards participating in the programme by Q4	DON		Q4				
		1	Strengthened approach to governance, professional and clinical leadership within Directorates to support operational management	DON		Q2				
		1	Development of a Community Safety Matrix	DON		Q4				
		3	100% achievement of CQUIN scheme	MD		Qrtly				
		3	Collaborate with partners to reduce deaths by suicide in the Trust – ongoing work will continue past 2017/18	MD		Q4				
		2	Investment in environmental ligature improvements as per the 2016/19 plan	DO		Q4				
S	Improvement in medicines management	2	100% compliance with the protocol for the safe storage of medicines	MD		Q1				
		1	100% compliance for daily fridge temperature monitoring	MD		Qrtly				
		1	100% compliance with the reason for omitted doses recorded	MD		Qrtly				
		2	100% compliance with the documentation of the	MD		Qrtly				

			administration of covert medicines							
S	Zero tolerance for non-compliance with the Mental Health Act and Mental Health Law	1	Monthly mental health act audit demonstrates 100% compliance in all areas	MD		Qrtly				
A R	Services are responsive to the needs of service users	1	92% compliance for all national waiting time targets and 18 week waits for first definitive treatment for all services	DO		Monthly				
		1	100% compliance with 3 hour assessment target for service users entering the Place of Safety	DO		Qrtly	Trajectory by Quarter: Q1 – 70% Q2 – 80% Q3 – 90% Q4 – 100%			

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

RISK: *The Trust fails to exploit its potential in research and innovation, losing credibility and reputation and under achieving in delivering evidence based care.*	**Gross Risk (no mitigation)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/18)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
Risk Trend Arrow	4	3	12	3	3	9	2	3	6

Links to 12+ Trust Risks	**Description of linked 12+ Trust Risks**
	• **Not Linked to any Trust Wide Risk**

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

• **Complaints and Concerns Report** • **Incident Reports** • **SI Reports** • **Clinical Audit**		• **Quality Account** • **Annual Governance Statement**

SPAR Reference	CONTROLS to Mitigate Strategic Risk	Level of Assurance	Description of Assurance	Exec Owner	Year Start RAG	Quarter Due	Forward Plan / Progress	Q1 RAG	On Target RAG	Year End RAG
A	Increased reputation and profile as an influential mental health research organisation	3	Develop and agree a formal partnership agreement with Higher Education Institutions in areas of mutual interest	MD		Q2				
		1	Increased number of research collaborations by 10% from baseline	MD		2.5 % by Q1				
		1	Increased external funding for research by 10% from baseline	MD		2.5 % by Q1				
		2	A strategic appointment is made with a local Higher Education Institution	MD		Q4				
A	Refreshed Research Strategy is implemented	1	To refocus the research strategy to incorporate innovation, with Board approval following the appointment of a new R&D Director	MD		Q3				
S P A R	Empowering innovation across our workforce and service users	1	Dragons Den is re-launched with a focus on innovation and value makers under the auspices of the Research and Innovation Team, co-led with the service user and carer council	MD		Q4				

		2	The innovative shared care ward (ward 4) is commissioned recurrently by commissioners	DO		Q1				
S P A R	The 'Towards Outstanding' leadership programme is implemented	3	The Trust participates in the 'Go Engage' programme internally branded as 'Towards Outstanding - Engagement'. It partakes in 4 annual quarterly checks and 2 cohorts of 10+ pioneer teams.	DLW		Q4				
		3	The Trust will demonstrate improved engagement via Go Engage Survey by end Q4 from the baseline survey	DLW		Q4				
		1	The trust will hold two open LiA events this year to listen and respond to staff ideas and suggestions contributing to increased staff engagement	DLW		Q3				
		1	The directorates will develop a plan to hold 10 Leadership academy sessions throughout the year - linked to Board Development, BAF and SLT development themes.	DLW		Q1				
A	Review of models of care and care pathways	2	Review of care pathways associated with Meridian work on productivity	DSD		Q2				

		2	Plan to deliver directorate specific and cross directorate benefits of productivity improvements linked to a review of the 2 year plan	DSD		Q3				
		1	The PICU development is delivered to time and target	DO		Q4				
		1	The Place of Safety development is delivered to time and target	DO		Q2				
P A R	Digital innovations	1	Extension of the FLO and autographer innovation to develop a self-managed integrated care pathway for MCI and dementia patients	MD		Q3				
			Work will be undertaken in collaboration with Primary Care and UHNM to become more accessible to patients through the use of video consultation	MD		Q4				

Objective 4:	To create a learning culture to continually improve							
SPAR PRIORITY								
Exec owner:	Director of Leadership and Workforce							
Assurance Committee:	People and Culture Committee							
Risk appetite	Financial		Quality (Innovation)		Regulation		Reputation	

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 (31/03/18)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
Risk Trend Arrow	3	4	12	2	4	8	2	4	8

Links to 12+ Trust Risks	**Description of linked 12+ Trust Risks**
	• **Not Linked to any Trust Wide Risk**

Internal Assurance Examples		**External Assurance Examples**
Level 1	**Level 2**	**Level 3**
• **Corporate Performance Report/ Dashboard** • **Internal Performance** • **Reportable Issues Alert** • **Quality Account** • **Internal Audit Reports** • **Practice Improvement & Lessons Learnt Report** • **Complaints and Concerns Report** • **Incident Reports**	• **Internal Audit (linked to annual plan)** • **Strategy implemented** • **Plan realised**	• **National Patient Satisfaction Surveys (F & F Test)** • **Healthwatch Reports** • **Independent Reviews (e.g. Ombudsman Reports)** • **External Visits / Inspection Reports** • **CQC** • **External Audit** • **Benchmarking** • **Quality Account** • **Annual Governance Statement**

• **SI Reports** • **Clinical Audit**										
SPAR Reference	**CONTROLS to Mitigate Strategic Risk**	**Level of Assurance**	**Description of Assurance**	**Exec Owner**	**Year Start RAG**	**Quarter Due**	**Forward Plan / Progress**	**Q1 RAG**	**On Target RAG**	**Year End RAG**
S	Investment in workforce development - Staff knowledge of risk assurance is strengthened	1	Risk assurance is determined at three levels: • Internal level 1 • Internal level 2 • External	ADG		Q2				
		2	Trustwide risks are aligned to the strategic risks as described in the Board Assurance Framework	ADG		Q1				
		1	Team risk registers are developed for Corporate Teams	ADG		Q2				
		3	Assurance on strengthened processes is provided through the Annual Governance Statement	ADG		Q4				
A	Increase financial skills and business and commercial acumen of leaders across the Trust.	1	A comprehensive finance training programme for all non-finance staff is introduced	DFP		Q1				
		1	90% of all budget holders receive annual effective budget management training	DFP		Q4				
S P A R	Develop a strategic partnership with Advancing Quality Alliance (AQuA) as part of towards Outstanding improvement	1	Refreshed Board Development programme	DLW		Q1				
		1	Upskill staff in lean methodology skills releasing time to care and	DLW		Q1				

			enabling staff the lead improvement							
S P A R	The Trust has a wider workforce strategy to attract local people to work here enhanced through a learning and education programme	1	The Trust will reach a target of 34 apprentices trust wide and recoup the levy of £265,000.	DLW		Q4				
		1	Develop a plan for work experience across the trust, with the aim of improving exposure and opportunity.	DLW		Q2				
		2	Deliver plan for work experience resulting in 100% increase from Q4 2016/17	DLW		Q4				
		2	Junior Doctor satisfaction scores (JEST) are maintained within the top 3 trusts in the region	MD		Q4				
P	The quality of PDRs is improved	2	The action plan from the 2016/17 PDR audit undertaken by RSM is implemented	DLW		Q1				
		2	A repeat audit of the quality of PDRs is undertaken by RSM which demonstrates an improvements in the quality of PDRs	DLW		Q4				

Objective 5:	Attract and inspire the best people to work here								
SPAR PRIORITY									
Exec owner:	Director of Leadership and Workforce								
Assurance Committee:	People and Culture Committee								
Risk appetite	Financial		Quality (Innovation)		Regulation		Reputation		

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 (31/03/18)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
Risk Trend Arrow	4	4	16	3	4	12	2	4	8

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

Internal Assurance Examples		**External Assurance Examples**
Level 1	**Level 2**	**Level 3**
• **Corporate Performance Report/ Dashboard** • **Internal Performance** • **Reportable Issues Alert** • **Quality Account** • **Internal Audit Reports** • **Practice Improvement & Lessons Learnt Report** • **Complaints and Concerns Report**	• **Internal Audit (linked to annual plan)**	• **National Patient Satisfaction Surveys (F & F Test)** • **Healthwatch Reports** • **Independent Reviews (e.g. Ombudsman Reports)** • **External Visits / Inspection Reports** • **CQC** • **External Audit** • **Benchmarking** • **Quality Account**

• **Incident Reports** • **SI Reports** • **Clinical Audit**		• **Annual Governance Statement**

SPAR Reference	**CONTROLS to Mitigate Strategic Risk**	**Level of Assurance**	**Description of Assurance**	**Exec Owner**	**Year Start RAG**	**Quarter Due**	**Forward Plan / Progress**	**Q1 RAG**	**On Target RAG**	**Year End RAG**
S P A R	A talented Board with strong leadership skills	2	Trust self-assessment of the new model well-led CQC inspection process is undertaken	ADG		Q2				
		3	External Trust assessment of the new model well-led CQC inspection process is undertaken	ADG		Q4				
		1	Board Development programme commissioned to align with output from assessment	CEO		Q4				
S A	Attraction and retention schemes are implemented	1	Each directorate will have a competency based work force plan	DLW		Q3				
		1	Each directorate will have plans for utilising the competencies of staff approaching retirement encouraging the retention of skills	DLW		Q2				
		1	Refresh Trust policy to strengthen flexible approaches to employment and career progression	DLW		Q2				
A P	Diversity and Inclusion is strengthened	2	The trust Diversity and Inclusion plan is finalised and implemented resulting	DLW		Q2				

			in improved perception of staff for protected characteristics in the staff survey scores.							
		1	Demonstrate improvement in WRES Actions	DLW		Q4				
S P	A productive workforce through the development and delivery of a Health and Wellbeing strategy	3	100% achievement of the health and wellbeing CQUIN	DLW		Q3 & Q4				
		1	Absence is reduced to below the England average for mental health trusts (4.74%)	DLW		Q4	In month by Q2 and rolling by Q4			
		1	A staff turnover target of under 10% per annum across all staff groups is introduced	DLW		Qrtly	In month by Q2 and rolling by Q4 excluding internal transfers			
A	Improve reputation, support engagement and promote mental health and learning disabilities services	2	The Communications Strategy is fully implemented resulting in wider, more representative and more engaged stakeholders and service users. And, a fully modernised and integrated infrastructure and suite of communication and engagement tolls to promote trust aims, messages and achievements.	DLW		Q4				
		1	The use of social media will be doubled across twitter,	DLW		Q4				

			YouTube and Facebook from the baseline							
			Demonstrate improvement in reputation by undertaking survey in Q1 and Q4 using the process from the NHS Elect survey in Q3 2015	DLW		Q1 and Q4				
S P A R	Professional contribution is enhanced to maximise quality of care	1	An AHP and Social Work strategy is developed	DON		Q2				
		2	Following development of the strategy, key priorities are identified and implemented	DON		Q4				
		1	A medical leadership development programme is developed and implemented with a minimum of 10 medics participating in the programme	MD		Q4				
S P A R	There is an improvement in keys areas of the staff survey to improve the Trust as a place to work	2	Staff engagement score is above national average (current 3.73: national average 3.77)	DLW		Q4				
		2	Presenteeism score is within the national average category (current 68%: national average 58%)	DLW		Q4				
		2	Staff confidence in reporting unsafe clinical practice is increased to above average (current 3.61: national average	DLW		Q4				

			3.64)							
		2	Score for staff recommending the trust as a place to work or receive care is above national average (current 3.56: national average 3.57)	DLW		Q4				
S P A R	Talent management is implemented	1	Implement process and system for recording talent management conversation	DLW		Q1				
		2	All staff bands 8A and above who have had a PDR will have a centrally recorded talent score	DLW		Q2				
		2	All staff who have had a PDR will have a centrally recorded talent score	DLW		Q3				
		2	Using the talent management data, identify two roles and use the talent pools to fill the posts.	DLW		Q4				
		2	Evidence that the talent management data has been used to in career progression and staff development through staff stories and examples.	DLW		Q4				
		2	Succession plans are in place for all senior roles across the organisation (band 8A and above)	DLW		Q4				

Objective 6:	Maximise and use our resources intelligently and efficiently							
SPAR PRIORITY								
Exec owner:	Director of Finance and Performance							
Assurance Committee:	Finance and Performance Committee							
Risk appetite	Financial		Quality (Innovation)		Regulation		Reputation	

RISK: *The Trust fails to optimise its resources resulting in an inability to be sustainable and increased regulatory scrutiny.*	**Gross Risk (no mitigation)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/18)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
Risk Trend Arrow 	4	5	20	4	4	16	3	4	12

Links to 12+ Trust Risks	**Description of linked 12+ Trust Risks** • 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 Examples		**External Assurance Examples**
Level 1	**Level 2**	**Level 3**
• **Corporate Performance Report/ Dashboard** • **Internal Performance**	• **Internal Audit (linked to annual plan)** • **Strategy implemented**	• **National Patient Satisfaction Surveys (F & F Test)** • **Healthwatch Reports**

• **Reportable Issues Alert** • **Quality Account** • **Internal Audit Reports** • **Practice Improvement & Lessons Learnt Report** • **Complaints and Concerns Report** • **Incident Reports** • **SI Reports** • **Clinical Audit**	• **Plan realised**	• **Independent Reviews (e.g. Ombudsman Reports)** • **External Visits / Inspection Reports** • **CQC** • **External Audit** • **Benchmarking** • **Quality Account** • **Annual Governance Statement**

SPAR Reference	CONTROLS to Mitigate Strategic Risk	Level of Assurance	Description of Assurance	Exec Owner	Year Start RAG	Quarter Due	Forward Plan / Progress	Q1 RAG	On Target RAG	Year End RAG
S A	Development and implementation of a new performance framework resulting in as close to real time data thus enabling credible information to inform the trust strategy	1	Introduction of new Integrated Performance Report	DFP		Q3				
		1	Automation through Data Warehouse of existing manual reporting processes	DFP		Q3				
		2	Development of a Trustwide Information Strategy	DFP		Q1				
		1	Creation of a Data Quality Forum	DFP		Q1				
		1	Development of a Business Intelligence Unit	DFP		Q4				
		2	Effective and collaborative working across areas of clinical and corporate governance are embedded	ADG		Q3				
S	NHSI confidence in the Trust's ability to deliver financial targets	3	Trust maintains segment of 2 or above	TEAM		Qrtly				
		3	Trust meets use of resources metric of 2 or above	DFP		Monthly				

		1	Control target is delivered	TEAM		Q4				
		1	A cash management model is implemented	DFP		Q1				
		1	Agency spend contained within agency cap by the end of Q2	DLW		Q2				
		1	Granular one year CIP plan developed	DO		Q3				
		2	CIP target of £3.2m delivered	DO		Qrtly				
		1	CIP Plans are Quality Impact Assessment (QIA)	DON/ MD		Qrtly				
		2	Affordable 5 year capital plan set	DFP		Q1				
S P A R	Launch Value Makers across the Trust	1	Creation of Value Makers Forum 20 Value Makers awarded	DFP		Q2				
		1	Launch of Value Makers website	DFP		Q1				
		1	Development of value dashboard	DFP		Q3				
A	Increased financial capacity and capability	1	Restructure of the Finance function is undertaken and implemented	DFP		Q3				
A	Provide outstanding quality workforce data as near to real time as possible to inform decision making	1	The trust reduces duplication, increases access to near real time workforce information for managers/team leaders and systems for entering workforce information are improved	DLW		Q4				
		2	Implementation of E-	DON		Q2				

			rostering and centralised temporary staffing services							
A	Improved communication and access to information	1	Replacement of the Trust intranet site	DLW		Q3				
A	Increased workforce productivity and reduced estate	2	As part of Rose benefit realisation – Ensure implementation of agreed approach to agile and mobile working across the Trust	DSD		Q2				
S	Estates capacity / capability is maximised	3	The Estates function within the Trust is fit for purpose	DO		Q3	Q1 – Estates review to be carried out and recommendations implemented. Q1/2 – Potential Management of Change process			
		2	A North Staffordshire MCP Estates plan is developed and implemented, to be linked to the rationalisation of the Trust's estate	DSD		Q3				
		2	An estates optimisation strategy is developed with partner organisations	DSD		Q4				
S P A R	Raising our Service Excellence (ROSE) is implemented	2	Directorate level benefits realisation plans are developed and initiated	DO		Q3				
		1	Increased functionality within clinical teams is deployed across care pathways	DSD		Q3	Pathways Outcome data capture to be introduced and reported			
S P A R	Business planning cycle is embedded in the organisation	2	BDC agrees and monitors action plan in response to the internal audit on business planning and	DSD		Q1				

			bidding							
			BDC approves a framework for decision making on bidding	DSD		Q1				
			All directorates have trust board approved annual plans for delivery of in-year targets within the 2 year plan	DSD		Q1				
			The existing 5 year plan (IBP) is revisited to refresh the strategic aims and objectives	DSD		Q2				
			The 2 year plan is refreshed at the end of the first year to reflect in-year achievements, commissioner intentions and progress of the delivery of the STP	DSD		Q3				

Objective 7:	To continually improve our partnership working
SPAR PRIORITY	
Exec owner:	Director of Strategy and Development
Assurance Committee:	Business Development Committee
Risk appetite	Financial | Quality (Innovation) | Regulation | Reputation

RISK: *The Trust fails to engage its partners resulting in fragmented patient pathways and doesn't align with STP sustainability and transformation plans.*	Gross Risk (no mitigation)			Residual Risk (with mitigation)			Target Risk (31/03/18)		
	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE
Risk Trend Arrow	3	4	12	2	4	8	2	4	8

Links to 12+ Trust Risks	**Description of linked 12+ Trust Risks** • 792 – MCP • 834 – STP • 747 - ROSE

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

Report • **Complaints and Concerns Report** • **Incident Reports** • **SI Reports** • **Clinical Audit**		• **Benchmarking** • **Quality Account** • **Annual Governance Statement**

SPAR Reference	CONTROLS to Mitigate Strategic Risk	Level of Assurance	Description of Assurance	Exec Owner	Year Start RAG	Quarter Due	Forward Plan / Progress	Q1 RAG	On Target RAG	Year End RAG
A	Strengthened partnership working for clinical leads	1	Delivery of a six monthly integrated care conference in partnership with GP colleagues	MD		Q2 and Q4				
A	The organisational structure is aligned to the MCP footprint	2	Plans for an outward facing internal structure to be considered in Q1, aligned to both MCP localities and the Alliance Board thinking	DSD		Q1				
S P A R	Trust works with health economy partners to deliver the concept of a north Staffordshire MCP	2	Respond to outcome of Urgent Care Centre and Out of Hours tender	DSD		Q1				
		2	Co-develop joint specification with partners and commissioners for a Care Coordination hub	DSD		Q3	In-line with commissioner timetable (yet to be decided)			
		2	Alliance Board becomes MCP Board	DSD		Q3				
		2	Development of a joint plan with Stoke –on-Trent City Council for integration of learning disability services	DSD		Q2				
S P A R	Trust develops partnerships with the north Staffordshire GP Federation	2	The Clinical Partnership Board becomes the forum at which shared opportunities for business	DSD		Q1				

			development and discussed and agreed							
		2	A joint strategy is developed to encompass business aims and objectives for the two partners	DSD		Q2				
		1	Develop proposal for HR offer to GP Federation	DLW		Q1				
		1	Develop proposal for Communications offer to GP Federation	DLW		Q1				
		1	Develop an OD plan to support the MCP	DLW		Q2				
S P A R	CEO takes significant leadership role in the STP	3	CEO chairs the Mental Health, digital and System Leadership /OD workstreams enabling delivery of transformation programmes across the STP	CEO		Ongoing				
A	Investment in mental health results in transformation of mental health services	2	There is a clear plan for reducing the number of out of area placements	DFP		Q2				
S P A R	CEO increases trust profile across the region	2	CEO chairing and leading HEE Midlands and East Mental Health programme	CEO		Ongoing				
S P A R	Increased role in corporate / social responsibility and sustainability	2	Development of a corporate / social responsibility strategy	ADG		Q3				
		2	Development of a trust wide energy sustainability strategy	DO		Q2	Q1 – Identify best practice in area. Q1 – Produce draft strategy. Q2 – Strategy to Committee.			

							Q3 – Invest to save opportunity business cases produced for approval in Q4 Risk appetite - Medium			
A	New Models of Care requires a new financial model	2	An agreed set of outcome measures with primary care	DFP		Q3				
		2	A shadow payment model is developed	DFP		Q4				

REPORT TO TRUST BOARD

Enclosure 12

Date of Meeting:	11 May 2017
Title of Report:	Citizens Jury to examine Mental Health Services in North Staffordshire
Presented by:	Maria Nelligan, Executive Director of Nursing & Quality
Author of Report:	Maria Nelligan, Executive Director of Nursing & Quality Carol Sylvester, Deputy Director of Nursing & Quality
Purpose / Intent of Report:	Information
Executive Summary:	North Staffordshire Clinical Commissioning Group developed a Citizens Jury, the first of its kind in the country in 2014. The Citizens Jury puts patients, carers and the interested public at the heart of healthcare commissioning in order to give a real opportunity for patients to shape future services. The concept for a Citizen`s Jury arises from the NHS Constitution and the Francis reports and links to the principles of National Voices, a coalition of Health and Social Care charities in England.
Seen at SLT or **Exec** Meeting & date	SLT / EXEC (and date): Seen by Exec Lead : 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])	
Resource Implications:	

Funding source:	
Equality & Diversity Implications:	
Recommendations:	Note and receive the report for information

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

North Staffordshire Combined Healthcare NHS Trust

CITIZENS JURY TO EXAMINE MENTAL HEALTH SERVICES IN NORTH STAFFORDSHIRE

1 INTRODUCTION/BACKGROUND

North Staffordshire Clinical Commissioning Group developed a Citizens Jury, the first of its kind in the country in 2014. The Citizens Jury puts patients, carers and the interested public at the heart of healthcare commissioning in order to give a real opportunity for patients to shape future services.

The concept for a Citizen`s Jury arises from the NHS Constitution and the Francis reports and links to the principles of National Voices, a coalition of Health and Social Care charities in England.

The first publication of the Citizens Jury review of Diabetic services was described by the CCG as being “highly influential”, making 18 recommendations which were taken up by the CCG in the redesign and specification of commissioned services.

2 CONTEXT

The importance of involving people with lived experience of mental health problems in well-being and mental health policy making is undisputed.

In 2015, a report was published by the North Staffordshire Clinical Commissioning Group detailing the findings from a citizen-led inquiry into the services and experiences of care for people with Diabetes in North Staffordshire. The approach to this enquiry used the Citizens Jury framework.

In November 2016, the Trust was notified of a second commissioned review, “Citizens Jury for Mental Health” with the focus on Adult Mental Health Services.

Sally Parkin, Clinical Director for Partnerships and Engagement outlined that the Patient Congress have been consistent in their view that mental health should have a higher profile and, as such, a decision taken by the CCG to focus energy and resource in this area and the pledge by the CCG for meaningful engagement at every stage of the commissioning cycle.

The CCG welcomed the offer of support from the Trust to ensure that service users and carers including the Service User and Carer Council and professionals will be involved to enable gathering of information.

3 CITIZENS JURY MODEL

The approach is described as being a completely different model of patient involvement, complementing the traditional range of engagement and involvement activities.

The term Citizens Jury was debated at length, however concluded that the Patient Congresses and CCG Boards considered the robust wording would carry more weight and be recognised as different from other types of engagement.

The Jury is independent from the CCG Executive, and led by Board Lay Members for Patient and Public Involvement, Margy Woodhead and Peter Dartford.

The Jury is made up of 10 individuals who may or may not have experience of the topic area. They develop key questions and invite patients and professionals to meet them.

Additionally, national evidence is considered and evidence compiled to produce a report, shared with the Patient Congresses and CCG Boards.

The process is described as “non-adversarial, no organisation or person is on trial” the belief that lay wisdom is of great value and that the process provides great insight. The CCG acknowledges that the process can be challenging however it is confident that the approach works following the success of the Diabetes Jury.

4 PROGRESS TO DATE

The Board Lay Members have been recruited to the Jury which is citizen led and independent of the CCG`s corporate processes. Twelve members make up the Jury who are required to prepare for and attend 6 Jury panel meetings, read through associated material, agree on who should give evidence and contribute to the final report developing recommendations from the review.

Public events are taking place locally and events are to be organised with mental health across other agencies. The Director of Nursing & Quality has offered support to the process and met with one of the Jurors in April. This will also be an agenda item on the Service User & Carer Council.

The Jury will run through 2017 with a report expected in Summer 2017.

5 CONCLUSION

The Trust is committed to working with the service users and carers and responding to feedback to improve the quality of services we provide to people.

We will actively support this process and respond to the call to participate accordingly. A further update will be provided to the Board once the consultation with mental health professionals has taken place.

REPORT TO TRUST BOARD

Date of Meeting:	11 May 2017
Title of Report:	Service User & Carer Council Report
Presented by:	Wendy Dutton, Vice Chair of Service User & Carer Council
Author of Report:	Carol Sylvester, Deputy Director of Nursing
Purpose / Intent of Report:	Information and Assurance
Executive Summary:	This report has been prepared to provide an update of the Service User & Carer Council. The report provides an update on meeting activity and achievements to date.
Seen at SLT or **Exec** Meeting & date	SLT / EXEC (and date): N/A Seen by Exec Lead : Executive Director of Nursing and Quality 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])	None identified
Resource Implications: Funding source:	None identified
Equality & Diversity Implications:	None
Recommendations:	The Trust Board receives the update for information and assurance.

North Staffordshire Combined Healthcare NHS
NHS Trust

SERVICE USER & CARER COUNCIL UPDATE TO TRUST BOARD ON THURSDAY 11 MAY 2017

1 INTRODUCTION

Brief for Board following an Open Space event held on 29 March 2017 and Service & User Carer Council meeting held on 27 April 2017.

2 CONTENT

Workshop at the Service User & Carer Council on 27 April 2017 following Open Space event to look at service/quality improvement the Council wished to prioritise. Feedback was collated and included the following comments and themes:-

- Ensuring care plans are provided during transition from in-patient to community services
- Provision of sufficient supply of medication on discharge
- Ensuring Care Co-ordinator cover consistently when there are absences due to leave or sickness
- Increased focus on recovery
- Provision of a resource pack for staff and service users
- Need to avoid anagrams and jargon in care plans
- Inviting carers as part of the interview process
- Ensuring value is placed on the role of carers in the persons care
- Ensuring consistency in service user involvement in projects, for instance Lorenzo
- Ensure GP awareness of mental health and substance misuse issues - to take back to the MCP.
- To improve communication between teams and ensure timely feedback to service users
- That clinical notes are read prior to service user attending appointments to avoid having to repeat
- Set timescales when care plan is due to be written
- Telephone calls from service users not being returned
- Need Service User and Carer Council information visible on the Trust website

3 NEXT STEPS

The Acting Chair to meet with the Director of Nursing to refresh the Service User & Carer Council Terms of Reference and make arrangements for the election of a new Chair.

Wendy Dutton
Vice Chair - Service User & Carer Council
5 May 2017

REPORT TO Trust Board

Enclosure 14

Date of Meeting:	11th May 2017
Title of Report:	People & Culture Development Committee Summary
Presented by:	Lorien Barber, Chair/Non-Executive Director
Author of Report:	Paul Draycott, Executive Director of Leadership and Workforce
Purpose / Intent of Report:	For information and assurance
Executive Summary:	To summary provides an overview of the People & Culture Development Committee meeting held on May 2nd 2017
Seen at SLT or **Exec** Meeting & date	SLT / EXEC (and date): N/A Seen by Exec Lead : Executive Director of Leadership and Workforce 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])	N/A
Resource Implications: Funding source:	N/A
Equality & Diversity Implications:	N/A
Recommendations:	The Board notes the detail of the summary for assurance.

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

People & Culture Development Committee
Summary to Trust Board
Tuesday 2nd May 2017, 2.30 – 4.30pm

The meeting was chaired by Miss Barber.

1. Policies

The following policies were approved extensions until the end of August 2017:

- Acting Down Policy (Medical Staff)
- Employee Travel Expenses
- On Call Policy

2. Staff Story

A positive staff story was presented to the Committee. This centred on a nurse working in Older Peoples Services that wanted to share her development journey supported by the Trust. She had worked for nearly 30 years for the Trust and developed through roles and various courses and advanced qualifications since joining the Trust in 1988. This had culminated in her becoming a highly specialist and valued member of her team and Directorate, providing excellent patient care.

It was decided that staff members would be invited/videoed to future meetings to provide a first-hand account of their experiences.

3. Staff Survey 2016

The staff survey results had been widely discussed at Board twice, PCD Culture Group and various management meetings so the issue of actions was the focus of the update. Directorates will largely be focussed on PDR quality, presenteeism and openness. Directorate development plans will continue to be monitored by the Committee, and the Go Engage, LIA and Aston processes will continue to be used to effect service improvement and support engagement.

4. Workforce Directorate Performance & Rectification Plans

Updates by exception were received by the Committee. There was noted a general decrease in sickness in the last month but still around the Trust target level.

Overall Trust Rectification Plans were reviewed for Clinical Supervision (80.5%), Statutory/Mandatory training (85%), PDRs (83%), and Agency. Plans provided trajectories for improvement and actions identified. One action is that the new Learning Management System (Moodal) will go live in June after the ROSE launch, and this will assist greatly in the recording of supervision and training. It was also noted that, as anticipated, Statutory/Mandatory Training had been impacted by the increase demands of ROSE implementation. Once implemented it is expected that this performance will improve.

It was also noted that individual Directorates are submitting rectification plans to the SLT Performance management sessions to provide additional assurance that action is being taken and these are monitored on a monthly basis.

5. Board Assurance Framework (BAF)

The Committee review the Quarter 4 2016/17 BAF and signed off the progress for the year.

The Committee reviewed the proposed 2017/18 BAF and agreed the it subject to the the addition of a Talent Management action and an additional action on measuring Trust reputation with stakeholders in Q1 and Q4.

6. Health Education England Mental Health Workforce Strategy

The draft strategy was reviewed by the Committee. The strategy responds to the specific mental health recommendations and outlines and confirms the current specific challenges facing NHS Mental Health Trusts in terms of a current deficit in skills and competencies, high turnover and leavers within the existing workforce set against significant expansion and transformation ambitions.

It is further categorised by five pillars which describe areas of workforce interventions in order to meet the capacity gap.

1. Increasing the attractiveness and improving retention
2. New staff
3. New roles
4. New skills
5. Delivering care differently

The strategy was received and the contents will help inform the Trust Workforce Plan.

7. PDR Audit Findings

An audit of the Performance Development Reviews (PDR) Process was undertaken as part of the approved Internal Audit Periodic Plan for 2016/17. The approved final version of the report was received on 16th March 2017.

The audit was split into two parts with part one of the audit focussing on the practical application of the Personal Development Review Policy across the Trust. This was performed through sample testing of documentation held on staff personal files from various Trust locations and through testing and reviewing of documentation held at the Trust Headquarters by the Workforce, Performance and Governance Teams.

The second part of the audit focused on interviewing a sample of appraisers and appraisees. The interviews covered 17 questions in total and were asked in order to assess their understanding of the PDR process and the processes that they follow. From the review it has been identified that although the Trust has a Performance Development Review framework in place it is not being consistently followed by all in the Trust. This was mainly as a result of changes made part way through the 2016/17 PDR year to the documentation. The audit covered PDRs from April 2017 to October 2017 and therefore different documentation was in place during the timeframe of the audit. There was also confidence expressed that adequate training had been provided however there had been an issue with recording attendance on the system.

The Action Plan has been developed and all agreed actions required to date have been completed. Go Engage will also assist in addressing the actions.

8. Management of Change Ongoing and Pending

It was noted that there are currently no ongoing or pending Management of Change programmes within the Trust.

9. Leadership Academy Masterclass Service

The Leadership Academy Programme was received by the Committee for assurance. Sessions planned for each month over the year include; Medicines Management: MCP Development; Quality Improvement; Diversity and Inclusion; Coaching at Combined; and the intriguingly named "Chimp Paradox".

10. Guidance on Pay for Very Senior Managers

Mr Draycott updated the Committee on the guidance for Very Senior Managers for assurance. This will be discussed in greater detail at the forthcoming Remuneration Committee meeting.

11. Workforce & OD Risks

The Committee reviewed the Workforce & OD Risks and agreed to the following changes:

Risk 868 relating to temporary staffing – No change, retain the residual risk at 12
Risk 901 relating to diverse and inclusive workforce – No change, retain the residual risk at 12
Risk 12 relating to insufficient staff related to vacancies – It was agreed to increase the residual risk from 8 to 12. This relates to the need to increase recruitment activities to fill existing vacancies and recruit to both Ward 4 and later in the year PICU. Therefore the likelihood increased to 3 from 2.
Risk 330 relating to absence because of to stress/anxiety/depression – No change, retain the residual risk at 9

12. PCD Reporting Groups

The relevant papers from SEAL, PLAG, JNCC were submitted to the Committee for information.

13. Any Other Business

The Preceptorship Policy was discussed. It was agreed that the policy would be submitted to JNCC to allow for review and if agreed at JNCC this will then be submitted for a virtual PCD for ratification.

It was noted that the Trust had been shortlisted for the forthcoming Healthcare People Management Association (HPMA) Awards with the Feel Good Friday health and wellbeing initiative which has been chosen as a finalist in the Social Partnership Forum Award for partnership working between employers and trade unions.

In addition the Trust has also been shortlisted in the Academi Wales Award for Excellence in Organisational Development for the Leading with Compassion scheme where staff, patients and carers are able to recognise someone who they believe has demonstrated compassion.

14. Date & Time of Next Meeting

Monday 3rd July 2017at 9.30 am, Boardroom, Trust HQ, Lawton House, Trentham

REPORT TO TRUST BOARD

Enclosure 15

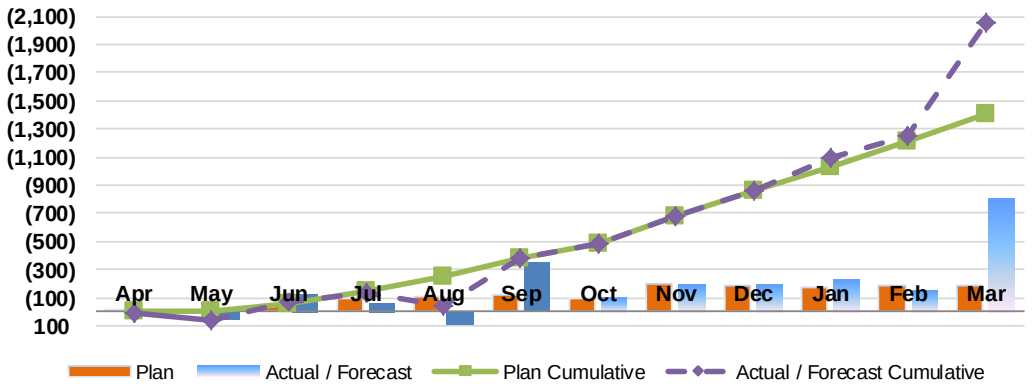
Date of Meeting:	11th May 2017
Title of Report:	Finance Report M12
Presented by:	Suzanne Robinson, Director of Finance and Performance
Author of Report:	Lisa Dodds, Assistant Director of Finance
Purpose / Intent of Report:	Performance and monitoring
Executive Summary:	The report summarises the finance position at month 12
Seen at SLT or **Exec** Meeting & date	SLT/EXEC: (and date) Seen by Exec Lead: Suzanne Robinson Document Version number: 1
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 12

Financial Overview as at 31st March 2017

Income & Expenditure - Control Total (Surplus) / Deficit

£000	Plan	Actual	Var	%	RAG
YTD	(1,400)	(2,051)	(651)	(47)	G

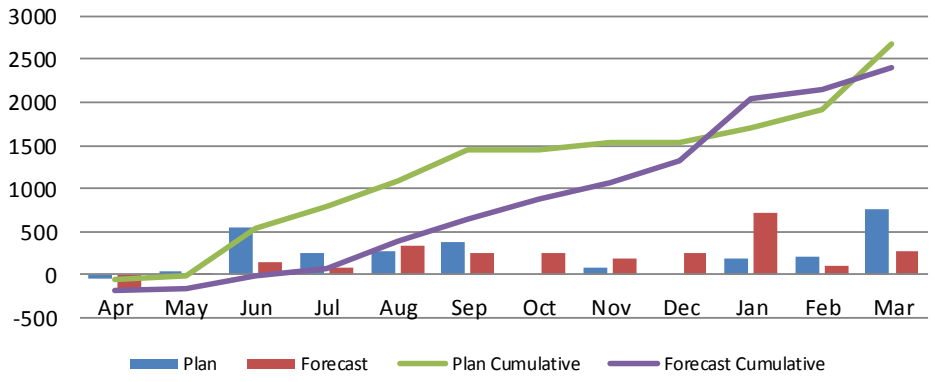
Retained (Surplus) / Deficit Run Rate 2016/17



Net Capital Expenditure

£000	Plan	Actual	Var	%	RAG
YTD	2,743	2,594	(149)	(5)	G

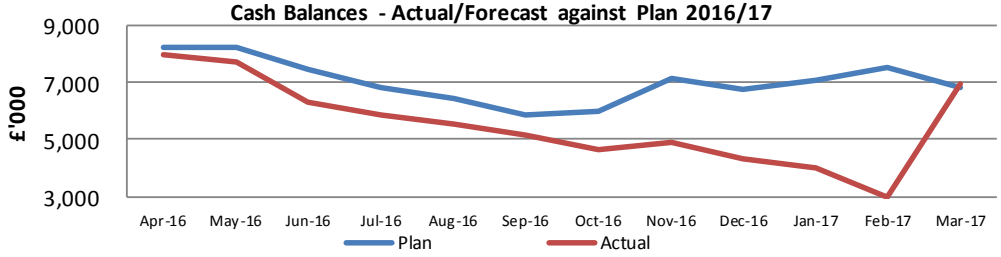
Net Capital Expenditure - Plan / Forecast 2016/17



Cash Balances

£000	Plan	Actual	Var	%	RAG
YTD	6,827	6,964	137	2	G

Cash Balances - Actual/Forecast against Plan 2016/17



Cost Improvement

£000	Plan	Actual	Var	%	Rec Var	RAG
Clinical	1,799	1,181	(618.0)	(34)	(219.0)	R
Corporate	801	742	(59.0)	(7)	44.0	A
Total	2,600	1,923	(677)	(26)	(175)	R

Use of Resource

Overall Risk Rating	3
Liquidity Ratio	1
Capital Servicing Capacity	2
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.

1. Income & Expenditure (I&E) Performance

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

- The trust had an adjusted retained outturn of £947k against a plan of £900k; **a favourable variance to plan of £47k**;
- When including Sustainability and Transformation Funding (STF), the trust had a Control Total surplus £2,051k against a plan of £1,400k; **a favourable variance to plan of £651k**.

		Month 12			Year to Date		
Table 1: Statement of Comprehensive Income	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
Income	(80,600)	(7,058)	(7,161)	(104)	(80,600)	(80,778)	(179)
Pay	61,349	5,330	4,705	(625)	61,349	59,275	(2,074)
Non Pay	16,149	1,410	1,776	366	16,149	17,863	1,715
EBITDA (Surplus)/Deficit	**(3,102)**	**(317)**	**(680)**	**(363)**	**(3,102)**	**(3,640)**	**(538)**
Other Costs	2,202	174	521	347	2,202	2,692	490
Adjusted Retained Position (Surplus)/Deficit	**(900)**	**(143)**	**(158)**	**(15)**	**(900)**	**(947)**	**(47)**
Sustainability Transformation Funding	(500)	(42)	(646)	(604)	(500)	(1,104)	(604)
Control Total (Surplus)/Deficit	**(1,400)**	**(184)**	**(804)**	**(619)**	**(1,400)**	**(2,051)**	**(651)**

2. Income

Table 2 below shows the trust income position by contract:

- The NHS Stoke-on-Trent CCG and NHS North Staffordshire CCG contracts are set on a block basis. The Trust is showing an **over performance of £268k** year to date across both CCG's, relating to RAID 24/7, Healthcare Facilitation and Children's Services waiting list funding.

- Under recovery of £235k on Specialised Services is due to a reduction of beds during construction period at the Darwin Centre.

- Other income is over performing by £243k, mainly as a result of income received for Dyke Street Carers income (£61k), ESCA drugs (£90k), dementia income (£87k), and workforce (£60k).

- SFT targeted fund income was fully achieved at £500k. Due to the trust exceeding its control total of £900k, additional STF was awarded to the trust of £604k.

		Month 12			Year-to-Date		
Table 2: Income	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
NHS Stoke-on-Trent CCG	(33,549)	(2,892)	(2,905)	(13)	(33,549)	(33,750)	(200)
NHS North Staffordshire CCG	(24,330)	(2,029)	(2,013)	16	(24,330)	(24,398)	(68)
Other NHS	(1,446)	(559)	(680)	(121)	(1,833)	(1,830)	2
Specialised Services	(2,577)	(250)	(240)	9	(2,577)	(2,343)	235
Stoke-on-Trent CC s75	(3,659)	(305)	(299)	6	(3,659)	(3,653)	6
Staffordshire CC s75	(1,062)	(88)	(88)	0	(1,062)	(1,056)	6
Stoke-on-Trent Public Health	(383)	(30)	(2)	28	(383)	(299)	84
Staffordshire Public Health	(613)	(51)	(64)	(13)	(613)	(613)	0
ADS/One Recovery	(2,527)	(211)	(211)	0	(2,527)	(2,527)	0
Other Non NHS	(77)	0	0	0	(77)	(77)	0
Total Clinical Income	**(70,223)**	**(6,414)**	**(6,502)**	**(88)**	**(70,610)**	**(70,546)**	**65**
Other Income	(10,376)	(643)	(1,263)	(620)	(9,989)	(10,233)	(243)
Total Income	**(80,600)**	**(7,058)**	**(7,765)**	**(707)**	**(80,600)**	**(80,778)**	**(179)**
Sustainability Transformation Funding	(500)	(42)	(42)	(0)	(500)	(1,104)	(604)
Total Income Incl. STF	**(81,100)**	**(7,099)**	**(7,807)**	**(708)**	**(81,100)**	**(81,882)**	**(783)**

3. Expenditure

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

		Month 12			Year to Date		
Table 3: Expenditure	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
Medical	7,287	613	597	(16)	7,287	6,374	(913)
Nursing	27,177	2,347	1,886	(461)	27,177	26,498	(679)
Other Clinical	14,302	1,206	1,083	(123)	14,302	12,558	(1,744)
Non-Clinical	10,707	879	871	(8)	10,707	9,916	(791)
Non-NHS	1,875	285	269	(17)	1,875	3,929	2,054
Total Pay	**61,349**	**5,330**	**4,705**	**(625)**	**61,349**	**59,275**	**(2,074)**
Drugs & Clinical Supplies	2,135	177	221	44	2,135	2,142	6
Establishment Costs	1,656	135	211	75	1,656	1,697	41
Premises Costs	1,780	141	265	124	1,780	1,941	162
Information Technology	549	166	80	(87)	549	644	95
Private Finance Initiative	3,923	327	340	13	3,923	4,093	170
Other	6,105	463	660	197	6,105	7,346	1,241
Total Non-Pay	**16,149**	**1,410**	**1,776**	**366**	**16,149**	**17,863**	**1,715**
Depreciation exc. IFRIC	891	65	72	7	891	898	7
Investment Revenue	(20)	(2)	(0)	1	(20)	(13)	7
Other Gains & (Losses)	0	0	0	0	0	0	0
LGPS	0	0	8	8	0	8	8
Finance Costs	1,327	111	111	0	1,327	1,327	(0)
Fixed Asset Impairment	0	0	0	0	0	1,173	1,173
Change in Discount Rate	0	0	35	35	0	35	35
Unwinding of Discounts	0	0	3	3	0	3	3
Dividends Payble on PDC	561	47	48	1	561	562	1
IFRIC Adjustment	(557)	(46)	246	292	(557)	(127)	430
Impairment Adjustment	0	0	0	0	0	(1,173)	(1,173)
Total Non-op. Costs	**2,202**	**174**	**521**	**347**	**2,202**	**2,692**	**490**
Total Expenditure	**79,699**	**6,915**	**7,003**	**89**	**79,699**	**79,831**	**131**

Key

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

Impairment

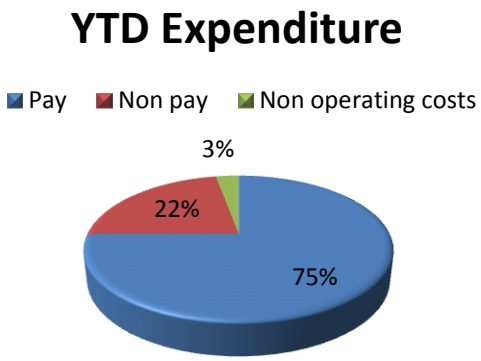
The impairment is a consequence of the revaluation of the Trust estate and is explained fully on page 5.

Pay

- There is a net underspend on pay of £2,074k year to date due to vacancies across the trust, particularly in Medical (£913k), Other Clinical (£1,744k) and Nursing (£1,155k) being backfilled with premium agency and bank.

- Agency expenditure of £3,929k year to date, with £1,336k being attributable to ROSE. Excluding ROSE and ward 4 agency staffing, this is above the agency ceiling projected expenditure of £2,068k by £395k. This is mainly driven by Medical agency (£301k) above projection, nursing agency above projection (£92k).

- A £476k 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 (£250k) 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 (£220k). IT is overspend year to date due to Microsoft licences (£95k).

- '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	17,365	16,302	(1,063)	3,910	4,636	726	(1,923)	(1,935)	(12)	19,352	19,003	(349)
AMH Inpatients	6,346	6,842	496	179	414	235	0	(4)	(4)	6,525	7,252	727
Children's Services	5,961	5,920	(41)	699	796	97	(925)	(895)	29	5,736	5,821	85
Substance Misuse	3,098	2,935	(163)	785	663	(121)	(483)	(354)	129	3,400	3,244	(155)
Learning Disabilities	5,118	4,752	(366)	399	337	(62)	(55)	(54)	1	5,462	5,035	(427)
Neuro & Old Age Psychiatry	10,434	10,533	99	747	706	(41)	(932)	(995)	(63)	10,249	10,244	(5)
Corporate	13,026	11,991	(1,035)	11,632	13,004	1,372	(76,782)	(77,645)	(863)	(52,124)	(52,651)	(527)
Total	**61,349**	**59,275**	**(2,074)**	**18,351**	**20,556**	**2,205**	**(81,100)**	**(81,882)**	**(783)**	**(1,400)**	**(2,051)**	**(651)**

- AMH Community is underspent on pay. The staffing model has been reviewed in conjunction with the Meridian productivity analysis. Non pay is overspent due to the remaining un-transacted CIP target.
- AMH inpatient is overspent on pay mainly due to agency expenditure (£423k – Nursing £237k, Medical £169k), over and above vacancy underspend. Non pay over spends is driven by under achievement of CIP.
- 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 12. The Trust wide CIP achievement is 74% at M12 compared to plan. Of the £1,923k achieved, 87% is recurrent.

		YTD as at M12				FY Value Transacted at M12				
Table 2 : CIP Delivery against Plan	**Annual Target £000's**	**Plan £000's**	**Actual £000's**	**(Under) / Over Achievement £000's**	**% Achievement**	**Non Recurrent £000's**	**Recurrent £000's**	**TOTAL £000's**	**Variance to Annual Target £000's**	**Recurrent Variance to Annual Target £'000**
Clinical:										
AMH Inpatient	289	289	57	(232)	20%	0	57	57	(232)	(136)
AMH Community	707	707	239	(468)	34%	15	224	239	(468)	(121)
Children and Young persons	240	240	287	47	120%	0	287	287	47	48
Learning Disability	153	153	190	37	124%	20	170	190	37	17
Neuro and Old Age Psychiatry	410	410	408	(2)	99%	25	383	408	(2)	(27)
Total Clinical	**1799**	**1,799**	**1,181**	**(618)**	**66%**	**60**	**1,121**	**1,181**	**(618)**	**(219)**
Corporate:										
Quality	33	33	33	(0)	100%	20	13	33	(0)	(19)
Operations	47	47	49	2	104%	0	49	49	2	2
CEO	71	71	0	(71)	0%	0	0	0	(71)	(71)
Strategy	38	38	0	(38)	0%	0	0	0	(38)	(32)
Finance	72	72	29	(43)	40%	0	29	29	(43)	(33)
MACE	48	48	30	(18)	62%	30	0	30	(18)	(49)
Workforce	145	145	145	0	100%	145	0	145	0	(145)
Central/Trustwide	347	347	456	109	132%	0	456	456	109	391
Total Corporate	**801**	**801**	**742**	**(59)**	**93%**	**195**	**547**	**742**	**(59)**	**44**
Total CIP	**2600**	**2,600**	**1,923**	**(677)**	**74%**	**255**	**1,668**	**1,923**	**(677)**	**(175)**

- The year to date CIP achieved stands at £1,923k (74%)
- This is £677k behind plan, in year.
- The recurrent value of transacted is **£2.425k** or **93%** against the **£2.6m** target.

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	31/03/2017 £'000
Non-Current Assets			
Property, Plant & Equipment	30,863	30,726	28,037
Intangible Assets	52	17	222
Trade and Other Receivables	0	568	897
Long Term Receivables (Bucknall)			1,426
Total Non-Current Assets	**30,915**	**31,311**	**30,581**
Current Assets			
Inventories	86	96	88
NHS Trade and Other Receivables	3,017	1,643	2,880
Non NHS Trade and Other Receivables		2,160	2,268
Cash & Cash Equivalents	6,805	7,903	6,964
Total Current Assets	**9,908**	**11,802**	**12,199**
Non-current assets held for sale	2,520	2,198	0
Total Assets	**43,343**	**45,311**	**42,781**
Current Liabilities			
NHS Trade Payables	(864)	(1,963)	(1,114)
Non-NHS Trade Payables	(4,374)	(4,783)	(6,055)
Non-NHS Trade Payables Capital		(116)	(303)
Borrowings	(351)	(346)	(457)
Provisions for Liabilities and charges	(1,682)	(1,298)	(333)
Total Current Liabilities	**(7,271)**	**(8,506)**	**(8,262)**
Net Current Assets / (Liabilities)	**5,157**	**5,494**	**3,938**
Total Assets less Current Liabilities	**36,072**	**36,805**	**34,519**
Non Current Liabilities			
Borrowings	(12,992)	(12,647)	(12,189)
Trade and Other Payables	(558)	0	0
Provisions for Liabilities and charges	(604)	(383)	(474)
Total Non-Current Liabilities	**(14,154)**	**(13,030)**	**(12,663)**
Total Assets Employed	**21,918**	**23,775**	**21,856**
Financed by Taxpayers' Equity			
Public Dividend Capital	7,998	7,648	7,648
Retained Earnings	814	1,800	3,987
Revaluation Reserve	13,664	13,759	9,323
Other Reserves	(558)	568	897
Total Taxpayers' Equity	**21,918**	**23,775**	**21,856**

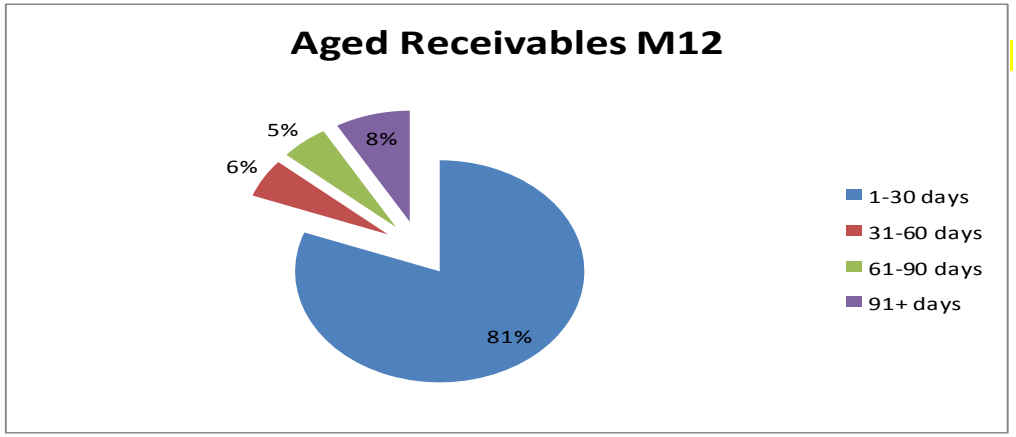
Current receivables are £5,148k

- £2,434k is based on accruals (not yet invoiced) and relates in the main to STF and prepayments.
- £2,714k in awaiting payment on invoice. (£1,589k within terms)

£524k is overdue by 31 Days or more and therefore subject to routine credit control processes;

- £10k has been escalated to management /solicitors;
- £14k has been formally disputed through the M12 Agreement of Balances process;
- £500k 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	727	6	2	29	764
Receivables NHS	1,463	146	143	198	1,950
Payables Non NHS	1,710	26	19	110	1,865
Payables NHS	1,044	17	71	45	1,177

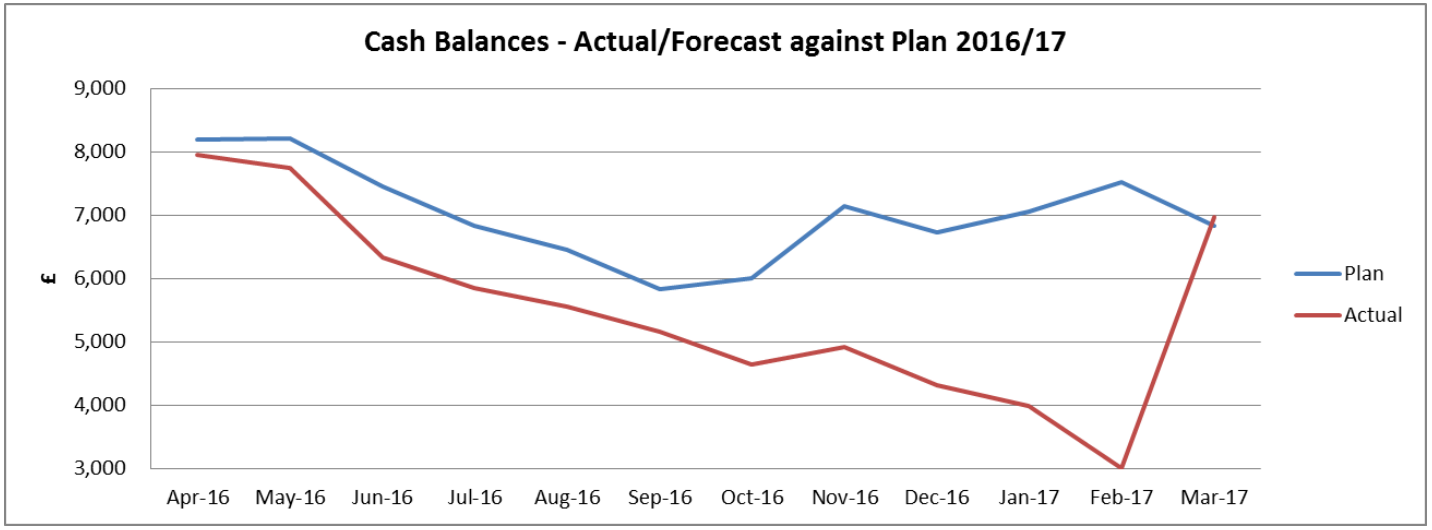


7. Cash Flow Statement

The Trust's cash position was £7.903m at 31 March 2016. The cash balance at 31st March 2017 has decreased to **£6.964m** due to an increase in the value of receivables. The Trust cash position at 31 March 2017 is **£137k higher than planned**

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	(847)	4,107	**1,589**
Net Inflows/(Outflow) from Investing Activities	142	24	(84)	(233)	(173)	(246)	(244)	(185)	(244)	(717)	(109)	(113)	**(2,182)**
Net Inflows/(Outflow) from Financing Activities	(29)	(29)	(29)	(29)	(29)	(29)	(29)	(29)	(28)	(29)	(28)	(29)	**(346)**
Net Increase/(Decrease)	**54**	**(212)**	**(1,417)**	**(480)**	**(284)**	**(405)**	**(518)**	**281**	**(604)**	**(335)**	**(984)**	**3,965**	**(939)**
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**	**2,999**	
Closing Cash & Cash Equivalents	**7,957**	**7,745**	**6,328**	**5,848**	**5,564**	**5,159**	**4,641**	**4,922**	**4,318**	**3,983**	**2,999**	**6,964**	
Plan	8,204	8,219	7,457	6,827	6,453	5,841	5,997	7,137	6,738	7,057	7,527	6,827	
Variance	**247**	**474**	**1,129**	**979**	**889**	**682**	**1,356**	**2,215**	**2,420**	**3,074**	**4,528**	**(137)**	



The significant increase in the cash balance from February to March is due to NHS Digital Paying EPR implementation invoices, for which the trust had incurred expenditure.

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.

Table 8: Capital Expenditure	Annual Plan £'000	Year to Date		
		Plan £'000	Actual £'000	Variance £'000
Darwin Upgrade	704	704	711	7
Reduced Ligature Risks Darwin	0	0		0
A&T and Telford Unit Purchase	432	432	438	6
IOU beds	0	0	2	2
Hazelhurst Unit Development	300	300	0	(300)
Psychiatric Intensive Care Unit	150	150	195	45
EPR	57	57	56	(1)
e-rostering	90	90	98	8
Information Technology	450	450	449	(1)
Environmental Improvements	46	46	46	0
Equipment & Other Schemes	313	313	399	86
Backlog Maintenance	143	143	136	(7)
Be-Able	30	30	36	6
Go-Engage	28	28	28	0
Total Gross Capital Expenditure	**2,743**	**2,743**	**2,594**	**(149)**

- 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 2016; the project has been delayed and with full completion of the project at the end of April; the beds however were fully opened in March 2017.
- The purchase of the A&T Telford building has now been finalised.
- Other schemes have been developed during the year for the IT replacement programme, backlog maintenance programme and environmental improvements.

9. Use of Resource Metrics

The NHSI Single Oversight Framework has been in effect from 1st October 2016. 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	3,850	
Annual Operating Expenses	77,319	
Liquidity Ratio days	18	
Liquidity Ratio Metric	**1**	
Capital Servicing Capacity (times)		
Revenue Available for Debt Service	4,569	
Annual Debt Service	2,247	
Capital Servicing Capacity (times)	2.0	
Capital Servicing Capacity Metric	**2**	
I&E Margin		
Normalised Surplus/(Deficit)	2,051	
Total Income	81,882	
I&E Margin	0.03	
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	2,068	
Agency Spend	3,929	
Agency %	90	
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 **19%** above the providers cap at a risk rating of 2 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 12, the Trust has under-performed against this target for the number of invoices, having paid 88% 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. Non 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	508	13,183	13,691
Total Paid within Target	418	12,405	12,823	459	11,610	12,069
% 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%**	**-4.6%**	**-6.9%**	**-6.8%**
Value of Invoices						
Total Value Paid (£000s)	6,477	19,136	25,613	6,860	29,380	36,240
Total Value Paid within Target (£000s)	6,429	18,393	24,822	6,385	27,914	34,299
% 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%**	**-1.9%**	**0.0%**	**-0.4%**

11. Recommendations

The Trust Board is asked to:

Note:

- Month 12 the trust reported a surplus of **£2,051k against a plan of £1,400k surplus**;
- CIP achievement in month 12 is
    - 74% achieved in year of £1,923k, with an adverse variance of £677k from plan
    - 93% recurrent achievement of £2.425m, with an adverse variance of £175k from plan
- The cash position of the Trust as at 31st March 2017 with a **balance of £6,964k**; £137k above plan.
- Capital expenditure for 2016/17 is £2,594k compared to a plan of £2,743k. This an **underspend against the capital plan of £149k**; and
- Use of resource rating of **3**.

Approve

- The month 12 position reported to NHSI

REPORT TO TRUST BOARD

Enclosure 16

Date of Meeting:	11 May 2017
Title of Report:	Summary of the Finance and Performance Committee meeting held on 4th May 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 4th May 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, 11th May 2017

Finance and Performance (F&P) Committee Report to the Trust Board – 4th May 2017

This paper details the issues discussed at the Finance and Performance Committee meeting on the 4th May. The meeting was quorate with minutes approved from the previous meeting on the 30th March 2017. Progress was reviewed and actions confirmed taken from previous meetings.

Director of Finance Update

The following updates were given by the Director of Finance;

Local updates;

- An update was provided on the Capped Expenditure Process (CEP) which given the distance from control levels at an STP level has been triggered by NHSE/NHSi.

Accounts Updates;

- As requested at Audit Committee accounts review, a detailed breakdown of the provisions and consultancy spend in 17-18 was provided for assurance
- A summary of the Year-End financial position was provided for clarity, which presented the trading surplus before and after any technical accountancy adjustments.

Finance

The committee reviewed the Month 12 Finance position which is £2.051m surplus against a plan of £1.4m which included an additional £604k of SFT funding earned through achieving the £1.4m control.

The capital spend was £149k behind spend at £2,594k

Cash balances were within required limits.

Other Reports and Updates

The Committee received additional assurance reports as follows:

- Capital outturn
- Cost Improvement Programme
- Agency utilisation report
- Corporate Benchmarking

Performance

- **Performance Report (PQMF)**

This report provides the committee with a summary of performance to the end of Month 12 (March 2017).

Delayed Transfers of Care (DTOCs) – concerns were raised about the delayed discharges although assurance was provided that the deep dive report would pull out any key issues. A trend line will be included going forward to understand performance over a longer period. Readmissions will also be considered in the review, and will provide assurance that the trust is recording emergency reemissions accurately.

The committee discussed the CAMHS waiting times for CYP and ASD. There was acknowledgment that improvement had been made overall, however there were concerns that the performance had plateaued. It was confirmed that the directorate acknowledged that a degree of operational and management transformation was required to support the further recovery of the waiting list position. It was agreed that scrutiny of the list was required at the committee until performance had improved. The committee cannot provide assurance that this will be achieved, but is assured that adequate importance is placed on addressing this.

The CPA target remains off track and although the numbers are low this was not recovering at the rate expected. NHSE have indicated the standard could be increased to allow for 48 hour follow and the committee have asked for shadow monitoring of this ahead on mandatory reporting.

- **Financial Risk Register**

The paper describes the risks contained within the Trust risk register which falls under the portfolio of the Finance and Performance Committee. The committee was comfortable that all relevant risks were being captured.

- **Board Assurance Q4**

The paper was received and performance deemed variable. It was acknowledged that further work was required to finalize the year end position. There was some good achievement on key objectives. It was agreed that further transparent and reporting to committee would be provided on the PFI.

- **Board Assurance 1718**

The committee confirmed approval of the objectives outlined for 1718 noting the key challenges around CIP delivery and financial control alongside maintaining good performance.

- **For Information**
  - Market Assessment / Tenders
  - Business Development Group Committee minutes received
  - Finance and Activity Attendance Monitoring Schedule
  - Cash Management
  - Cycle of Business - The Committee was informed that this is being reviewed and will be reissued on the new financial year.

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

Enclosure 17

Date of Meeting:	11th May 2017
Title of Report:	Trust Self Certification – Condition G6 – The provider has taken all precautions necessary to comply with the license, NHS Acts and NHS Constitution.
Presented by:	Laurie Wrench, Associate Director of Governance
Author of Report:	Laurie Wrench, Associate Director of Governance
Purpose / Intent of Report:	Approval
Executive Summary:	This is the first year NHS trusts must self-certify. Although NHS trusts are exempt from needing the provider licence, directions from the Secretary of State require the NHS Trust Development Authority to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate. The Single Oversight Framework (SOF) bases its oversight on the NHS provider licence. NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions (including Condition G6 and Condition FT4) and must self-certify under these licence provisions. NHS trusts are required to self-certify that they can meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that they have complied with governance requirements. Trust Board must self-certify and confirm compliance against condition G6 by 31st May 2017
Seen at SLT or **Exec** Meeting & date	SLT/EXEC: Execs Date: 2nd May 2017 Document Version number: 1
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 Single Oversight Framework (SOF) bases its oversight on the NHS provider licence. NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions (including Condition G6 and Condition FT4) and must self-certify under these licence provisions
Resource Implications: Funding source:	None
Equality & Diversity Implications:	None
Recommendations:	• The Board approve the self-certification for condition G6

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

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

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

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

Signature		**Signature**	
Name	David Rogers	**Name**	Caroline Donovan
Capacity	Chair	**Capacity**	Chief Executive
Date	11th May 2017	**Date**	11th May 2017

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

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North Staffordshire Combined Healthcare NHS Trust

REPORT TO Trust Board

Enclosure 18

Date of Meeting:	11th May 2017
Title of Report:	Register of Board Members - Declarations of Interest
Presented by:	Laurie Wrench, Associate Director of Governance
Author of Report:	Jo Lloyd, Corporate Governance Manager
Purpose / Intent of Report:	To provide an update as at 30th April 2017 of current member's interests, given the change in membership - Andrew Hughes joined.
Executive Summary:	It is the Trust Board's responsibility to ensure the Trust operates its services in an open and transparent way. In line with the Code of Conduct and Accountability for NHS Board members and the Trust's Standards of Business Conduct Policy this information is published on the website and available for public view.
Seen at SLT or **Exec** Meeting & date	SLT / EXEC (and date): - Seen by Exec Lead : - Not applicable 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])	The register enclosed is in line with current legislation.
Resource Implications: Funding source:	n/a
Equality & Diversity Implications:	n/a
Recommendations:	To accept the register as a true and accurate record. This will be

	uploaded to our external Trust website.

NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST

REGISTER OF DIRECTORS' DECLARED PRIVATE INTERESTS

As at 30th April 2017

NAME OF DIRECTOR	INTEREST DECLARED
D Rogers Chairman	**Crystal Care Solutions Ltd** Chairman and Stakeholder
T Gadsby Non Executive Director	**MedicAlert Foundation, British Isles and Ireland** Chairman of Trustee Board **MedicAlert Trading, British Isles and Ireland** Director
P Sullivan Non Executive Director	**Care Quality Commission** Mental Health Act Reviewer **Health, Education and Social Care Chamber (Mental Health)** Fee-paid Specialist Lay Member of the First-tier Tribunal **HMP Drake Hall** Member of Independent Monitoring Board
B Johnson Non Executive Director	**No interests declared**
J Walley Non Executive Director Commenced 01/12/16	**City Learning Trust** Vice Chairperson **Burslem Regeneration Trust** Chairperson **Carrick Court Freehold Company** Director **Aldersgate Group** Chairperson
L Barber Non Executive Director Commenced 01/12/16	**Macmillan Cancer Support** Employee
K Tattum GP Associate Director	**Baddeley Green GP Surgery** Senior Partner **BGS Medical Ltd** Director/owner **North Staffordshire Local Medical Committee** Member
J Harvey Staff Side Representative	**No interests declared**

C Donovan Chief Executive	**Health Education England – Midlands & East LETB** Mental Health LETB (Local Education Training Board) Group Chair.
Dr B Adeyemo Executive Medical Director	**Staffordshire University** Honorary Lecturer
P Draycott Director of Leadership & Workforce (*non-voting*)	**No interests declared**
M Nelligan Director of Nursing & Quality	**Hospice of the Good Shepherd** Company Director
S Robinson Director of Finance and Performance	**No interests declared**
A Rogers Director of Operations (*non-voting*)	**No interests declared**
L Wrench Associate Director of Governance	**Wrench Fine Jewellery (t/a Timecraft)** Family business
A Hughes Joint Director of Strategy & Development	**Joint Director of Strategy & Development** Joint post with GP Federation **Partners in Paediatrics** Chair **Teenage Cancer Trust** Safeguarding Trustee (Non-Executive Director), **Meant Ltd** Owner and Director **Meant Consortium Ltd** Owner and Director **The Village Rainbow Ltd** Owner and Director **Ashbourne Retailers Association** Member **School of the Built Environment, Oxford Brookes University** Specialist Lecturer

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

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

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

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

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

The Code of Conduct and Code of Accountability in the NHS can be viewed on the Department of Health website at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4116281